

Family Tree Acupuncture

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(612) 805-8131 • www.familytreeacu.com

Health History Form

All information is confidential and shall not be shared without your written consent.

I. Personal Information

Name _____ Date of Birth _____ Today's Date _____

Address _____

Phone (day) _____ (evening) _____

Email _____

Height _____ Weight _____ Marital/Relationship status _____

Primary physician _____

How did you hear about our clinic? _____

Have you ever tried acupuncture/Chinese medicine before? If so, with whom? _____

II. Primary Health Concerns

Please list your primary health concern(s) at this time in order of importance.

(most concerning to least, along with the duration of the symptom)

1. _____

2. _____

3. _____

Onset of condition(s)

1. _____

2. _____

3. _____

How does this interfere with daily activity? _____

Have you been given a physician's diagnosis for this condition? If so, what? _____

What kinds of treatments have you tried, and to what extent have they helped you? _____

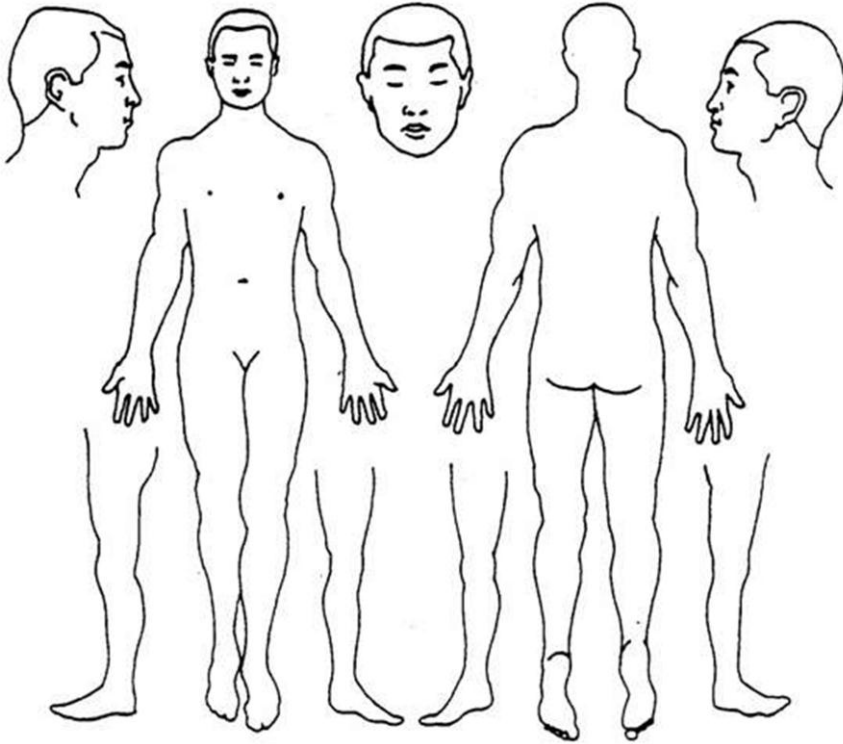
Do you wear a pacemaker? Yes No

Do you have any bleeding disorders? Yes No

Any other health conditions *other than your main complaint(s)* (i.e. high blood pressure, bad back) that I should be aware of that might complicate treating you? (i.e. getting on/off table, etc) _____

Pain:

Use the following illustration to indicate any areas of pain or distress:



Are you experiencing pain/discomfort in any area of your body? **Y / N**

If yes, using the models to the left, please indicate the location of the discomfort by using the symbol that best describes the feeling:

- X X X Sharp/stabbing
- P P P Pins & Needles
- D D D Dull/Aching
- N N N Numbness

For Women:

1. Are you pregnant now? Yes No Unsure
2. Indicate number of pregnancies: Live Births _____ Pregnancies _____ Miscarriages _____
Abortions _____ Caesarian sections _____ Premature Births _____
3. Age: First period ____ Menopause (if applicable) _____
4. Do you have early menopausal symptoms? Yes No If yes, list: _____
5. Date: Last menstrual period ____/____/____ Last Pap Smear ____/____/____ Last Mammogram ____/____/____
6. Any History of an Abnormal Pap Smear? Yes No If so, what / when? _____
7. Is your menses cycle regular? Yes No
 - a) Average number of days of flow _____
 - b) The flow is: Normal Heavy Light
 - c) The color is: Normal Dark Purple Light Brown Brown
 - d) Painful periods: Before period After period Relieved by Heat Relieved by Pressure
8. Do you have the following menstruation related signs/symptoms?
 - Difficulty with orgasm Cramps PMS Heavy Vaginal discharge between periods
 - Pain with Intercourse Nausea Bleeding between Periods
 - Blood Clots Breast Distention Vaginal Discharge
 - Color White Yellow Greenish Bloody/Pus
 - Consistency Thin Thick Watery
9. Any other menstrual/pregnancy related conditions or procedures: _____

