Acct #

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Health History

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail: _____
Date of Birth: _____Age: _____ Marital Status: _____
Occupation: _____ Physician: _____
In Emergency, call: _____ Phone: _____
Referred by: _____
Insurance Company: _____
Subscriber Name: _____ Relationship: _____ DOB_____
Policy or ID Number: _____ Group Number: _____

Primary Complaint (symptoms, diagnosis, duration, etc.)

What makes it better?

_____

What makes it worse?

_____

Medications (prescribed and over-the-counter) _____

_____

Vitamins and supplements: _____

_____

Surgeries:

_____

Allergies:

_____

Height: _____ Current Weight: _____ Past Maximum: _____

Most recent blood pressure reading? _____/_____ When? _____

Exercise
Days per week _____ Length of Workout _____ Activity _____

Diet
Typical meal: _____
Meals per day _____ Snacks _____
Caffeine/Alcohol_____
How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Interests and hobbies:

_____

_____

Family Health History
Briefly describe your family's health:

Mother_____

Father _____

Siblings_____

Known prominent family illnesses _____

General History Please ✓ any conditions you have had in the last year.
Please ○ any conditions you had in the past but not any longer.

□ Anemia	□Tremors	□Lyme Disease	□Fevers
□Chills	□Night Sweats	□Sweats Easily	□ High cholesterol
□Chronic infections	□Fatigue	□Bruise Easily	□Raynaud's Disease
□Alcoholism	□Dental/gum disease	□Muscle weakness	□Low Energy
□Peculiar tastes/smells	□Poor Sleep: # of hours? _____		Cancer

Skin and Hair

□Rashes	□Slow to heal	□Dermatitis	□Itching
□Eczema/Psoriasis	□Dandruff	□Hair loss	□Recent moles
□Discoloration	□Acne	□Texture change	□Face flushing
□Hives	□Warts	□Fungal infections	□Weak/ridged nails

Head, Eye, Ear, Nose, and Throat

□Dizziness	□Headaches	□Migraines	□Poor/blurred vision
□Eye strain/pain	□Night blindness	□Cataracts	□Glaucoma
□Earaches	□Ringing in ears	□Poor hearing	□Spots in vision
□Sinus problems	□Nose bleeds	□Sore Throat	□Grinding teeth
□Difficulty swallowing	□Sores on lips/tongue	□Jaw pain/clicks	□Facial pain

Heart

□Chest pain/pressure	□Irregular heart beat	□Palpitations	□Fainting
□Cold hands/feet	□Swelling	□Blood clots	□Phlebitis
□Heart disease	□Low blood pressure	□Shortness of breath	□High blood pressure
□Varicose/spider veins	□Spontaneous sweating	□Stroke	□Heart Murmurs

Lungs

□Frequent colds	□Cough/Wheezing	□Coughing blood	□Asthma
□Difficult inhale/exhale	□Respiratory Allergies	□Difficulty breathing when lying down	□Bronchitis
□Tight chest	□Pneumonia	□Phlegm:	
□ Tuberculosis	□ Emphysema	□Smoker	

Digestion

□Nausea	□Vomiting	□Diarrhea	□Constipation
□Gas	□Stomach pain	□Black stools	□Blood in stool
□Heart burn/reflux	□Bad breath	□Rectal pain	□Hemorrhoids
□Bloating	□Loose stools	□Abdominal pain	□Excessive appetite
□Poor appetite	□Hernia	□Significant thirst	□IBS/Crohn's
□Weight loss/gain	□Cravings	□Ulcer	□ Pancreatitis
□ Food Intolerance	□Gallbladder disease	□Hepatitis: _____	

Endocrine

□Diabetes	□Hypoglycemia	□Thyroid disease	□Abnormal sweating
□Feeling hot or cold	□ Hormone replacement		

Genito-urinary

□Painful urination	□Frequent urination	□Blood in urine	□Urgent urination
□Incontinence	□Kidney stones	□Scanty flow	□Copious flow
□Infections	□Genital sores	□Herpes	

□Night time urination How often? _____

Male Reproduction

□ Sexual difficulties	□Prostatitis	□Testicle pain	□Abnormal libido

Female Reproduction

□Painful intercourse	□Ovarian cysts	●Age of first menses	_____
□Vaginal dryness	□Endometriosis	●Date of last menses	_____
□Vaginal sores	□Fibroids	●# of days of flow	_____
□Vaginal discharge	□Fibrocystic breasts	●Length of cycle	_____
□Infertility	□Polycystic Ovaries	●# of pregnancies	_____
□Irregular cycles	□PMS	●# of miscarriages	_____
□Painful menses	□Heavy flow	●# of abortions	_____
□Breast tenderness		●# of births	_____
□ Type of birth control	□Menopausal symptoms	●Date of last PAP	_____

Musculoskeletal

□Neck pain	□Shoulder pain	□Hand/wrist pain	□Elbow pain
□Knee pain	□Sciatica	□Foot/ankle pain	□Hip pain
□Muscle pain	□Tendonitis	□Bursitis	□Arthritis

□Back pain: where? _____

Neuropsychological

□ Seizures	□Poor Balance	□Dizziness	□Numbness
□Poor coordination	□Poor memory	□Depression	□Anxiety
□Irritability	□Stress	□Mood swings	□ADD/ADHD
□Seasonal Affective Disorder	□Difficulty concentrating		

□Predominant emotion: _____

Other pertinent information:

Would you like to receive our email newsletter?

Acupuncture Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other Chinese medicine procedures on me (or on the patient named below for whom I am legally responsible) by the above licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, electroacupuncture, body work, Chinese or Western herbal medicine and nutritional counseling.

The herbs and nutritional supplements, which are from plant, animal and mineral sources, are traditionally considered safe in the practice of Chinese medicine. I understand the same herbs may be inappropriate during pregnancy and I will inform my practitioner immediately of my pregnancy status. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. If I experience any gastro-intestinal reactions to the herbs, I will inform the practitioner immediately.

I have been informed that I have a right to refuse any form of treatment. I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. _____ intials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation. I understand this charge cannot be billed to my insurance. _____ intials

I agree to pay all charges incurred for services which are over and above insurance coverage. _____ intials

Signature of Patient or Patient Representative Date

_____

Print Name of Patient

If you are signing as patient's representative:

_____

Print Name of Representative Relationship to Patient

Consent to Use and Disclose Protected Health Information

I hereby consent to the use and disclosure of my protected health information for the purposes of **treatment, payment and healthcare operations**, or as otherwise required by law.

The practitioners have posted their Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my protected health information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.

- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received at the following address:

2450 SE Belmont St.
Portland, OR 97214

I understand that while the practitioners may honor these requests, they are not required by law to do so.

I am aware that the practitioners reserve the right to change the terms of their Notice of Privacy Practices and to make new Notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, the practitioners will make available a revised Notice of Privacy Practice for my review.

As a courtesy, the practitioners may call your home to remind you of your appointment time or to change your appointment. We may leave a message on your answering machine or with a person answering the phone – no personal health information will be disclosed.

- ☐ I agree to this standard method of communication.
- ☐ Please change as follows:
  - ☐ Please contact me at the following telephone number:
  - ☐ I prefer not to receive calls.

_____

Signature of Patient or Patient Representative Date

_____

Print Name of Patient

If you are signing as patient's representative:

_____

Print Name of Representative Relationship to Patient

☐ Requested and received a copy of the Notice of Privacy Practices Initials _____