

**Linden Hills Acupuncture**  
**2826 West 43<sup>rd</sup> Street**  
**Minneapolis, MN 55410**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ E-mail : \_\_\_\_\_

Emergency Contact (Name & Phone): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you had acupuncture before? \_\_\_\_\_

Do you have any infectious diseases? Please indicate:

Hepatitis     Yes     No    If yes, type: \_\_\_\_\_

HIV/AIDS     Yes     No

Tuberculosis     Yes     No

STD     Yes     No    If yes, type: \_\_\_\_\_

Other: \_\_\_\_\_

If female, any chance of pregnancy? \_\_\_\_\_

What is your chief complaint? Please describe your symptoms and any previous treatment you have received for them.

Other present illnesses or conditions:

Are you receiving any other treatment at this time?  Yes  No

If yes, describe: \_\_\_\_\_

Please list any medications you are currently using, including prescriptions, OTC, painkillers, dietary supplements, vitamins, minerals, herbs, etc:

**Medical History**  
(Please include dates.)

Surgeries: \_\_\_\_\_

\_\_\_\_\_

Trauma (physical, emotional, abuse): \_\_\_\_\_

\_\_\_\_\_

Addictions (substances and amounts): \_\_\_\_\_  
\_\_\_\_\_

Chemical/Environmental/Occupational Hazard Exposure: \_\_\_\_\_  
\_\_\_\_\_

Parents' Addictions: \_\_\_\_\_  
\_\_\_\_\_

Birth History: \_\_\_\_\_  
\_\_\_\_\_

**Family Medical History** (Please check any that apply):

- Diabetes     Cancer     Seizures     Stroke     Asthma  
 Allergies     Alcoholism     High Blood Pressure     Heart Disease

**Your Habits** (Please check any that apply):

- Cigarettes     Coffee     Tea     Cola     Alcohol  
 Drugs     Sugar     Salt     Other \_\_\_\_\_

**Do you have any allergies?**     Yes     No

If yes, please indicate allergen, symptoms, and season if applicable: \_\_\_\_\_  
\_\_\_\_\_

**Diet** (Please check all that apply):     Vegetarian     Vegan     Whole Foods

- Refined Foods     Meat     Fish     Dairy  
 Chem-Free     Cooked     Junk Food     Other \_\_\_\_\_

Please describe your appetite: \_\_\_\_\_

How many meals do you eat per day? \_\_\_\_\_

Please list any cravings you have: \_\_\_\_\_

What type of beverage do you usually prefer? (Please check.)

Hot       Cold       Room temperature

Do you fast?       Yes       No

If yes, please describe the duration and frequency: \_\_\_\_\_

\_\_\_\_\_

Have you had any eating disorders?       Yes       No

If yes, please describe (include dates): \_\_\_\_\_

\_\_\_\_\_

Is your weight generally stable?       Yes       No

Please describe any recent changes in your weight, if applicable: \_\_\_\_\_

\_\_\_\_\_

Do you like your present weight? \_\_\_\_\_

Please describe any regular exercise: \_\_\_\_\_

\_\_\_\_\_

**Sleeping Patterns:**

How much sleep do you usually get? \_\_\_\_\_

Please describe your sleep schedule: \_\_\_\_\_

Any recent changes? \_\_\_\_\_

Is your sleep generally restful or restless? \_\_\_\_\_

Please check all applicable conditions in the following fields:

**Sleep**

- difficulty falling asleep       difficulty staying asleep  
 dreams disturbed       morning fatigue       night sweats

**Eyes**

- blindness     night blindness     color blindness     glasses/contacts  
 cataracts     glaucoma     blurry vision     laser surgery  
 eye strain     eye pain     infections     discharge  
 spots     floaters     pink eye

**Ears**

- earaches     infections     ringing     hearing loss

**Nose**

- nose bleeds       congestions       sinus problems       polyps

**Mouth/Throat**

- sores       dry throat       copious saliva       gum disease  
 cavities     grinding of teeth     TMJ

**Skin/Hair**

- rashes       eczema       psoriasis       dryness  
 itching       oiliness

**Respiratory**

- asthma       bronchitis     tight chest     cough       coughing blood  
 difficulty breathing (please give details below):  
     at rest       with exercise       while lying down)

**Cardiovascular**

- high blood pressure       low blood pressure       irregular heartbeat  
 fainting       dizziness       cold hands/feet  
 swelling of hands/feet     blood clots       chest pain

**Gastrointestinal**

- nausea       vomiting       belching       bad breath       heartburn
- diarrhea       hemorrhoids       gas       pain/cramps
- gallstones       bloody stools       black stools       anal fissures
- laxative use: (frequency: \_\_\_\_\_)

Bowel movements (please give details below):

Frequency: \_\_\_\_\_

Color: \_\_\_\_\_

Consistency: \_\_\_\_\_

**Musculoskeletal**

- back pain       neck pain       muscle pain       joint pain       arthritis
- cramps       weakness       limited range of motion
- headaches (please give details below):

When? \_\_\_\_\_

Location: \_\_\_\_\_

Quality: \_\_\_\_\_

Severity: \_\_\_\_\_

**Neuropsychological**

- dizziness       seizures       numbness       tingling       pain
- concussion       depression       anxiety       poor memory

Have you ever considered/attempted suicide?       Yes       No

Have you received treatment for any emotional problems?       Yes       No

Do you see a counselor?       Yes       No

**Sexual**

Are you sexually active?       Yes       No

If yes, with what frequency? \_\_\_\_\_

What is your present method of birth control, if any? \_\_\_\_\_

Please describe your previous methods of birth control and any related complications you have experienced: \_\_\_\_\_

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Have you had problems with infertility?     Yes             No

Do you experience pain with sex?             Yes             No

Have you experienced any problems (physical or emotional) related to desire or performance?     Yes             No

If yes, describe: \_\_\_\_\_

**Genitourinary**

- pain with urination     frequent urination     dribbling     blood in urine
- kidney stones             incontinence             urgency     STD
- urinary tract infection                             sleep disrupted by need to urinate

**Male:**     prostate problems     impotence     genital sores             hernia  
               testicular torsion     vasectomy     pain with ejaculation/erection

**Female:**             vaginal discharge     genital sores             breast lumps  
                           breast pain             PID                         STD

Age at menarche: \_\_\_\_\_    Age at menopause: \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

Frequency of menstrual periods: \_\_\_\_\_

Duration: \_\_\_\_\_    Number of heavy days: \_\_\_\_\_

Color: \_\_\_\_\_    Clots: \_\_\_\_\_    Cramps: \_\_\_\_\_

Physical/emotional changes prior to menses: \_\_\_\_\_

\_\_\_\_\_

**Pregnancy history, if applicable:**

Number of pregnancies: \_\_\_\_\_ Number of births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_

Premature births: \_\_\_\_\_ Anesthesia used: \_\_\_\_\_

Complications: \_\_\_\_\_

**Preferences:**

FAVORITE

LEAST FAVORITE

Season

Climate

Temperature

Time of Day

Temperature

Missed Appointment Policy (please initial):

Clients must pay for all scheduled appointments unless cancelled 24 hours in advance.

Initials: \_\_\_\_\_

Thank you,

C. Pruszynski, L. Ac.