Healing InSight

Thank you for choosing Healing InSight!
We're delighted to work with you to help you feel better, look younger and love life.

Name: _____ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

E-mail Address: _____

Would you like to join Healing InSight's email list and stay up-to-date on specials and holistic health topics?
☐ Yes ☐ No ☐ I'm already on it!

Date of Birth: _____ Age: _____ Weight: _____ Height: _____ Gender: _____

Marital Status: ☐ Single ☐ Married or living with significant other
☐ Separated ☐ Divorced ☐ Widowed

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

How did you hear about us?

☐ Twin Cities Live	☐ Facebook	☐ Friend/Family
☐ TV Show	☐ Instagram	☐ Healthcare Provider
☐ TV Commercial	☐ Podcast	☐ Other: _____
☐ Best to the Nest	☐ Magazine	

If you heard about us from someone, please share their name so we can thank them: _____

Have you ever received acupuncture before: _____

Do you have a:
Flex Spending Account (FSA)? ☐ Yes ☐ No Health Savings Account (HSA)? ☐ Yes ☐ No

Payment is due on the day of the appointment.
Receipts for insurance & healthcare/flex spending accounts reimbursements can be provided, please ask!

Please give us 24 hours advance notice if you need to cancel an appointment.
You may be charged if you cancel an appointment without 24 hours notice.

Medical History

What health concern(s) bring you in today? _____

_____

_____

How do these affect your daily life? _____

_____

Have you been examined by a medical doctor for any of these health concerns? Yes / No
If yes, what was the diagnosis? _____

Do you have other health concerns you wish we could help? _____

_____

List any major surgeries you've had: _____

_____

Significant trauma (accidents, falls): _____

_____

Dental Work (fillings, root canals, etc.):_____

Blood Type: □ A □ B □ AB □ O □ Don't know

Have you ever been diagnosed with any of the following:

□ Diabetes	□ High blood pressure	□ Anemia	□ Tuberculosis
□ Blood clots	□ Low blood pressure	□ Depression	□ Cancer
□ Stroke	□ Peripheral neuropathy	□ Anxiety	□ HIV/AIDS
□ Heart Attack	□ Seizures	□ Asthma	□ Hepatitis B

Family medical history (parents, siblings, grandparents) _____

_____

Typical weekly exercise: _____

List what you typically eat during the day: □ Paleo □ Gluten Free □ Vegetarian □ Vegan □ Other

Breakfast: _____

Mid-Morning snacking: _____

Lunch: _____

Afternoon snacking: _____

Dinner: _____

Evening snacking: _____

Foods you avoid/minimize: _____

Health History

Please mark any symptoms you currently have or have had in the past year.

TEMPERATURE
- ☐ Tend to feel hot
- ☐ Tend to feel cold
- ☐ Cold feet
- ☐ Cold back/knees
- ☐ Hot flashes
- ☐ Chills
- ☐ Fever
- ☐ Alternating chills & fever

PERSPIRATION/THIRST
- ☐ Sweat with little exertion
- ☐ Night sweats
- ☐ Can't sweat
- ☐ Thirsty and drink cold
- ☐ Thirsty and drink hot
- ☐ Thirsty but don't drink
- ☐ Not thirsty

ENERGY
- ☐ High energy/nervous
- ☐ Good energy
- ☐ Okay energy/slightly low
- ☐ Low energy/fatigue
- ☐ Frequent yawning
- ☐ Body heaviness

HEAD
- ☐ Headaches
- ☐ Migraines
- ☐ Dizzy/lightheaded
- ☐ Fainting
- ☐ Foggy-headedness
- ☐ Seizures
- ☐ Tremors
- ☐ Sinus congestion
- ☐ Nasal discharge

SENSES
- ☐ Declining vision
- ☐ Eyes sensitive to light
- ☐ Red/itchy eyes
- ☐ Floating spots in vision
- ☐ Poor hearing
- ☐ Ear ringing
- ☐ Poor sense of smell
- ☐ Earaches
- ☐ Decreased night vision

MOUTH
- ☐ Frequent sore throats
- ☐ Poor teeth
- ☐ Mouth/canker sores
- ☐ Lip sores
- ☐ Dry/chapped lips
- ☐ Dry mouth and throat
- ☐ Lump in the throat
- ☐ Swollen/painful gums
- ☐ Taste in mouth, describe: _____

SKIN, HAIR & NAILS
- ☐ Thin/dry nails
- ☐ Thin skin
- ☐ Dry skin
- ☐ Easily bruised
- ☐ Psoriasis
- ☐ Eczema
- ☐ Dark under eyes
- ☐ Lumps
- ☐ Acne
- ☐ Abscesses/infection
- ☐ Prematurely gray hair
- ☐ Hair loss
- ☐ Dry/brittle hair

LUNGS & HEART
- ☐ Wheezing
- ☐ Coughing
- ☐ Short of breath
- ☐ Tight sensation in chest
- ☐ Frequent colds, >2/year
- ☐ Seasonal allergies
- ☐ Slow heart rate
- ☐ Fast heart rate
- ☐ Irregular heart rhythm
- ☐ Palpitations/fluttering sensation
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure

APPETITE & DIGESTION
- ☐ Excessive appetite
- ☐ Poor appetite
- ☐ Excessive saliva
- ☐ Heartburn/reflux
- ☐ Nausea/vomiting
- ☐ Gas
- ☐ Tired after eating
- ☐ Bad breath
- ☐ Bloating/distention
- ☐ Stomach pain
- ☐ Abdominal pain
- ☐ Belching/hiccups
- ☐ Gall stones
- ☐ Pain under ribs

