Acupuncture

Patient Health History

Date:________________

Patient Name:_________________________________ Date of Birth:____________________

Preferred Name: ________________________Marital Status: S M D W DP Sex: M / F

Address:____
Street City State Zip Code

Home Number:___________________________ Cell Number:___________________________

Email Address:____

Occupation:________________ Employer:________________ Work Number:________________

Emergency Contact:______________________________ Phone Number:___________________

The following questions allow us to provide you with the best care possible. Please complete this questionnaire as thoroughly as possible. Print all information. Ask your practitioner if you have further questions. Thank you.

1. When and where did you last receive healthcare? ____________________________________

2. For what reason? ______________________ Primary care physician: ____________________

3. Please identify the main conditions for which you are seeking acupuncture.

   A.___________________ How does this condition affect you? ________________________

   B.___________________ How does this condition affect you? ________________________

   C.___________________ How does this condition affect you? ________________________

   Past treatment for any of the above conditions: ___________________________________

____

4. Allergies (food, medication, pollen, pets, etc.) _______________________________________

____

5. Please list any medication (prescriptions or over-the-counter), vitamins, supplements, and herbs that you are currently taking. ____

____

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6. Are you currently pregnant, or trying to get pregnant? Y N

7. **Family History**

Father: Living? Y N Healthy? Y N If no, please list current health challenges

____

Mother: Living? Y N Healthy? Y N If no, please list current health challenges

____

Brother: Living? Y N Healthy? Y N If no, please list current health challenges

____

Sister: Living? Y N Healthy? Y N If no, please list current health challenges

____

8. Height: ___________ Weight: __________

9. Blood Pressure (your most recent reading) __________/_________ When taken? __________________

10. Immunizations (circle any that you have had) Polio Tetanus Measles Mumps Rubella (MMR)

German Measles Chicken Pox Diphtheria Small Pox Hepatitis B Influenza

11. Have you had any of the above conditions? _________ At what age? _______

12. Hospitalization/Surgeries:

A. Reason __________________________ When ___________________________

B. Reason __________________________ When ___________________________

C. Reason __________________________ When ___________________________

13. Diagnostic studies (x-rays, MRI's, CT scans, Ultrasounds)

A. Reason __________________________ When ___________________________

B. Reason __________________________ When ___________________________

C. Reason __________________________ When ___________________________

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Circle any of the following that you experience now and **underline** any that you have had in the past.

Respiratory: (Lungs)	pneumonia frequent colds difficulty breathing emphysema persistent cough asthma tuberculosis nasal congestion sinus congestion/infection
Cardiovascular: (Heart)	Heart Disease Chest Pain Swelling of Ankles High Blood Pressure Palpitations/Fluttering (heart skips) Heart murmurs Rheumatic Fever Stroke Varicose Veins Other _____________
Gastrointestinal (stomach/ digestive system)	ulcers changes in appetite nausea/vomiting abdominal pain gas/bloating heartburn belching gallbladder disease liver disease Irritable bowel disease Crohn's Other________________________
Bowel Patterns	constipation diarrhea frequency of b.m.s per day_______ any other changes in elimination patterns? Y N
Emotional	mood swings nervousness anxiety depression stress eating disorders
Energy/ Immunity	average energy level on a scale of 1-10 _____ fatigue chronic infections Slow wound healing chronic fatigue syndrome impaired immunity
Head eyes ears nose throat	glasses/contacts impaired vision eye pain/strain glaucoma cataracts tearing/dryness flashes of lights or floaters redness macular degeneration impaired hearing ear ringing earaches headaches dizziness impaired smell impaired taste nose bleeds teeth grinding TMJ/jaw problems
Genito-urinary	kidney problems difficult urination frequent urinary infections blood in urine bladder problems
Female Reproductive/ Breasts	irregular menstrual cycles painful menstruation heavy flow vaginal discharge difficulty conceiving bleeding between cycles breast lumps/tenderness nipple discharge menopausal symptoms
Menstrual/ Birthing History	age of first period ____ length of cycle ___days length of period ___days # of pregnancies___ live births___ contraception method ____________________
Male Reproductive	erectile dysfunction prostate problems testicular pain/swelling penile discharge
Musculoskeletal	neck/shoulder pain muscle spasms/cramps arm pain back pain leg pain foot pain hand pain joint pain (where) ______________________________
Neurologic	vertigo/dizziness paralysis numbness/tingling seizures/epilepsy poor memory dementia Alzheimer's disease
Endocrine	hypothyroid diabetes night sweats feeling excessively hot or cold pituitary disorder

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Do you have any other health challenges? ____

____

Are you in pain? Y N if yes, where?____

Severity on a scale of **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain imaginable**

Lifestyle # of meals eaten per day __________

Fluid intake # glasses per day _________

Exercise ____ Frequency ____________________

Spiritual practice ____

Hours of sleep per night ______ Sleep problems ____________________________________

Tobacco use Y N

Coffee/Tea # of glasses per day _________

Alcohol Y N # of glasses per week _________

Work Hours per week ______ Place of employment __________________________________

Years of employment ______ Do you enjoy work? Y N

Why? ____

Interests/Hobbies ____

Do you have questions about acupuncture, herbs, or massage? _________________________

____

How did you hear about us? ____________________

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Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental materia medica provided by the licensed acupuncture practitioners of Pacific Northwest Acupuncture & Herbal Clinic, LLC.
I understand that acupuncturists practicing in the state of Oregon are not primary care providers. I understand that the Pacific Northwest Acupuncture & Herbal Clinic requires that all patients have a primary care provider as part of a conjunctive care program and that all patients provide medical records from this primary care provider upon request.

I understand that data from this clinic may be used for research purposes; however, in all cases all information will be anonymous and held in strictest confidence. All practitioners and staff are held to strict confidentiality requirements.

I understand that acupuncture is preformed by the insertion of needles through skin. Additionally, application of heat, electro-acupuncture, Chinese massage, cupping, and other Oriental medicine therapies may be applied in the treatment protocol. I have been informed that only disposable needles will be used during each treatment. I have been made aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, temporary pain or discomfort, and the possible temporary aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

I understand that the acupuncturists may recommend substances from the Oriental materia medica to treat dysfunction or diseases, to modify or prevent the perception of pain, and to normalize the body's physiological functions. I understand that I am not required to take these substances but made aware that certain adverse side effects may result from taking these substances. These could include, but not limited to: changes in bowel movement, temporary abdominal pain or discomfort, and the possible temporary aggravation of symptoms existing prior to herbal treatment. Should I experience any problems which I associate with these substances, I should suspend taking them and call the Pacific Northwest Acupuncture & Herbal Clinic.

I understand that if I receive moxibustion as part of therapy, there is a small risk of burning or scarring from its use. I understand that I may refuse this therapy.

I consent for my practitioners to consult with other practitioners in Pacific Northwest Acupuncture & Herbal Clinic regarding my diagnosis and treatment program.

I have carefully read and understand all the above information, and I give my consent to be treated.

Signature: ______________________________ Date: ______________________

Parent/Guardian Signature (if applicable): ____________________________________