Patient Information Sheet

CONFIDENTIAL

Prairie Acupuncture ☯ 4747 Pioneers Blvd, Suite 700 B ☯ Lincoln, NE 68506 ☯ Phone: (402)-937-1810 ☯ 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	Date of Birth	Age	Marital Status
M F	_____ / _____ / _____		**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): _____ seeking one? □ Y □ N
Chiropractor: _____ seeking one? □ Y □ N
Massage Therapist:_____ seeking one?□Y□N
Physical Therapist:_____ seeking one?□Y□N
Psychotherapist:_____ 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) _____

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. _____	**MEDICAL CONDITIONS** Please List conditions & surgeries you have had and year diagnosed. **ALLERGIES** Medications, Seasonal, Environmental, Food.

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

_____ Irritability / Anger
_____ Depression / Stress
_____ Headaches / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness
_____ Blurred Vision
_____ Feeling of Lump in Throat
_____ Clenching of Teeth at Night
_____ Muscle Cramping / Twitching
_____ Tension
_____ Joints/Neck/Shoulder Pain/Tight
_____ Poor Circulation
_____ Soft / Brittle Nails
_____ Emotional Eater

KIDNEY / URINARY BLADDER

_____ Urinary Problems
_____ Bladder Infection
_____ Lack of Bladder Control
_____ Weakness / Pain in Lower Back
_____ Decrease Bone Density
_____ Feel Cold Easily
_____ Low Sex Drive
_____ Excess Sexual Desire
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities
_____ Craving / Avoiding Salty Foods
_____ Fear
_____ Hot Flush / Night Sweating

HEART / SMALL INTESTINES

_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life

LUNG / LARGE INTESTINE

_____ Dry Cough
_____ Cough with Sputum
_____ Nasal Discharge
_____ Post-Nasal Drip
_____ Sinus Infection / Congestion
_____ Itchy, Red or Painful Throat
_____ Dry Mouth / Throat / Nose
_____ Skin Rashes / Hives
_____ Snoring
_____ Grief / Sadness
_____ Shortness of Breath
_____ Allergies / Asthma
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever Comes & Goes
_____ Smoke Cigarettes

SPLEEN / STOMACH

_____ Heaviness Anywhere in Body
_____ Fatigue / Worse After Eating
_____ Hard to Get Up in the Morning
_____ Edema (Swelling)
_____ Muscles Feel Tired Often
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____ Decreased / Increased Appetite
_____ Crave Sweets
_____ Hypoglycemia
_____ Difficulty Digesting Oily Foods
_____ Nausea / Vomiting
_____ Gas / Belching
_____ Insulin Sensitivity
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over-Thinking
_____ Tendency to Gain Weight
_____ Brain Foggy

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.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
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.

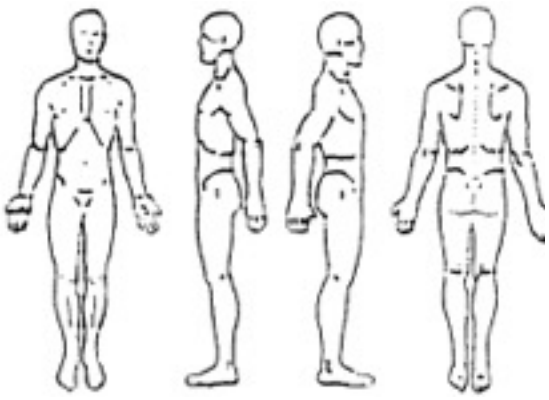
_____

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

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

Men Only

☐ 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_____