Blackstone Acupuncture, LLC
blackstoneacu@gmail.com
612.747.6489

3249 Hennepin Avenue Suite 227
Minneapolis, Minnesota 55408

2913 Harriet Ave. S. Suite 103
Minneapolis, Minnesota 55408

DATE:_____

PATIENT INFORMATION:

Name: _____ Gender: _____

Age: _____ Date of Birth: _____

Home Address: _____

Phone: _____ Email: _____

Emergency Contact:_____ Relationship to Patient: _____

Emergency Contact Phone number: _____

Primary Care Physician (PCP): _____ PCP Phone: _____

Date of last medical examination: _____

Do I have permission to contact your PCP regarding your treatment? Yes No

EXPERIENCE WITH ACUPUNCTURE

Have you received acupuncture treatment before? YES NO

If yes, for what conditions and what was the outcome?

What are your main complaints?

Primary Complaint: _____

_____

_____

Secondary Complaint: _____

_____

_____

_____

PRIMARY COMPLAINT:

Please answer the following questions focusing on your Primary Complaint ONLY:

1. Briefly explain history of your Primary Complaint, i.e. how long have you had this condition; was the onset SUDDEN or GRADUAL; was there a significant event that lead to this condition?

2. Have you seen a physician (or other primary care provider) for your Primary Complaint? If yes, when and what diagnosis did you receive?

3. Other Care: what other therapies are you doing/ have you done to manage your Primary Complaint, e.g. physical therapy, medication, chiropractic, etc.? Did these/are these other therapies helping?

SECONDARY COMPLAINT:

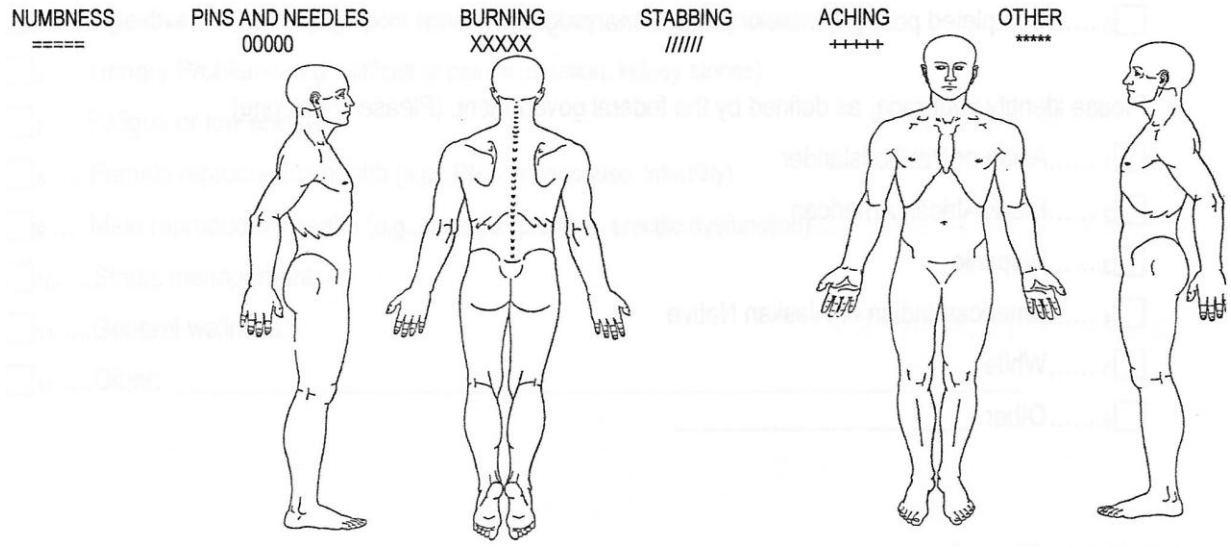
Please answer the following questions focusing on your Secondary Complaint ONLY:

1. Briefly explain history of your Secondary Complaint, i.e. how long have you had this condition; was the onset SUDDEN or GRADUAL; was there a significant event that lead to this condition?

