Three Rivers Clinic, Inc.
A Center for Healing

11900 Wayzata Blvd
Suite 110
Minnetonka, MN 55305
952.545.0200
www.threeriversclinic.com

PATIENT INFORMATION

Date_____

First Name_____ M.I. _____Last Name_____

Address _____

City _____ State_____ Zip Code_____

Home phone _____ Work phone _____

Cell _____ E-mail_____

Birth Date _____ Life Status (S W M D G B L T) Partner's Name_____

# of Children _____ Occupation_____Employer_____

Please Circle: INSURANCE or CASH/CHECK **WE DO NOT ACCEPT CREDIT CARDS**

How did you hear about our clinic (if friend, please write name)? _____

HealthPartners referring clinic: _____

HealthPartners referring doctor: _____

INSURANCE INFORMATION (*Please fill in one of the below areas*)

1) PRIVATE INSURANCE: *Please give your health insurance card to the Front desk.*

2) AUTO ACCIDENT/PERSONAL INJURY: Company Name _____

Company Address_____

Claim Representative's Name_____ Phone _____

Date of Accident _____Name of Insured _____

Relationship of Insured to Patient _____Claim No _____

3) WORKER'S COMPENSATION: Date of Injury _____Claim No _____

Employer _____Position _____

Contact at Workplace _____ Phone _____

4) ATTORNEY: Name _____ Phone _____

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HEALTH HISTORY QUESTIONNAIRE

Name _____ Date _____

Age _____ Height _____ Weight _____

Relationship Status: Single _____ Married/Life Partner _____ Other _____

Family Physician _____

Other Health Care Providers: _____

_____

MAIN PROBLEM YOU WOULD LIKE TO ADDRESS: _____

_____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)? _____

_____

How long has it been since you first noticed any symptoms? _____

Have you been given a diagnosis for the problem by your family physician? _____

If so, what is it? _____

Do you have other current problems? Describe them. _____

_____

What kinds of treatment have you tried? _____

What medications, vitamins, or other treatments are you now taking/doing? _____

_____

PAST MEDICAL HISTORY (*indicate how long you have had symptom on the line after the symptom*):

☐ Allergies _____ ☐ Cancer _____ ☐ Surgeries _____

☐ Diabetes _____ ☐ Hepatitis _____ ☐ Thyroid Disease _____

☐ High Blood Pressure _____ ☐ Heart Disease _____ ☐ Venereal Disease _____

☐ Seizures _____ ☐ Rheumatic Fever _____

☐ Other significant Illnesses (describe) _____

OTHER RELEVANT MEDICAL HISTORY (*including illnesses, childhood and other, and accidents*): _____

_____

_____

_____

FAMILY MEDICAL HISTORY (*indicate who had the symptom on the line after the symptom*):

☐ Allergies _____ ☐ Diabetes _____ ☐ Asthma _____

☐ Cancer _____ ☐ Heart Disease _____ ☐ High Blood Pressure _____

☐ Seizures _____ ☐ Stroke _____ ☐ Other _____

OCCUPATION: _____

Occupational stress factors (physical, psychological, chemical): _____

_____

_____

LIFESTYLE:

Do you follow a regular exercise program? _____ If so, please describe: _____

_____

Please describe your average daily diet: _____

_____

Please check any of the following habits that apply. Indicate how much and how often you consume them:

☐ Cigarette Smoking_____ ☐ Coffee, Tea, or Cola _____ ☐ Alcoholic Beverages_____

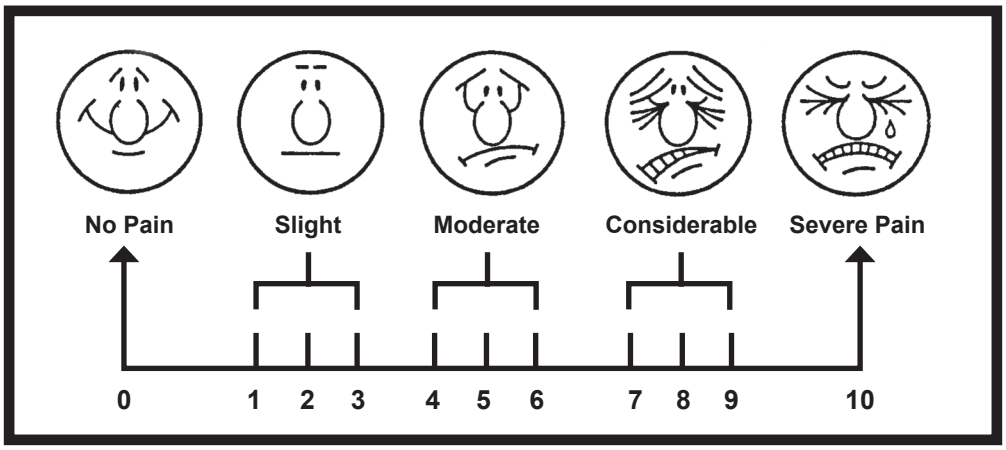
☐ Sugar_____ ☐ Other _____

Please describe any use of drugs for non-medical purposes: _____

_____

Living Situation: ☐ Alone ☐ With Family or Partner ☐ Housemates

MUSCULOSKELETAL:



