MANKATO Acupuncture CLINIC
530 N. Riverfront Dr., Suite 130 • Mankato, MN 56001 • (507) 469-4788

Confidential Patient Information Sheet

Patient Information

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Email: _____

Height: _____ Weight: _____ Age: _____ Sex: M F Dominant Hand: L R

Date of Birth: _____ Marital Status: _____

Number of Children: _____ Ages of Children: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Relation: _____

Primary Care Physician: _____ Clinic: _____

Last Seen: _____ Reason for Visit: _____

How did you hear about Mankato Acupuncture Clinic? _____

Referred by: _____

Medical History

Reason for your visit today? _____

_____

How long have you had this condition? _____

Are you being treated for this condition by anyone else? _____If yes, who? _____

_____ Phone Number: _____

Has this condition been diagnosed by a MD? _____ Diagnosis? _____

Have these treatments helped? Yes Somewhat Not much Not at all

Have you had acupuncture before? Y N Name of acupuncturist: _____

Do you have any infectious diseases? Y N Possibly If yes, please identify: _____

Hospitalizations/Surgeries/Injuries: _____

_____

Health Inventory

Cardiovascular	**Emotional/Mental**	**Energy & Immunity**	**Respiratory**
___ Heart Disease ___ Pacemaker ___ High BP ___ Low BP ___Chest Pain ___Palpitations ___Stroke ___Varicose Veins ___Edema	___ Clinical Depression ___ Mild Depression ___ ADD or ADHD ___ Schizophrenia ___ Mood Swings ___ Panic Attacks ___ Nervousness ___ Anxiety ___ Alzheimer's ___ Dementia	___ Chronic Fatigue Syndrome ___ General Fatigue ___ Slow Wound Healing ___ Easy Bruising ___ Chronic Infections ___ Frequent Allergies	___ Pneumonia ___ Asthma ___ Frequent Common Colds ___ Difficulty Breathing ___ Emphysema ___ Persistent Cough ___ Pleurisy ___ Tuberculosis ___ Shortness of Breath
Musculo-Skeletal	**Head, Eye, Ear, Nose & Throat**	**Gastrointestinal**	**Endocrine**
___ Neck/Shoulder Pain ___ Muscle Spasm/ Cramps ___ Arm Pain ___ Upper Back Pain ___ Mid Back Pain ___ Low Back Pain ___ Leg Pain ___ Osteoporosis ___ Arthritis ___ Joint Pain	___ Impaired Vision ___ Eye Pain/Strain ___ Glaucoma ___ Glasses/Contacts ___ Tearing/Dryness ___ Impaired Hearing ___ Ear Ringing ___ Earaches ___ Ear Infections ___ Headaches ___ Sinus Problems ___ Nose Bleeds ___ Teeth Grinding ___ Frequent Sore Throat ___ TMJ/Jaw Problems ___Hay Fever	___ Stomach Ulcers ___ Changes in Appetite ___ Nausea/vomiting ___ Epigastric/Abdominal Pain ___ Passing Gas ___ Heart Burn ___ Belching ___ Gall Bladder Disease ___ Gall Bladder Stones ___ Hemorrhoids ___ Constipation ___ Diarrhea ___ Irritable Bowl Syndrome ___ Leaky Gut Syndrome	___ Hypothyroid ___ Hypoglycemia ___ Hyperthyroid ___ Diabetes Type I ___ Diabetes Type II ___ Night Sweats ___ Unusual Sweating ___ Feeling Hot or Cold **Liver Conditions** ___ Hepatitis A ___ Hepatitis B ___ Hepatitis C
Men Only	**Neurological**	**Genito-Urinary Tract**	**Other**
___ Impotence ___ Vasectomy Date: _____ ___ Prostate Problems ___ Testicular Pain/ Redness/Swelling ___ Low Libido ___ Excessive Libido ___ Painful Intercourse ___ Seminal Emissions	__ Vertigo/Dizziness __ Paralysis __ Numbness/Tingling __ Loss of Balance __ Seizures/Epilepsy	__ Kidney Disease __ Kidney Stones __ Painful Urination __ Dribbling Urination __ Frequent Urination __ Frequent UTI __ Blood in Urine __ Incontinence	__ Cancer Type: _____ __ Fibromyalgia __ Lupus __ Candida __ Anemia __ Rashes __ Eczema/Hives __ Cold Hands/F __ hemophilia __ Thin/Graying