2. Have you seen a physician (or other primary care provider) for your Secondary Complaint? If yes, when and what diagnosis did you receive?

3. Other Care: what other therapies are you doing/ have you done to manage your Secondary Complaint, e.g. physical therapy, medication, chiropractic, etc.? Did these/ are these other therapies helping?

On the diagram, please indicate the areas where you feel symptoms associated with your complaints.



MEDICATIONS, SUPPLEMENTS AND HERBS:

Please list all medications, (prescriptions and over-the-counter drugs) supplements and/or herbs you are CURRENTLY taking:

	Medications, supplements, or herbs:	*Indication/For treatment of:*
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

LIST ANY ALLERGIES (to medications, supplements, herbs):

_____

_____

_____

_____

PERSONAL MEDICAL HISTORY:

BIRTH: Describe anything significant/traumatic about your birth:

VACCINATION HISTORY: Any unusual reaction? Any unusual vaccination?

CHILDHOOD ILLNESSES (0-12 years): Any surgery, accidents and /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____

AGE: _____

ADOLESCENCE ILLNESSES (13-17 years): Any surgery, accidents and /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____

AGE: _____

ADULTHOOD ILLNESSES (18-35 years): Any surgery, accidents and /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____

AGE: _____

ADULTHOOD ILLNESSES (36 and up): Any surgery, accidents and /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____

AGE: _____

FAMILY MEDICAL HISTORY:

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

MOTHER: _____

FATHER: _____

SIBLINGS: _____

MATERNAL GRANDPARENTS: _____

PATERNAL GRANDPARENTS: _____

SYMPTOM OVERVIEW BY SYSTEM:

Please check all symptoms that you are CURRENTLY experiencing AND/OR experience FREQUENTLY. Please indicate (by circling) if the symptom is acute, chronic or experienced frequently.

A = Acute (under 3 months)
C = Chronic (over 3 months experience at some point most days)
F = Experience frequently (on and off)

MUSCULOSKELETAL
___ A C F Joint clicking
___ A C F Limitation of movement
___ A C F Stiffness
___ A C F Spasms or cramps
___ A C F Swelling
___ A C F Weakness
___ A C F Pain: Full body
___ A C F Pain: Facial (e.g. jaw)
___ A C F Pain: Neck
___ A C F Pain: Upper Back
___ A C F Pain: Mid Back
___ A C F Pain: Low Back
___ A C F Pain: Shoulder
___ A C F Pain: Elbow
___ A C F Pain: Wrist
___ A C F Pain: Hand
___ A C F Pain: Hip
___ A C F Pain: Knee
___ A C F Pain: Ankle
___ A C F Pain: Foot
___ A C F OTHER (Please list)

EYES, EARS, NOSE and THROAT
___ A C F Loss of vision
___ A C F Eye pain
___ A C F Tearing or eye dryness
___ A C F Eye discharge
___ A C F Eye redness
___ A C F Ear discharge
___ A C F Ear itching
___ A C F Ear pain and/or infections
___ A C F Loss of hearing
___ A C F Ringing or buzzing in ears
___ A C F Problems with balance (vertigo)
___ A C F Olfaction (sense of smell) impaired
___ A C F Nose obstruction (stuffiness)
___ A C F Nose bleeds
___ A C F Sinus pain, pressure and/or infections
___ A C F OTHER (Please list)

RESPIRATORY
___ A C F Chest pain and/or tightness
___ A C F Bluish discoloration of skin
___ A C F Cough
___ A C F Coughing up blood (hemoptysis)
___ A C F Shortness of breath (dypsnea)
___ A C F Sore throat
___ A C F Sputum production
___ A C F Voice changes
___ A C F Wheezing
___ A C F OTHER (Please list)

CARDIOVASCULAR
___ A C F Changes in skin temperature
___ A C F Chest pain and/or pressure
___ A C F Edema
___ A C F Fainting (syncope)
___ A C F Fatigue
___ A C F Palpitations
___ A C F Skin ulceration
___ A C F Swelling of ankles and/or legs
___ A C F OTHER (Please list)

