

Patient Information Sheet

CONFIDENTIAL

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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 M F	Date of Birth ____ / ____ / ____	Age	Marital Status Single Married Separated Divorced
Street Address		City	State Zip
Phone (Daytime) – Home Work Mobile <i>Circle One</i> ()		Alternate Phone # – Home Work Mobile <i>Circle One</i> ()	
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? <i>Please circle one and write the name</i> 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? _____

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.

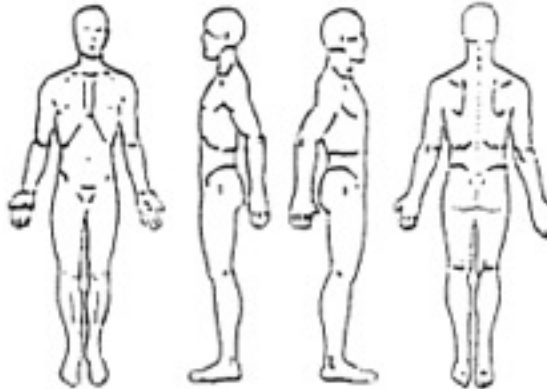
	You	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
<i>Age</i>							
AIDS / HIV							
Alcohol							
Anxiety							
Arthritis							
Asthma / Hay Fever / Allergy							
Back Trouble							
Bursitis							
Cancer							
Constipation							
Depression							
Diabetes							
Digestive Trouble							
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 Inflamm. 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	_____
Dairy: 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 _____