Below, please check off the areas of pain you experience and rate the pain according to the above pain scale (enter number from the scale after the symptom you experience). Then describe your pain (constant, intermittent, radiating, burning, shooting, stinging, tingling, throbbing, aching, stabbing, sharp, dull, fixed location, moves around, etc.) and also describe what makes the pain change (heat, cold, damp, dry, weather changes, rest or activity, foods or beverages, positions, etc.). Give as much information as possible:

☐ Neck Pain _____

☐ Back Pain/Where? _____

☐ Areas Numbness or Tingling _____

☐ Stiffness/Limitation Movement _____

☐ Muscle Pains/Aches _____

☐ Muscle Weakness _____

☐ Shoulder Pains _____

☐ Muscle Spasm_____

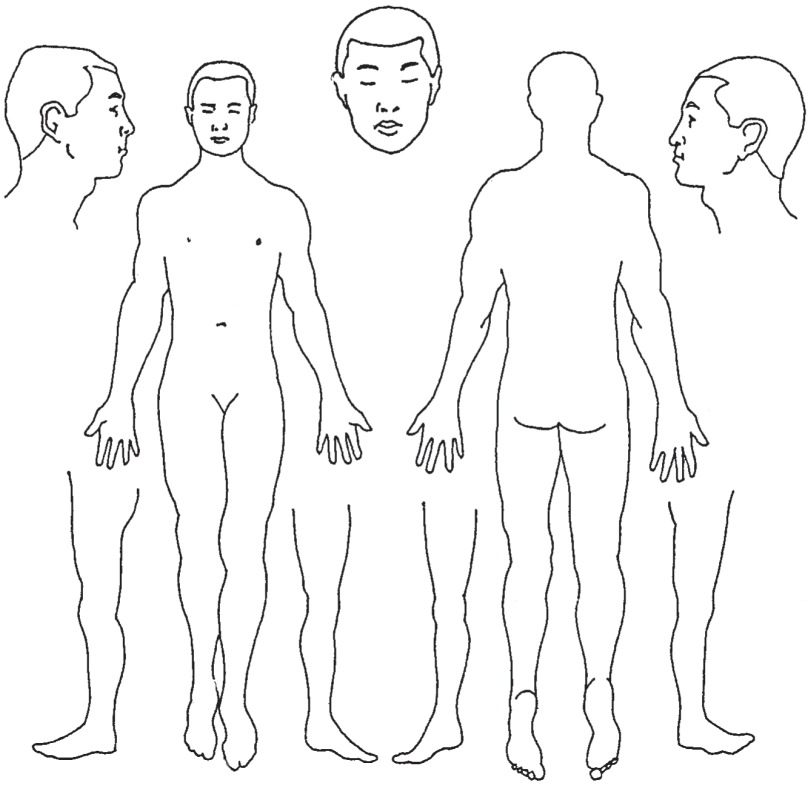
☐ Knee Pain _____

☐ Foot/Ankle Pains _____

☐ Hip Pain _____

☐ Hand/Wrist Pains_____

INDICATE PAINFUL OR DISTRESSED AREAS:



HEADACHE

Headaches? Yes _____ No _____ Migraines _____ Tension Headache_____ Other _____

How long have you had these symptoms? _____

On a scale of 1-10 (with 10 being the most severe pain) please note the range of severity _____

How often do you have these headaches? _____

Please describe the location and nature of the pain. _____

What makes the headache worse? _____ Better? _____

Are there things that trigger your headache (foods, hormones, smells, etc.)? _____

Do you use medication and if so, what? _____

QUALITY OF LIFE ASSESSMENT:

	0=	Pre-treatment testing	5=
Stress	no stress	0 1 2 3 4 5	extreme stress
Sleeping	little or no sleep	0 1 2 3 4 5	restful sleep
Depression	no depression	0 1 2 3 4 5	severe depression
Overall energy	extreme fatigue	0 1 2 3 4 5	good balanced energy
Anxiety	no anxiety	0 1 2 3 4 5	extreme anxiety
Sense of well-being	discontent	0 1 2 3 4 5	extremely satisfied
Ability to conduct daily activities at home	poor	0 1 2 3 4 5	excellent
Ability to work outside of the home	poor	0 1 2 3 4 5	excellent
Overall emotional state	poor	0 1 2 3 4 5	excellent

Using the Point Scale below, rate each of the following symptoms (in the box) based upon your typical health profile. Also, please indicate the length of time you have had each condition on the line following the symptom.