Women Only

Are you pregnant right now? Yes No Trying Maybe Method of Birth Control: _____

Age of your first period: _____ Date of last menses: _____ Age of menopause: _____

Typical length of menses (days): _____ Typical length of cycle in days: _____

Number of Pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____

Hysterectomy: Yes No Date: _____

Check all that apply:

___ Low libido	___ Excessive Libido	___ Painful Intercourse	___ Clotting
___ Painful periods	___ Heavy Flow	___ Bleeding Between Cycles	___ Scanty Flow
___ Irregular Cycles	___ Vaginal Discharge	___ Breast Lumps/Tenderness	___ Nipple Discharge
___ Infertility	___ Menopausal Symptoms	___ Premenstrual Problems	___ Endometriosis
___ Fibroids	___ Fibrocystic Breast	___ Abnormal Pap Smear	___ Ovarian Cysts

Medications

Please list the medications and supplements you are currently taking, or attach medication sheet:

Drug/Supplement	Reason for Taking	How Long	Dose	Frequency
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

I am taking Coumadin/Warfarin Yes No

I have a pacemaker Yes No

Lifestyle

Are you a vegetarian? Yes No Are you a vegan? Yes No

Do you have a special diet? Yes No If yes, explain: _____

_____

How would you rate the following areas of your health in the past month? Please circle

Energy:	Great	Good	Fair	Poor
Digestion:	Great	Good	Fair	Poor
Urination:	Great	Good	Fair	Poor
Sleep:	Great	Good	Fair	Poor
Appetite:	Great	Good	Fair	Poor
Diet:	Great	Good	Fair	Poor
Exercise:	Great	Good	Fair	Poor
Immunity:	Great	Good	Fair	Poor

How do you feel about the following areas of your life in the past month? Please circle

Significant Other: Great Good Fair Poor

Comments:

Family: Great Good Fair Poor

Comments:

Sex Life: Great Good Fair Poor

Comments:

Self: Great Good Fair Poor

Comments:

Work: Great Good Fair Poor

Comments:

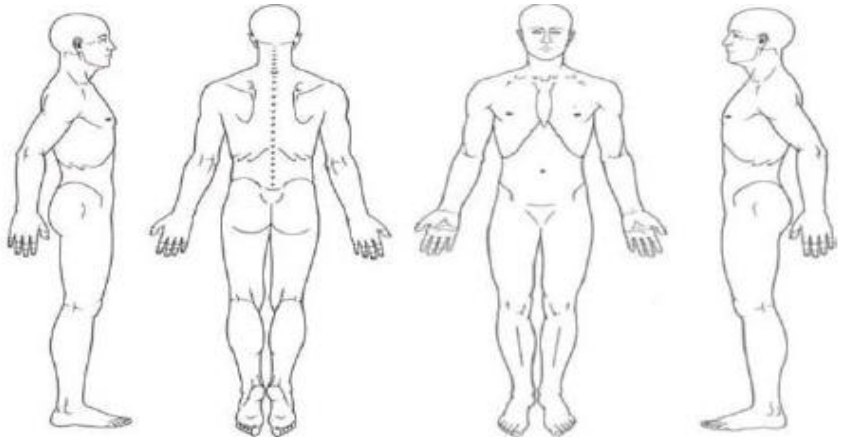
How would you rate your current stress level? Please circle

Extreme Very High High Moderate Low

Comments:

Pain

If you have pain, please indicate its location on the diagrams below.



What's the quality of the pain? Please circle all that apply.

Dull Sharp Stabbing Sore Cramping Burning Constant Fixed Wanders

On a scale of 1-10 (10 being worst) how strong is your pain? _____

Does the pain radiate? Yes No Where? _____

What's the cause of the pain? Injury/Accident Disease Unknown

What helps the pain?

Ice Heat Rest Movement Pressure Moisture Massage Nothing

Other: _____

What aggravates the pain?

Ice Heat Rest Movement Pressure Moisture Massage Nothing

Other: _____

What other treatments have you had for your pain? _____

Is there anything else you feel I need to know? _____

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Mankato Acupuncture Clinic 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

Signed: _____ Date: _____

Parent/Guardian (If applicable): _____