CRAVINGS
□ Sweet
□ Salty
□ Sour
□ Bitter
□ Hot/spicy
□ Strong flavor/pungent
□ Bland
□ Crunchy
□ Other _____

BOWEL MOVEMENTS
□ Constipation
□ Loose stool/diarrhea
□ Alternating constipation and diarrhea
□ Urgent BM
□ Cramps with BM
□ Incomplete BM
□ Burning with BM
□ Hemorrhoids
□ Bowel incontinence
□ Blood or mucus in stool
□ Foul odor
□ Green stool
□ Sticky stool

URINATION
□ Dark urine
□ Cloudy urine
□ Burning urination
□ Scanty urine
□ Profuse urine
□ Decreased bladder control
□ Frequent urination
□ Wake at night twice or more to urinate
□ Difficult urination
□ Incomplete voiding
□ Kidney stones

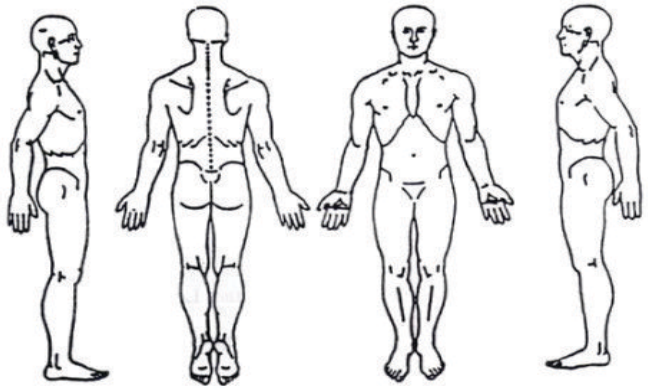
SLEEP
□ Insomnia
□ Excessive sleep
□ Difficulty falling asleep
□ Wake during the night
□ Lots of vivid dreams
□ Disturbing dreams
□ Don't get enough sleep
□ Wake unrefreshed
□ Sleep apnea

Number of hours of sleep each night _____

MENTAL & EMOTIONAL
□ Forgetful/poor memory
□ Poor concentration
□ Irritable/angry
□ Sad
□ Tearful/weepy
□ Restless
□ Anxious/worried
□ Can't stop thinking
□ Fearful/easily startled
□ Manic
□ Depressed
□ Frequent sighing

DIET & LIFESTYLE
□ Poor diet
□ Consume caffeine daily
□ Drink alcohol
□ Smoke cigarettes
□ Chew tobacco
□ Use drugs
□ Too little activity/ exercise
□ Exercise excessively
□ Eating disorder
□ Trauma
□ Job stress/concerns
□ Family stress/concerns
□ Other stress/concerns

MUSCULOSKELETAL & EXTREMITIES
Mark any areas where you experience pain or numbness



□ TMJ
□ Scoliosis
□ Joint swelling
□ All over body pain
□ Muscle tightness
□ Weak back or knees
□ Swelling/edema
□ Concussion/TBI

Gynecological Health History

GENERAL GYNECOLOGY
☐ High sexual energy
☐ Low sexual energy
☐ Chronic vaginal discharge
☐ Regular yeast infections
☐ Vaginal dryness
☐ Breast lumps/nodules
☐ Mastitis
☐ Cysts
☐ Endometriosis
☐ Pelvic abnormalities/adhesions
☐ Fibroids
☐ PID
☐ STDs
☐ Abnormal pap smear
☐ Uterine or bladder prolapse
☐ Other _____

REPRODUCTIVE HISTORY
Are you currently using birth control? Y / N
Are you trying to conceive? Y / N
Are you currently lactating? Y / N
How many pregnancies have you had? ____
How many children do you have? ____
How many abortions have you had? ____
How many miscarriages have you had? ____

Have you had any:
☐ High-risk pregnancies
☐ Difficult labor/deliveries
☐ Postpartum or lactation concerns

MENOPAUSE
Are you currently menopausal? Y / N
In what year was your last period? _____
Do you currently experience any:
☐ Night sweater
☐ Hot flashes (daytime)
☐ Vaginal dryness
☐ Spotting
☐ Other _____

MENSTRUATION
Age when menses began _____
Menstruation lasts _____ days
☐ Regular cycle of ___ days from period to period
☐ Irregular cycle: _____ to _____
Can you tell when you ovulate? Y / N

During your period, the flow is:
☐ Light/spotting on days _____
☐ Medium on days _____
☐ Heavy on days _____
☐ With clots on days _____
☐ Spotting between periods

What color is the blood?
☐ Light red on days _____
☐ Bright red on days _____
☐ Dark red on days _____
☐ Purple on days _____
☐ Brown on days _____
☐ Black on days _____

PMS
☐ Cramps
☐ Back pain
☐ Breast tenderness
☐ Bowel changes
☐ Food cravings
☐ Irritability or anger
☐ Sadness or weeping
☐ Acne
☐ Other _____

AFTER MENSTRUATION
☐ Dizziness
☐ Fatigue
☐ Insomnia
☐ Night sweats
☐ Other _____

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Medications and Supplements

Name _____ DOB _____ Age _____

Please list all medications (prescription and over-the-counter) and vitamins, supplements, and herbs you are currently taking.

Today's Date	MEDICATIONS (Prescription & Over-the-Counter)	Dose	Frequency	Purpose	Approximate Date Started

Today's Date	VITAMINS, SUPPLEMENTS, & HERBS	Dose	Frequency	Purpose	Approximate Date Started

ALLERGIES: Please list any known allergies to medications, foods, pollens, metals, etc.

_____

_____

_____

OTHER:

Do you have a pacemaker? ☐ Yes ☐ No

Do you have a bleeding disorder? ☐ Yes ☐ No

Are you or could you be pregnant? ☐ Yes ☐ No