# 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

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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.

- ☐ Alcoholism/Addiction
- ☐ Asthma
- ☐ Birth Trauma
- ☐ Cancer
  Type: _____
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Thyroid disorders
- ☐ Ulcers
- ☐ Others (specify):
  _____
  _____

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**Diet**

- ☐ Coffee: cups per day ___
- ☐ Soft drinks: cups per day ___
- ☐ Alcohol: cups per week ___
- ☐ Water: cups per day ___
- ☐ Sweets/Refined carbs ___ per day
- ☐ Cravings: Sweet Salty Stimulant

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**Lifestyle**

- ☐ Tobacco: packs per week ___
- ☐ Stress: scale of 1-10 (10 is high) ___
- ☐ Environmental/Occupation Hazards
  Describe: _____

Sleep: ☐ Difficulty falling asleep
☐ Wake early and/or often
# of hours per night: _____

Exercise: Type: _____ Frequency: _____ Type: _____ Frequency: _____

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**Head, Eyes, Ears, Nose and Throat**

- ☐ Headaches:
  Type: _____
  Frequency: ___ per wk/mo
- ☐ Allergies
- ☐ Sinus problems
- ☐ Eye: redness burning itching tearing
- ☐ TMJ
- ☐ Dry mouth/thirst
- ☐ Swollen glands
- ☐ Other: _____

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**Respiratory and Cardiovascular**

☐ What was your last blood pressure reading? _____ / _____ Is this typical for you? Y N

- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Palpitations
- ☐ Cough
- ☐ Cold hand/feet
- ☐ Frequent colds/flu
- ☐ Bruise easily
- ☐ Less stamina

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**Gastrointestinal and Metabolic**

- ☐ Fatigue
- ☐ Recent weight gain/loss
- ☐ Loss of appetite
- ☐ Constant hunger
- ☐ Tired after eating
- ☐ Nausea/Vomiting
- ☐ Gas/Bloating
- ☐ Acid reflux/heartburn
- ☐ Intestinal cramping

Bowel movements:
Frequency: _____ day
☐ Foul order
☐ Loose ☐ Dry. hard
Stool has: ☐ Blood ☐ Mucus

**Skin and Hair**

- ☐ Acne
- ☐ Rashes/Hives
- ☐ Fungal infections
- ☐ Changes in hair/skin texture
- ☐ Slow wound healing
- ☐ Other: _____

**Neuropsychological**

- ☐ Numbness/tingling
- ☐ Tics/Tremors
- ☐ Vertigo/Dizziness
- ☐ Fainting
- ☐ Hard to focus
- ☐ Mood swings
- ☐ Anxiety
- ☐ Depression
- ☐ Irritability/Anger
- ☐ Poor memory
- ☐ Easily stressed/frazzled
- ☐ Lack of Interest/motivation

**Genito-urinary**

Urination:
- ☐ Painful
- ☐ Frequent
- ☐ Urgent
- ☐ Cloudy/Bloody
- ☐ Incontinence
- ☐ Incomplete
- ☐ Hesitancy/Dribbling

Women:
- ☐ Vaginal dryness
- ☐ Vaginal pain/burning
- ☐ Libido: High Low
- ☐ Other: _____

Men:
- ☐ Premature ejac
- ☐ Impotence
- ☐ Libido: High Low
- ☐ Other: _____

**Female only**

Age menses began: ____
Cycle length: ____ days
Flow lasts _____ days
- ☐ Irregular periods
- ☐ Cramps
- ☐ Clots / Heavy bleeding
- ☐ PMS

History of:
- ☐ Ovarian cysts
- ☐ PCOS
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Fibrocystic breasts

Pregnancies:
# of pregnancies: ___
# of miscarriages: ___
# of births: ___

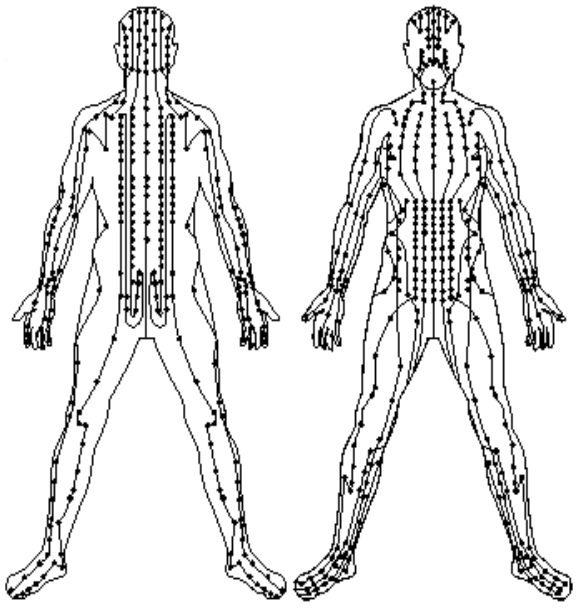
Menopause: Age ___
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Hysterectomy
- ☐ HRT

Type: _____

**Male only**

- ☐ Decreased strength / stamina
- ☐ Decreased motivation / interest
- ☐ Increased fat in hips, breasts, thighs
- ☐ Decreased productivity

**Please indicate any areas of concern or note any additional information you would like us to know.**



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# 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;
$68 for following visits

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