DIGESTIVE
___ A C F Abdominal distention
___ A C F Abdominal mass
___ A C F Abdominal pain
___ A C F Acid regurgitation and/or Heartburn
___ A C F Alternating constipation/diarrhea
___ A C F Rectal bleeding
___ A C F Constipation
___ A C F Diarrhea
___ A C F Gas
___ A C F Eating disorder
___ A C F Indigestion
___ A C F Jaundice (yellow tint to skin and/or eyes)
___ A C F Nausea
___ A C F Vomiting
___ A C F OTHER (Please list)

UROGENITAL
___ A C F Difficulty with urine flow
___ A C F Incontinence
___ A C F Painful urination (dysurea)

___ A C F Rashes
___ A C F Red urine
___ A C F Urinary tract infection (UTI)
___ A C F OTHER (Please list)

NEUROLOGICAL
___ A C F Changes in consciousness
___ A C F Confusion
___ A C F Difficulty concentrating
___ A C F Dizziness
___ A C F Dysphasia (impaired ability to speak)
___ A C F Gait disturbance
___ A C F Headache
___ A C F Numbness and/or tingling
___ A C F Loss of consciousness
___ A C F Paralysis
___ A C F Post shingles pain
___ A C F Problems coordinating movements
___ A C F Severe forgetfulness
___ A C F Tremor
___ A C F Visual disturbance
___ A C F Weakness
___ A C F OTHER (Please list)

INTEGUMENTARY (SKIN)
___ A C F Changes in hair
___ A C F Changes in nails
___ A C F Changes in skin color
___ A C F Itching (prurites)
___ A C F Never sweat
___ A C F Rash and/or skin lesion
___ A C F Unusual sweating
___ A C F Wounds that will NOT heal
___ A C F OTHER (Please list)

PSYCHOLOGICAL
___ A C F Feelings of grief
___ A C F Feeling of sadness
___ A C F Feeling fearful/anxious/nervous
___ A C F Difficulty managing anger
___ A C F Feeling manic
___ A C F Feeling worried or overly pensive
___ A C F Feelings of panic
___ A C F Feeling overwhelmed
___ A C F Extreme mood swings
___ A C F Extreme lack of emotion
___ A C F OTHER (Please list)

SLEEP
___ A C F Difficulty falling asleep
___ A C F Dream disturbed sleep
___ A C F Wake up and cannot fall back asleep
___ A C F OTHER (Please list)

MISCELLANEOUS
___ A C F Extremely low energy/fatigue
___ A C F OTHER (Please list)

FOR WOMEN ONLY
___ A C F Abnormal vaginal bleeding
___ A C F Changes in hair distribution
___ A C F Fertility concerns
___ A C F Irregular menstruation
___ A C F Menopausal symptoms
___ A C F No menses
___ A C F Pain with menses (dysmenorrhea)
___ A C F Pain during or after sexual relations
___ A C F Pelvic pain
___ A C F Premenstrual symptoms
___ A C F Sexual dysfunction
___ A C F Unusual discharge
___ A C F OTHER (Please list)

Are you pregnant OR trying to become pregnant? Y N

Have you ever been pregnant? Y N
If yes, how many pregnancies:
Births: _____
Miscarriages: _____
Abortions: _____

Periods:
Age of 1st period: _____
Date of most recent period: _____
# of days it lasts: _____

Have you ever had an abnormal pap result? Y N
If yes, please describe:
_____
_____
_____

FOR MEN ONLY
___ A C F Fertility concerns
___ A C F Prostate problems
___ A C F Sexual dysfunction
___ A C F Unusual discharge
___ A C F OTHER (Please list)

MEDICAL DISEASES/CONDITIONS:

Please check all that apply AND indicate (by circling) if it is chronic or if you had the problem in the past, but is now resolved.

C = Current condition
P = Past condition, but is now resolved.