POINT SCALE

0—Almost never have the symptom
1—Occasionally have it, effect is not severe
2—Occasionally have it, effect is severe
3—Frequently have it, effect is not severe
4—Frequently have it, effect is severe

GENERAL:

☐ Fatigue _____ ☐ Hyperactivity _____ ☐ Restlessness/Hyperactive _____
☐ Poor Appetite _____ ☐ Insomnia _____ ☐ Strong Thirst _____
☐ Weight Gain _____ ☐ Tremors _____ ☐ Bleeding or Bruising Easily _____
☐ Night Sweats _____ ☐ Fever _____ ☐ Chills _____
☐ Sudden Energy Drop (time of day?) _____ ☐ Poor Balance _____
☐ Do you wake feeling rested? _____
Other unusual or abnormal conditions you have noticed in your general sense of health? _____
_____

SKIN AND HAIR:

☐ Rashes _____ ☐ Ulcerations _____ ☐ Hives _____
☐ Itching _____ ☐ Eczema _____ ☐ Pimples _____
☐ Dandruff _____ ☐ Dryness _____ ☐ Psoriasis _____
☐ Hair Loss _____ ☐ Changes in Hair or Skin Texture _____
Any other hair or skin problems? _____
_____

HEAD, EYES, EARS, NOSE, THROAT:

☐ Dizziness _____ ☐ Concussions _____ ☐ Migraines _____
☐ Poor Vision _____ ☐ Spots in Front of Eyes _____ ☐ Eye Pain _____
☐ Cataracts _____ ☐ Night Blindness _____ ☐ Watery or Itchy Eyes _____
☐ Blurry Vision _____ ☐ Eyestrain _____ ☐ Dark Circles/Bags under Eyes _____
☐ Ringing in Ears _____ ☐ Poor Hearing _____ ☐ Earaches/Ear Infections _____
☐ Itchy Ears _____ ☐ Recurrent Sore Throats _____ ☐ Swollen/Tender Glands _____
☐ Stuffy Nose _____ ☐ Sneezing Attacks _____ ☐ Excessive Mucous _____
☐ Hay Fever _____ ☐ Post Nasal Drainage _____ ☐ Sinus Problems _____
☐ Grinding Teeth _____ ☐ Sores on Lips or Tongue _____ ☐ Facial Pain _____
☐ Teeth Problems _____ ☐ Jaw Clicks _____
☐ Difficulty Swallowing or Gagging _____
Any other head or neck problems? _____
_____

POINT SCALE

0—Almost never have the symptom 1—Occasionally have it, effect is not severe 2—Occasionally have it, effect is severe
3—Frequently have it, effect is not severe 4—Frequently have it, effect is severe

CARDIOVASCULAR:

☐ Dizziness _____ ☐ Low Blood Pressure _____ ☐ Chest Pain _____
☐ Irregular Heartbeat _____ ☐ High Blood Pressure _____ ☐ Fainting _____
☐ Cold Hands/Feet. _____ ☐Swelling of Hands _____ ☐ Swelling of Feet _____
☐ Blood Clots _____ ☐ Shortness of Breath _____ ☐ Phlebitis _____
☐ Rapid or Pounding Heart Beat _____
Any other heart of blood vessel problems? _____

RESPIRATORY:

☐ Cough _____ ☐ Coughing up Blood _____ ☐ Asthma _____
☐ Bronchitis _____ ☐ Pain w/Deep Inhalation _____ ☐ Pneumonia _____
☐ Frequent Colds _____ ☐ Respiratory Allergies _____ ☐ Difficulty Breathing _____
☐ Production of Phlegm (color?) _____
Any other lung problems? _____

GASTROINTESTINAL:

☐ Nausea _____ ☐ Vomiting _____ ☐ Diarrhea _____
☐ Constipation _____ ☐ Gas _____ ☐ Belching _____
☐ Black Stools _____ ☐ Blood in Stools _____ ☐ Indigestion _____
☐ Bad Breath _____ ☐ Rectal Pain _____ ☐ Hemorrhoids _____
☐ Food Allergies _____ ☐ Chronic Laxative Use _____ ☐ Bloating _____
☐ Binge Eating/Drinking _____ ☐ Craving Certain Foods _____ ☐ Compulsive Eating _____
☐ Eating Restriction _____ ☐ Water Retention
☐ Abdominal Pain or Cramps _____
Any other problems with stomach or intestines? _____

GENITO-URINARY:

☐ Pain/Burning Urination _____ ☐ Frequent Urination _____ ☐ Blood in Urine _____
☐ Urgency to Urinate _____ ☐ Unable to Hold Urine _____ ☐ Kidney stones _____
☐ Decrease in Flow _____ ☐ Sexual Difficulties _____ ☐ Sores on Genitals _____
☐ Vaginal Pain or Burning _____ ☐ Prostate Trouble _____
☐ Discharge from Penis/Vagina
☐ Do you wake at night to urinate? _____ If so, how often? _____
Any particular color to your urine? _____
Any other problems with your genital or urinary functions? _____
_____

POINT SCALE

0—Almost never have the symptom 1—Occasionally have it, effect is not severe 2—Occasionally have it, effect is severe
3—Frequently have it, effect is not severe 4—Frequently have it, effect is severe

REPRODUCTIVE AND GYNECOLOGIC:

☐ Menstrual Clots _____ ☐ Painful Menses_____ ☐ Irregular Menses_____
☐ Unusual Menses _____ ☐ Heavy or Light? _____ ☐ Menopause (age?) _____
☐ Other Problems _____
☐ Changes in Body/Psyche Prior to Menses? _____
Age at First Menses_____ Time Between Menses _____ Duration _____
First Day of Last Menses_____ Number or Pregnancies _____
Number of Births _____ Any difficulties with pregnancies? _____
Do you practice birth control? ____ If so, what type? _____ For how long?_____

NEUROPSYCHOLOGICAL:

☐ Seizures _____ ☐ Dizziness _____ ☐ Loss of Balance _____
☐ Areas of Numbness_____ ☐ Poor Memory _____ ☐ Lack of Coordination_____
☐ Concussious _____ ☐ Depression _____ ☐ Anxiety _____
☐ Irritability _____ ☐ Sadness _____ ☐ Grief _____
☐ Worry_____ ☐ Fear _____ ☐ Mood Swings _____
☐ Lack of Concentration _____ ☐ Brain Fog _____
☐ Easily Susceptible to Stress ___ ☐ Sensitivity or Pain in Hands or Feet _____
Have you ever been treated for emotional problems?_____
Have you ever considered or attempted suicide? _____
Any other neurological or psychological problems? _____
_____

COMMENTS:

Please tell us about any other problems you would like to discuss: _____
_____
_____
_____
_____
_____
_____
_____

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CONSENT FOR TREATMENT

I understand that the scope of practice of acupuncturists according to Minnesota State Law includes, but is not limited to, the following forms of therapy which all have benefits for specific types of problems:

USING ORIENTAL MEDICAL THEORY TO ASSESS AND DIAGNOSE A PATIENT; AND USING ORIENTAL MEDICAL THEORY TO DEVELOP A PLAN TO TREAT A PATIENT.

TREATMENT TECHNIQUES MAY INCLUDE:

- Insertion of sterile acupuncture needles through the skin
- Acupuncture stimulation including, but not limited to, electrical stimulation or the use of moxibustion
- Cupping
- Dermal friction
- Acupressure
- Herbal therapies
- Dietary counseling based on Traditional Oriental Medical principles
- Breathing techniques
- Exercise according to Oriental Medical principles

RISKS OF THE ABOVE FORMS OF THERAPY INCLUDE:

- Acupuncture needles inserted into the skin can cause pain or discomfort, bruising, infection, risks of feeling weak, fainting or nausea, and of broken needles.
- Electro-acupuncture can cause some conditions to worsen. It should be used with caution in cases where the patient has a heart condition. It should not be used across the midline of the body.
- Moxibustion can cause burns when used in areas with compromised sensation and/or circulation or when improperly used.
- Acupressure, cupping and massage may cause bruising and/or soreness.
- Herbs have different properties and may have adverse reactions/side effects if improperly used.

I hereby acknowledge that I have been advised of the benefits and risks of acupuncture and associated methods used in this practice. I understand these risks and benefits and consent to accept treatment using these methods. I agree to release below named acupuncturist from all legal responsibility for practices done here except in the case of negligence or unsafe practice on the part of said acupuncturist. I am aware that other modalities of healing which may be used during my treatment may include hypnotherapy, visualization, guided imagery, and Healing Touch.

I understand that Karen Nielsen has completed formal programs of study, is NCCAOM certified (National Commission for the Certification of Acupuncturists and Oriental Medicine), and is licensed in the State of Minnesota as acupuncturists.

I do / do not have a pacemaker or bleeding disorder.
I have been / have not been examined by a physician or other licensed health care provider. (You are advised to see your physician about the problem for which you have come here to be treated.)

_____ _____

Client Signature Date

_____ _____

Karen Nielsen, L.Ac. Date

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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your right concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient understands and agrees to allow this office to contact them by telephone, mail, or e-mail with appointment reminders, information about our clinic facilities, treatment alternatives, and other health-related information that may be of interest to them.

3. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

4. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

5. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

8. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the clinic will not be able to submit claims to insurance carriers or other third party payers and the health care provider has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____
Printed Name

_____
Signature

_____
Date