

**Long Acupuncture Studios: Patient Health History**

**HealthWise Family Chiropractic**

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**Spine & Sports Institute**

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Maple Grove, MN 55369  
Phone: 612-845-4668  
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Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Birthdate/Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employed by: \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Is it ok to contact you by (please circle): All Email Cell Home Work

Marital Status: S M W D Number of Children \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a Question Mark. Thank you.**

1. When and where did you last receive health care? \_\_\_\_\_

For what reason? \_\_\_\_\_

3. Please identify the health concerns that have brought you to Long Acupuncture Studios for Acupuncture in order of

importance below:

**Condition**

**Past Treatment**

a. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

b. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

c. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to

(please include reaction) \_\_\_\_\_

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking

\_\_\_\_\_

6. Do you have any reason to believe you may be pregnant? Y N If so, how far along are you? \_\_\_\_\_

7. Do you have any infectious diseases? Y N If yes, please identify: \_\_\_\_\_

**8. Family History: (Check those applicable)**

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (If Living)						
Health (G=Good, P= Poor)						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						

Allergies					
Kidney Disease					
Age (at Death)					
Cause of Death					

9. **Height:** \_\_\_\_\_ **Weight:** Currently: \_\_\_\_\_ Past Maximum: \_\_\_\_\_ How Long? \_\_\_\_\_

10. **Blood Pressure:** What is your most recent blood pressure reading? \_\_\_\_/\_\_\_\_

When was this reading taken? \_\_\_\_\_

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever    Diphtheria    Rheumatic Fever    Mumps    Measles    German Measles    Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio    Tetanus    Rubella/Mumps/Rubella    Pertussis    Diphtheria    Hib    Hepatitis B

Others: \_\_\_\_\_

13. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



Stroke Palpitations/Fluttering Heart Murmurs Rheumatic Fever Varicose Veins

20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain  
Passing Gas Heartburn Belching Gall Bladder Disease Liver Disease  
Hepatitis B or C Hemorrhoids Abdominal Pain

21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the

past): Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy  
Flow Kidney Stones Impaired Urination  
Blood in Urine Frequent Urination at Night

22. **Female Reproductive/Breasts**(please circle any that you experience now and underline any that you have experienced

in the past) Irregular Cycles Breast Lumps/Tenderness  
Nipple Discharge Heavy Flow Vaginal Discharge Premenstrual Problems Clotting Bleeding Between  
Cycles Menopausal Symptoms Difficulty Conceiving Painful Periods

23. **Menstrual/Birthing History:**

1. Age of First Menses: \_\_\_\_\_ 2. # of Days of Menses: \_\_\_\_\_ 3. Length of Cycle: \_\_\_\_\_  
4. Birth Control Type: \_\_\_\_\_ 5. # of Pregnancies: \_\_\_\_\_ 6. # of Miscarriages: \_\_\_\_\_  
7. # of Abortions: \_\_\_\_\_ 8. # of Live Births: \_\_\_\_\_

24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the

past): Sexual Difficulties Prostrate Problems

Testicular Pain/Swelling

Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain

Muscle Spasms/Cramps

Arm Pain

Leg Pain

Upper Back Pain

Mid Back Pain

Low Back Pain Joint Pain (if

so, where?): \_\_\_\_\_

26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling

Loss of Balance

Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid

Hypoglycemia

Hyperthyroid

Diabetes Mellitus Night Sweats

Feeling Hot or Cold

28. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia

Cancer

Rashes

Eczema/Hives

Cold Hands/Feet

Is there anything else we should know? \_\_\_\_\_

29. **Lifestyle:**

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

Exercise routine: \_\_\_\_\_

Spiritual practice: \_\_\_\_\_

How many hours per night do you sleep? \_\_\_\_\_ Do you wake rested? Y N

Level of education completed:    High School    Bachelors    Masters    Doctorate    Other

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Hours/Week: \_\_\_\_\_

Do you enjoy work?    Y/N    Why/Why not? \_\_\_\_\_

Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_

Have you experienced any major traumas?    Y    N    Explain: \_\_\_\_\_

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? \_\_\_\_\_

Television habits: \_\_\_\_\_

Reading habits: \_\_\_\_\_

Interests and hobbies: \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

**Would you like to receive our email newsletter?** \_\_\_\_\_