Patient Information Sheet

CONFIDENTIAL

Prairie Acupuncture ☐ 1674 W Hill Rd Ste 7 ☐ Boise, Id 83703 ☐ Phone: (303) 916-0911 ☐ www.prairieacupuncture.com

Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date ____ / ____ / ____	First Name	Last Name	Social Security Number

Gender **M F**	Date of Birth ____ / ____ / ____	Age	Marital Status **Single Married Separated Divorced**

Street Address	City	State	Zip

Phone (Daytime) – **Home Work Mobile** *Circle One* ( )	Alternate Phone # **– Home Work Mobile** *Circle One* ( )

Place of Employment ----------	Occupation ----------	Phone Numbers of Emergency Contact Primary ( )	Alternate ( )

Circle Insurance Coverage (Please circle one)

None Workers' Comp Auto Injury Health Insurance Company_____

E-Mail:

How did you hear about us? *Please circle one and write the name*

Current Patient: _____ Doctor: _____Advertisement: _____ Friend: _____Insurance: _____ Other: _____

Healthcare Providers ---please list those you work with.

Physicians: GP/Primary Care: _____ seeking one? □ Y □ N OB-GYN: _____ seeking one? □ Y □ N

Specialist (describe): _____ Chiropractor: ____ Massage Therapist: _____ Physical Therapist:_____

Psychotherapist:_____

seeking one? □ Y □ N seeking one? □ Y □ N seeking one?□Y□N seeking one?□Y□N seeking one?□Y□N

Personal Trainer:_____ seeking one?□Y□N

Midwife:_____ seeking one?□Y□N

Have you seen a Medical Doctor within the last 90 days? _____

Chief complaint: _____

How long? _____ How often: _____

What caused this (accident, lifestyle, drug, etc.)? _____

Describe the worst it can be: _____

What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? _____

Get temporary relief? _____
Fixes problem? _____
Causes side effects? ____

How does this affect your life? _____
Affect your family? _____ Affect your sleep? _____
Affect your work? _____ Affect your hobbies? _____
What is your goal/plan if the problem continues 5/10/20 years? _____

Complaint #2: _____
_____ How long? _____
How often: _____ What caused this (accident, lifestyle, drug, etc.)? ___
_____ Describe the worst it can be: _____
_____ What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? _____
_____

Get temporary relief? _____
Fixes problem? _____
Causes side effects? ____

How does this affect your life? _____
Affect your family? _____ Affect your sleep? _____
Affect your work? _____ Affect your hobbies? _____
What is your goal/plan if the problem continues 5/10/20 years? _____

Other Complaints:

3) _____ 4) _____

MEDICAL CONDITIONS
Please List conditions & surgeries you have had and year diagnosed.

ALLERGIES
Medications, Seasonal, Environmental, Food.

On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better____ Have you had acupuncture before? _____ If yes, where/who _____ Any concerns or fears about the needles? _____ If yes, what? _____ What are your goals of your acupuncture visits?

1. _____
2. _____

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops and nose sprays. NOTE: If need more space, use page 4.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

SYMPTOMS – ****NOTE**: For each symptom you currently have, rate its severity from 1- 5 (5 being the worst). LEAVE BLANK IF NOT APPLICABLE.**

LIVER / GALLBLADDER	***HEART / SMALL INTESTINES***	***SPLEEN / STOMACH***
_____ Irritability / Anger	_____ Heart Palpitations	_____ Heaviness Anywhere in Body
_____ Depression / Stress	_____ Chest Pain	_____ Fatigue / Worse After Eating
_____ Headaches / Migraines	_____ Insomnia / Sleep Problems	_____ Hard to Get Up in the Morning
_____ Visual Problems	_____ Easily Startled	_____ Edema (Swelling)
_____ Red / Dry / Itchy Eyes	_____ Restlessness / Agitation	_____ Muscles Feel Tired Often
_____ Gall Stones	_____ Vivid Dreams	_____ Easily Bruising & Bleeding
_____ Dizziness _____ Blurred Vision	_____ Lack of Joy in Life	_____ Bad Breath _____ Decreased / Increased Appetite
_____ Feeling of Lump in Throat	***LUNG / LARGE INTESTINE***	_____ Crave Sweets
_____ Clenching of Teeth at Night	_____ Dry Cough	_____ Hypoglycemia
_____ Muscle Cramping / Twitching	_____ Cough with Sputum	_____ Difficulty Digesting Oily Foods
_____ Tension	_____ Nasal Discharge	_____ Nausea / Vomiting
_____ Joints/Neck/Shoulder Pain/Tight	_____ Post-Nasal Drip	_____ Gas / Belching
_____ Poor Circulation	_____ Sinus Infection / Congestion	_____ Insulin Sensitivity
_____ Soft / Brittle Nails	_____ Itchy, Red or Painful Throat	_____ Hemorrhoids
_____ Emotional Eater	_____ Dry Mouth / Throat / Nose _____ Skin Rashes / Hives	_____ Constipation _____ Diarrhea
KIDNEY / URINARY BLADDER	_____ Snoring	_____ Abdominal Pain
_____ Urinary Problems	_____ Grief / Sadness	_____ Indigestion / Heartburn
_____ Bladder Infection	_____ Shortness of Breath	_____ Over-Thinking
_____ Lack of Bladder Control	_____ Allergies / Asthma	_____ Tendency to Gain Weight
_____ Weakness / Pain in Lower Back _____ Decrease Bone Density	_____ Low Resistance to Colds or Flu _____ Sneezing	_____ Brain Foggy
_____ Feel Cold Easily	_____ Mild Fever Comes & Goes	
_____ Low Sex Drive	_____ Smoke Cigarettes	
_____ Excess Sexual Desire		
_____ Poor Memory		
_____ Loss of Hair		
_____ Hearing Problems		
_____ Cavities		
_____ Craving / Avoiding Salty Foods		
_____ Fear		
_____ Hot Flush / Night Sweating		

