



# Zhen Qi Acupuncture Clinic

2213 East 38th Street, Minneapolis MN 55419  
612.558.1427

PATIENT INFORMATION	CONTACT INFORMATION
<p>Date _____</p> <p>Name _____</p> <p>Address _____</p> <p>City State Zip _____</p> <p>Age _____ Birthdate _____</p> <p>Occupation _____</p> <p>Company name _____</p> <p>Primary physician _____</p> <p>Physician phone number _____</p> <p>How did you hear about us? _____</p> <p>_____</p>	<p>Home phone _____</p> <p>Work phone _____</p> <p>Other/cell phone _____</p> <p>Email _____</p> <p>Another person we may contact if needed:</p> <p>Name _____</p> <p>Relationship _____</p> <p>Home phone _____</p> <p>Work phone _____</p>
HEALTH HISTORY	
<p>What are your primary concerns for coming in for treatment?</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>How is your sleep? _____</p> <p>_____</p> <p>How is your digestion? _____</p> <p>_____</p> <p>List medications or food supplements you are taking.</p> <p>_____</p> <p>_____</p> <p>List serious illnesses, accidents, or surgeries.</p> <p>_____</p> <p>_____</p> <p>Check illnesses that have occurred in blood relatives.</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease <input type="checkbox"/> Kidney disease</p>	<p>Check symptoms you have or have had in the last year.</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Difficulty in focusing</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Easily startled</p> <p><input type="checkbox"/> Excessive worry</p> <p><input type="checkbox"/> Excessive anger</p> <p><input type="checkbox"/> Excessive fear</p> <p><input type="checkbox"/> Fatigue/tiredness</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Loss of sleep/poor sleep</p> <p><input type="checkbox"/> Loss or gain of weight</p> <p><input type="checkbox"/> Nervousness/irritability</p> <p><input type="checkbox"/> Overwhelmed by life</p> <p>Check conditions you have or have had in the past.</p> <p><input type="checkbox"/> AIDS</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Bleeding disorders</p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Diabetes</p> <p>How long has it been since you have had a complete medical exam? _____</p>