Northwoods Acupuncture & Wellness Center

(612) 600-5761

New Patient Stress Relief Form

All information provided is held strictly confidential. This form will not be released to a third party without your consent.

Today's Date

Last Name **First Name** **Middle Initial**

Address: **State** Minnesota **Zip Code:**

Home Phone

Cell Phone

Work Phone

Which of these numbers is best to leave a message on?

Would you like to be on my email list to receive my newsletter and specials?

Birth Date **Age** **Height** **Weight** **Sex**

Occupation **Employer** **Hours/Week**

Marital Status

- ☐ Single
- ☐ Widowed
- ☐ Separated
- ☐ Divorced
- ☐ Married/Living with Significant Other

Person to Notify in Case of Emergency

Name

Phone

Relationship

Spouse's Name **Age** **Occupation**

How many children do you have?

Have you ever received acupuncture before?

Is there a possibility you might be pregnant?

Are you allergic to any essential oils?

Do you have a blood condition (i.e. anemia or clotting disorder?)

Are you taking any anticoagulants or antiplatelet drugs?

Do you have high blood pressure?

Have you ever been diagnosed with Hepatitis? **Type:** **Date Diagnosed**

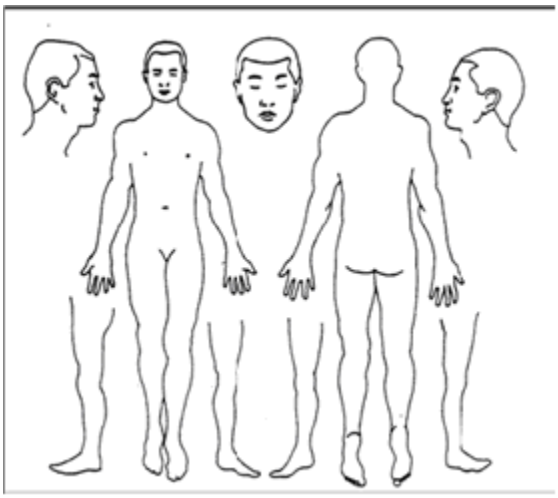
Have you ever been diagnosed with HIV/AIDS? **Which:** **Date Diagnosed**

Please check ALL symptoms that you currently experience:

- ☐ Fatigue
- ☐ Cannot shut mind off
- ☐ Poor Concentration
- ☐ Forgetful / Poor Memory
- ☐ Irritability / Anger
- ☐ Mood Swings
- ☐ Sadness / Depression
- ☐ Frequent crying
- ☐ Fearful
- ☐ Frequent sighing or yawning
- ☐ Headaches
- ☐ Migraines
- ☐ Back Pain
- ☐ Neck / Shoulder Pain

Please mark the following codes where you feel pain or discomfort:
XXX = sharp pain or stabbing pain; PPP = Pins & Needles; DDD = Dull/Aching; NNN = Numbness

******If completing this form online, the therapist will ask you to complete this diagram on your initial visit.**



What do you do to relax?

Do you participate in spiritual practices?
If yes, what?

How many hours per night do you sleep? **Do you fall asleep easily?** **Vivid Dreams?**

Wake in the middle of the night? **Disturbing Dreams?** **Wake rested?**

Is there anything else that you would like me to know?

I hereby give consent for treatment by Amy Kaiser, L.Ac..
I accept full financial responsibility for all medical services performed on my behalf.

Signed _____ **Date**_____

Once complete, save to your desktop and email as an attachment to amy@northwoodsacu.com