For Men:

1. Do you have any bothersome urinary symptoms? Yes No Describe: _____

2. Check all that apply:

- Erectile dysfunction
- Difficulty with orgasm
- Pain or swelling of the testicles
- Frequent need to urinate at night
- Impotence/erectile dysfunction
- Premature ejaculation
- Feeling of coldness or numbness in genitalia
- Pain/Subtly of testicles

3. Do you get up at night to urinate? Yes No How often? _____

4. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?

5. Have you sought Medical intervention for these problems? If so, when? _____

6. What treatments have you tried for these problems and how successful have they been? _____

III. Medical History

Please check all that apply	Date Diagnosed		Date Diagnosed
Diabetes	___/___/___	High Cholesterol	___/___/___
High Blood Pressure	___/___/___	High Blood Pressure	___/___/___
Thyroid Disease	___/___/___	Seizures	___/___/___
Cancer (type)	___/___/___	Hepatitis	___/___/___
HIV	___/___/___	Others	___/___/___

IV. Surgical History (including cosmetic surgery, laparoscopy, etc):

Surgery:	Date:
_____	_____
_____	_____
_____	_____

V. Medications/Supplements

List medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies (to medications, chemicals or foods):

_____	_____	_____
_____	_____	_____

VI. Family Medical History (Please check all that apply)

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart disease					
Cancer (type)					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Substance abuse					
Osteoporosis					
Diabetes					
Glaucoma					
Seizures					

VII. Nutrition

1. Do you follow a special diet? Yes No If yes, how would you describe the diet? (i.e. Vegetarian, Vegan, Low Carb, etc.)

2. Foods you tend to crave: _____

3. Do you or have you ever had an eating disorder? Yes No If yes, when? _____

VIII. Social History

1. How often do you use of the following?

a) Coffee, tea, soft drinks: _____ per _____

b) Alcohol: _____ per _____

c) Tobacco: _____ per _____

d) Other drugs(which?): _____ per _____

2. Have you ever had a problem with *alcohol* or *alcoholism*? Yes No

3. Have you ever had a problem with *dependency* on other drugs? Yes No

If yes, which and when? _____

7. In the past year, how many days did you feel generally in poor health? _____

8. In the past year, how many times were you in the hospital? _____

9. Please describe your current exercise regimen:

Hours per week: _____ Activities: _____ No Exercise

10. How many hours of sleep do you usually get per night during the week? _____

11. Do you awake feeling rested? Yes No Do you feel you sleep well at night? Yes No

12. Who would you describe as your source of primary social support? (relationship to you)

13. What are the primary areas of stress in your life?

IX. Other Information

Please list any significant events or traumas (including falls, auto accidents, divorces/ending of relationships, etc.)

Event:

Approximate Date:

_____	_____
_____	_____
_____	_____

Have you been treated for emotional issues? Yes No If yes, which therapies? _____

Have you ever considered or attempted suicide? Yes No

Have you ever experienced: Sexual assault Sexual abuse Physical abuse Verbal abuse

Do you have any other neurological or psychological problem? Yes No

Do you go on vacation and/or make time to relax regularly? Yes No

Please provide any other information that you think is relevant for us to know:

HEALTH: CHECK ALL THAT APPLY

GENERAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite
<input type="checkbox"/>	<input type="checkbox"/>	Excessive appetite
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Fevers
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Sweat easily
<input type="checkbox"/>	<input type="checkbox"/>	Chills
<input type="checkbox"/>	<input type="checkbox"/>	Localized weakness
<input type="checkbox"/>	<input type="checkbox"/>	Poor coordination
<input type="checkbox"/>	<input type="checkbox"/>	Bleed or bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	Catch cold easily
<input type="checkbox"/>	<input type="checkbox"/>	Change in appetite
<input type="checkbox"/>	<input type="checkbox"/>	Strong thirst
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

CARDIOVASCULAR

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Blood clots
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat
<input type="checkbox"/>	<input type="checkbox"/>	Cold hands / feet
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Difficult breathing
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of hands / feet
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