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "**C**" under the appropriate person's column. "**P**" should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the reverse side of this form.

Age	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
AIDS / HIV											
Alcohol											
Anxiety											
Arthritis											
Asthma / Hay Fever / Allergy											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Tobacco											
Weight Problem											
Other Emotional Problems:_____											
Other:_____											

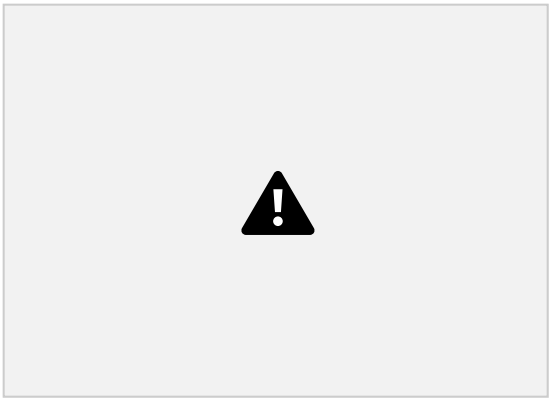
If any of the above family members are deceased, please list their age at death and cause.

MUSCULOSKELETAL

☐ Muscle Cramps – Where? ☐ Muscle Pain / Rheumatism – Where? ☐ Arthritis – Where?

☐ Joint Swelling – Where? ☐ Tendonitis – Where? ☐ Bursitis – Where?

Please mark problem areas on diagram:



Describe Pain and Location

☐ Sharp ☐ Burning ☐ Aching

☐ Fixed ☐ Other:_____

☐ Sharp ☐ Burning ☐ Aching

☐ Fixed ☐ Other:_____

☐ Sharp ☐ Burning ☐ Aching

☐ Fixed ☐ Other:_____

Women Only

Men Only

Hysterectomy – Ovaries Removed? □Yes □No Could You be Pregnant Now?
□Yes □No Number Of: _____ Pregnancies _____ Births _ Miscarriages __
_____ Abortions ___

Post-menopausal Bleeding? □Yes □No When did your last period end?_____ Number of days for monthly cycle?_____ Number of days bleeding lasts?_____

_____ Describe Menstrual Flow:

☐Heavy ☐Moderate ☐Light ☐None

Color of Menstrual Flow:
☐Dark ☐Bright Red ☐Slightly Reddish

Birth Control:

☐ None ☐ IUD ☐ Birth Control Pills

☐ Spermicides ☐ Barriers

☐ Impotence ☐ Weak Erection

☐ Discharge from Penis ☐ Prostate Problems

☐ Testicular Pain or Lump ☐ Infertility

☐ Premature Ejaculation ☐ Low Sex Drive

☐

Do You Suffer From:

☐ Cramping *(Mark as appropriate)*

☐ Severe ☐ Moderate

☐ Mild ☐Before Period

☐ During Period ☐ After Period

☐ Clotting *(Mark as appropriate)*

☐ Bright in Color ☐ Dark in Color

☐ Bleeding Between Periods ☐ Infertility

☐ Pelvic Inflam. Disease ☐ Ovarian Cysts

☐ Endometriosis ☐ Hot Flashes

☐ Mastitis ☐ Breast Cysts

☐ Yeast Infection / Vaginitis / Other Discharge

☐ Premenstrual Syndrome *(Mark as appropriate)*

☐ Fluid Retention ☐ Cravings

☐ Fluctuating Emotions ☐ Irritability

☐ Tenderness in Breasts ☐ Depression

☐ Fatigue

Men and Women

Diet

What kinds (circle)	How much per day/week
Sugar: Candy	_____
Cookies / Baked goods	_____
Regular Soda / Diet Soda	_____
Chocolate	_____
Diary: Milk	_____
Cheese	_____
Yogurt	_____
Ice-cream	_____
White Flour: Bread	_____
Pasta	_____
Coffee	_____
Alcohol	_____
Protein 50g per day?	_____
Eggs	_____
Dark green/vegetables	_____
Fruits	_____
Eat Breakfast?	_____
Eat fast food / on the run?	_____

Additional Notes

Thank you for completing this form. Your time is greatly appreciated and we value this opportunity to serve you!

Everything I have written and answered in this form is true to the best of my knowledge. I will update this office when there are significant changes.

Signature_____ Date_____