Minneapolis Community Acupuncture
Health History Questionnaire and Registration

PATIENT INFORMATION:

Date: _____

Name: _____
Preferred Pronouns:_____

Address: _____

City State Zip: _____

Age: _____ Birthdate: _____

Occupation: _____

Company Name: _____

Primary Physician: _____

Physician Phone No.: _____

How did you hear about us? _____
_____

CONTACT INFORMATION:

Cell phone: _____

Work Phone: _____

Home/Other phone_____

E-mail: _____

Another person we may contact if needed:

Name: _____

Relationship: _____

Phone: _____

LIST ANY ALLERGIES: _____
_____
_____

HEALTH HISTORY:

What are your primary concerns for coming in for treatment?
1. _____
2. _____
3. _____

How is your sleep? _____
_____

How is your digestion? _____
_____

List medications or supplements you are taking: _____
_____
_____
_____

List serious illnesses, accidents or surgeries: _____
_____
_____

Check illnesses that have occurred in blood relatives:
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Heart disease
- ☐ Kidney disease

Check symptoms you have had in the last year:
- ☐ Depression
- ☐ Difficulty in focusing
- ☐ Dizziness
- ☐ Easily startled
- ☐ Excessive worry
- ☐ Excessive anger
- ☐ Excessive fear
- ☐ Fatigue/tiredness
- ☐ Headaches
- ☐ Loss of sleep/poor sleep
- ☐ Loss or gain of weight
- ☐ Nervousness/irritability
- ☐ Overwhelmed by life

Check conditions you have or have had in the past:
- ☐ HIV/AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Bleeding disorders
- ☐ Seizures
- ☐ Cancer
- ☐ Diabetes
- ☐ PTSD

How long ago did you have a complete medical exam?
_____

HEALTH HISTORY (continued)

Check conditions you have or have had in the past:

MUSCLE/JOINT/BONES
- ☐ Tremors or cramps
- ☐ Swollen joints

Pain, weakness, numbness in:
- ☐ Arms or hips
- ☐ Back or legs
- ☐ Feet or knees
- ☐ Neck
- ☐ Hands
- ☐ Shoulders
- ☐ Other _____

EYES/EAR/NOSE/THROAT/RESPIRATORY
- ☐ Asthma/wheezing
- ☐ Blurred or failing vision
- ☐ Difficulty breathing
- ☐ Earache
- ☐ Enlarged glands
- ☐ Eye pain
- ☐ Frequent colds
- ☐ Hay fever/Allergies
- ☐ Hoarseness
- ☐ Gum trouble
- ☐ Nose bleeds
- ☐ Loss of hearing
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

SKIN
- ☐ Boils
- ☐ Bruise easily
- ☐ Dry Skin
- ☐ Itching/rash
- ☐ Sensitive skin
- ☐ Sore won't heal
- ☐ Sweats

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Low blood pressure

CARDIOVASCULAR (continued)
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Previous heart attack
- ☐ Rapid/irregular heart beat
- ☐ Swelling of ankles
- ☐ Pacemaker
- ☐ Bleeding disorder

GENITO/URINARY/ENDOCRINE
- ☐ Blood/pus in urine
- ☐ Frequent urination
- ☐ Inability to control urine
- ☐ Kidney infection/stones
- ☐ Lowered libido
- ☐ Erection difficulties
- ☐ Penis discharge
- ☐ Prostrate trouble
- ☐ Gender reassignment surgery
- ☐ Hormone therapy
- ☐ Bleeding between periods
- ☐ Clots in menses
- ☐ Extreme menstrual pain
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ PMS
- ☐ Scanty menstrual flow
- ☐ Previous miscarriage

Are you trying to conceive? ☐ Yes ☐ No

Are you possibly pregnant at present? ☐ Yes ☐ No

GASTROINTESTINAL
- ☐ Belching, gas or bloating
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Distention of abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Indigestion
- ☐ Nausea
- ☐ Pain in stomach area
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Hemorrhoids

The information on this form is correct to the best of my knowledge.

SIGNATURE: _____ DATE: _____