FEMALE

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urinary tract infections
<input type="checkbox"/>	<input type="checkbox"/>	Frequent vaginal infections
<input type="checkbox"/>	<input type="checkbox"/>	Pain / itching of genitalia
<input type="checkbox"/>	<input type="checkbox"/>	Genital lesions / discharge
<input type="checkbox"/>	<input type="checkbox"/>	Pelvic inflammatory disease
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal pap smear
<input type="checkbox"/>	<input type="checkbox"/>	Irregular menstrual periods
<input type="checkbox"/>	<input type="checkbox"/>	Painful menstrual periods
<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Menopausal syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Breast lumps
<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	Menopausal syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

RESPIRATORY

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds
<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary disease
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood
<input type="checkbox"/>	<input type="checkbox"/>	Production of phlegm
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

SKIN & HAIR

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Rashes
<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Pimples
<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	Tumors, lumps

NEUROLOGICAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling of limbs
<input type="checkbox"/>	<input type="checkbox"/>	Concussion
<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

HEAD & NECK

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Neck stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Enlarged lymph glands
<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Concussions
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

EARS

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Infection
<input type="checkbox"/>	<input type="checkbox"/>	Ringing
<input type="checkbox"/>	<input type="checkbox"/>	Decreased hearing
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

EYES

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	<input type="checkbox"/>	Visual changes
<input type="checkbox"/>	<input type="checkbox"/>	Poor night vision
<input type="checkbox"/>	<input type="checkbox"/>	Spots
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	<input type="checkbox"/>	Glasses / contacts
<input type="checkbox"/>	<input type="checkbox"/>	Eye inflammation
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

NOSE, THROAT, MOUTH

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds
<input type="checkbox"/>	<input type="checkbox"/>	Sinus infections
<input type="checkbox"/>	<input type="checkbox"/>	Hay fever or allergies
<input type="checkbox"/>	<input type="checkbox"/>	Recurring sore throats
<input type="checkbox"/>	<input type="checkbox"/>	Grinding teeth
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing

GASTRO-INTESTINAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Belching
<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools/black
<input type="checkbox"/>	<input type="checkbox"/>	Loose Stools
<input type="checkbox"/>	<input type="checkbox"/>	Bad breath
<input type="checkbox"/>	<input type="checkbox"/>	Rectal pain
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Pain or cramps
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disorder
<input type="checkbox"/>	<input type="checkbox"/>	Gas
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

GENITO-URINARY

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	Pain or urination
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	Urgency to urinate
<input type="checkbox"/>	<input type="checkbox"/>	Unable to hold urine
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

MALE

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Pain / itching genitalia
<input type="checkbox"/>	<input type="checkbox"/>	Genital lesions/ discharge
<input type="checkbox"/>	<input type="checkbox"/>	Impotence
<input type="checkbox"/>	<input type="checkbox"/>	Weak urinary stream
<input type="checkbox"/>	<input type="checkbox"/>	Lumps in testicles
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

PSYCHOLOGICAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety / stress
<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Treated for emotional or
<input type="checkbox"/>	<input type="checkbox"/>	Psychological problems
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

INFECTION SCREENING

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	HIV
<input type="checkbox"/>	<input type="checkbox"/>	TB
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea
<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia
<input type="checkbox"/>	<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	<input type="checkbox"/>	Genital warts
<input type="checkbox"/>	<input type="checkbox"/>	Herpes: oral
<input type="checkbox"/>	<input type="checkbox"/>	Herpes: genital

MUSCULAR-SKELETAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Stiff neck / shoulders
<input type="checkbox"/>	<input type="checkbox"/>	Low back pain
<input type="checkbox"/>	<input type="checkbox"/>	Back pain
<input type="checkbox"/>	<input type="checkbox"/>	Muscle spasm, twitching, cramps
<input type="checkbox"/>	<input type="checkbox"/>	Sore, cold or weak knees
<input type="checkbox"/>	<input type="checkbox"/>	Joint pain

Prices and policies

Should you have to cancel an appointment, a 24 hour advance cancellation notice is required. I understand that certain emergent situations prevent one from having 24 hours in which to cancel an appointment-- in those cases, a phone call informing me of your inability to make your appointment is appreciated. Failure to keep your scheduled appointments and appointments cancelled without 24 hour notice (or a phone call in emergent situations) are subject to a \$50.00 late fee. You are responsible for all fees generated through services rendered at this clinic. Some insurance coverage exists for acupuncture however, at this time; insurance forms will not be submitted from this clinic to your insurance company.

Office Location:

2720 E. 50th St. • Minneapolis, MN 55417
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