

# Patient Information and History

Your statements are confidential. This form will not be released to a third party without your consent.

Two Turtles Acupuncture Center – 1001 Center Ave, Suite K – Moorhead MN 56560 – (218) 287-4501

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Referred by: \_\_\_\_\_  
City, State & Zip \_\_\_\_\_ Email: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

What is your principle complaint? \_\_\_\_\_  
How long have you had this condition? \_\_\_\_\_ Is it work-related? Y N Auto accident related? Y N  
What activities aggravate your condition? \_\_\_\_\_  
Have you had this or a similar in the past? Y N How long has it been since you really felt good? \_\_\_\_\_

We strive for an integrative approach in every case so please tell us who else is on your health team

MD: \_\_\_\_\_ Clinic: \_\_\_\_\_ Are you happy with their care? Y N  
MD: \_\_\_\_\_ Clinic: \_\_\_\_\_ Are you happy with their care? Y N  
Chiropractor: \_\_\_\_\_ Are you happy with their care? Y N  
Massage: \_\_\_\_\_ Are you happy with their care? Y N  
Other: \_\_\_\_\_ Are you happy with their care? Y N

Childhood Illnesses: Any surgeries or accidents?

Age: \_\_\_\_\_

Adolescent Illnesses: Any surgeries or accidents?

Age: \_\_\_\_\_

Adulthood: Any surgeries or accidents?

Age: \_\_\_\_\_

Please note all major illnesses in your immediate family, like diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please note all medications, herbs, or supplements you are currently taking (use back of sheet if necessary).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Major Medical Conditions

Check any of the following that you or someone in your family has had.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Alcoholism/Addiction | <input type="checkbox"/> Fibromyalgia       | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Gout               | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Birth Trauma         | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Thyroid disorders    |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Ulcers               |
| Type: _____                                   | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Others (specify):    |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Osteoporosis       | _____   |
| <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Pneumonia          | _____   |

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## Diet

- |   |  |
|---|--|
| <input type="checkbox"/> Coffee: cups per day ____      | <input type="checkbox"/> Water: cups per day ____          |
| <input type="checkbox"/> Soft drinks: cups per day ____ | <input type="checkbox"/> Sweets/Refined carbs ____ per day |
| <input type="checkbox"/> Alcohol: cups per week ____    | <input type="checkbox"/> Cravings: Sweet Salty Stimulant   |

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## Lifestyle

- |  |   |
|--|---|
| <input type="checkbox"/> Tobacco: packs per week ____            | Sleep: <input type="checkbox"/> Difficulty falling asleep |
| <input type="checkbox"/> Stress: scale of 1-10 (10 is high) ____ | <input type="checkbox"/> Wake early and/or often          |
| <input type="checkbox"/> Environmental/Occupation Hazards        | # of hours per night: ____                                |
| Describe: _____  |   |

Exercise: Type: \_\_\_\_\_ Frequency: \_\_\_\_\_ Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

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## Head, Eyes, Ears, Nose and Throat

- |   |   |
|---|---|
| <input type="checkbox"/> Headaches:     | <input type="checkbox"/> Eye: redness burning itching tearing |
| Type: _____                             | <input type="checkbox"/> TMJ                                  |
| Frequency: ____ per wk/mo               | <input type="checkbox"/> Dry mouth/thirst                     |
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Swollen glands                       |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Other: _____                         |

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## Respiratory and Cardiovascular

- What was your last blood pressure reading? \_\_\_\_ / \_\_\_\_ Is this typical for you? Y N
- |  |                                       |   |  |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Cold hand/feet     | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Cough        | <input type="checkbox"/> Frequent colds/flu | <input type="checkbox"/> Less stamina  |

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## Gastrointestinal and Metabolic

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Nausea/Vomiting       | Bowel movements:   |
| <input type="checkbox"/> Recent weight gain/loss | <input type="checkbox"/> Gas/Bloating          | Frequency: ____ day  |
| <input type="checkbox"/> Loss of appetite        | <input type="checkbox"/> Acid reflux/heartburn | <input type="checkbox"/> Foul order                                      |
| <input type="checkbox"/> Constant hunger         | <input type="checkbox"/> Intestinal cramping   | <input type="checkbox"/> Loose <input type="checkbox"/> Dry, hard        |
| <input type="checkbox"/> Tired after eating      |  | Stool has: <input type="checkbox"/> Blood <input type="checkbox"/> Mucus |



## Two Turtles Acupuncture Center Financial Policies

Two Turtles Acupuncture Center has a variety of payment methods for your convenience. Payment may be in the form of cash, check, Visa, MasterCard, or Discover.

We offer a variety of services to meet our clients' needs. Please initial next to the service that applies to your visit:

\_\_\_\_\_ Acupuncture; \$95 for your initial visit and treatment;  
\$65 for following visits

\_\_\_\_\_ Nutritional or Herbal consultations; \$95 for initial visit  
\$65 for following visit (plus the cost of herbs/supplements)

We request payment for your treatment at the time of service.

*If your treatment is covered by your health insurance, you may request a receipt to bill your insurance company by attaching the receipt to your claim form and mailing both to your insurance company. All information needed by insurance companies for reimbursement will be included on the receipt.*

If you should need to cancel or reschedule an appointment, we ask that you do so at least 24 hours before your appointment time. **Please note that all missed appointments and all appointments cancelled without 24 hour notice are subject to a \$30 missed appointment fee.**

I have read, understand, and agree to the above information:

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date