___ C P AIDS/HIV
___ C P Alcoholism and/or substance addiction
___ C P Allergies
(If yes, pls indicate diagnosis and history)

___ C P Anemia
___ C P Asthma
___ C P Bell.s Palsy
___ C P Blood clotting disorder
(If yes, pls indicate diagnosis and history)

___ C P Bipolar disorder
___ C P Cancer (If yes, pls give history)

___ C P Chron.s Disease and/or colitis
___ C P Chronic Fatigue Syndrome (CFIDS)
___ C P Depression (Major)
___ C P Diabetes
___ C P Eczema
___ C P Endometriosis
___ C P Fibroids
___ C P Infertility
___ C P Lung disease, e.g. COPD
(If yes, pls indicate diagnosis and history)

___ C P Fibromyalgia
___ C P Gallstones
___ C P Heart disease
(If yes, pls indicate diagnosis and history)

___ C P Hepatitis A / B / C
___ C P Hernia
___ C P Herpes
___ C P Hypertension
___ C P Hypoglycemia
___ C P Irritable Bowel Syndrome (IBS)
___ C P Joint Replacement
(If yes, pls indicate diagnosis and history)

___ C P Kidney Stones and/or Disease
(If yes, pls indicate diagnosis and history)

___ C P Lupus
___ C P Lyme Disease
___ C P Lymph node removal

___ C P Mitral valve prolapse
___ C P Mood Disorder

___ C P Mononucleosus
___ C P Multiple Sclerosis
___ C P Organ removal or transplant
(If yes, pls indicate diagnosis and history)

___ C P Osteoarthritis
___ C P Osteoporosis
___ C P Pacemaker (heart or stomach)
___ C P Parkinson.s Disease
___ C P Pelvic Inflammatory Disease
___ C P Polio
___ C P Psoriasis
___ C P PTSD (Post-Traumatic Stress Disorder)
___ C P Reflux esophagistis (GERD)
___ C P Rheumatic fever
___ C P Rheumatoid arthritis
___ C P Scarlet Fever
___ C P Schizophrenia
___ C P Scoliosis
___ C P Seizures and /or epilepsy
___ C P Shingles
___ C P Sleep Disorder
___ C P Stroke
___ C P Schizophrenia
___ C P Thyroid disease
(If yes, pls indicate diagnosis and history)

___ C P Ulcer
___ C P Trigeminal Neuralgia
___ C P Tuberculosis
___ C P Vascular disease (e.g. phlebitis)
(If yes, pls indicate diagnosis and history)

___ C P OTHER (pls list)

LIFESTYLE INFORMATION:

Stress, Energy Level and Sleep

What aspects of your life do you enjoy?

What aspects of your life are stressful to you?

Do you think that stress, including any recent major life changes, is contributing to your main complaints and/or negatively impacting any other aspect of your physical or mental health? If yes, briefly describe:

Do you have any problems with your energy level? If yes, please briefly describe:

Do you have any problems with sleep? If yes, please briefly describe:

Do you have any problems with your sexual drive? If yes, please briefly describe:

What do you do for stress reduction?

Diet and Nutrition

Please describe what you typically eat throughout the day:

Breakfast (time of day ____):

Lunch (time of day _____):

Dinner (time of day _____):

Snacks (times of day _____):

What beverages do you drink?

How much water do you drink a day?

Do you experience food cravings? If yes, please describe:

Do you wish to make any changes in what you eat? If yes, please describe:

Do you wish to make any changes in what you drink? If yes, please describe:

Do you believe that your diet has any impact on your complaints? YES NO

Please indicate usage per day or per week. Please circle if the usage was in the past

Cigarettes: _____ Per _____ In the past

Alcohol: _____ Per _____ In the past

Recreational Drugs: _____ Per _____ In the past

Tea: _____ Per _____ In the past

Soft Drinks: _____ Per _____ In the past

Sugar: _____ Per _____ In the past

Coffee: _____ Per _____ In the past

Chocolate: _____ Per _____ In the past

Other: _____ Per _____ In the past

EXERCISE

Do you get regular exercise? If yes, please describe:

Do you spend time outdoors?

What are your goals, hopes and expectation for your acupuncture treatments?