Oregon City Acupuncture
619 Madison #110 Oregon City, OR 97045 503-653-1468

Patient Name:____**Office ID #** __________

WELCOME!

Thank you for coming to see us. We strive to provide protection & support on your journey to optimal wellness and look forward to working with you. An emphasis is placed on preventative care and health maintenance. Our clinic includes acupuncture, acupressure, and massage, herbs, dietary and lifestyle advice, ETPS & NAET therapy. These approaches may differ from other modalities, but they are complementary to other medical approaches. We can work with any of your usual physicians, medical specialists, other complimentary practitioners, and especially with you to accomplish your goals.

To serve you properly, we will need the following information. Please print and answer all questions completely. All information will be strictly confidential.

Name:____**Date:**____________________

Gender: F M **Age:**_______**DOB:**__________________ **Status:** Single Married Partner Divorced Widowed

Address:____

City/State/Zip:___________________________________**email**:_________________________________

Home phone:_______________________________**Cell phone:**____________________________________

Employer:____**Occupation:**_________________________

Address:____**Work Phone#:**__________________

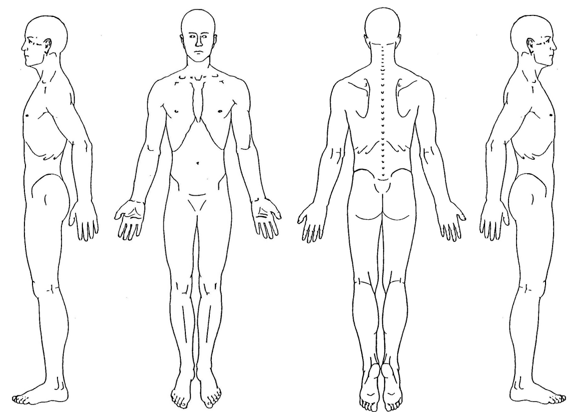
Emergency Contact:____________________________**Relation**:_______________**Phone:**______________

Referred by:____**Relation:**_____________________________

Symptom Survey

What are your 3 most important health concerns for which you are seeking treatment?
What treatments have you already received?
If you are seeking treatment for a work-related injury or auto accident please list details and give the location of your pain.

Please mark figures in areas of injury or pain.



Primary Care Physician – Phone, Address ____

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This survey will help your practitioner to evaluate your health issues more completely. Please mark the box next to any symptoms which you are experiencing NOW or in the PAST. Include all those complaints which are familiar to you. If there are one or more words in a line which describes your specific problem, then *circle* that word(s). Please leave the lines between the boxes following the (*) blank.

NOW	PAST	ALLERGIES additional list provided
☐	☐	Food:______________________________
☐	☐	Medications:_________________________
☐	☐	Plants:_____________________________
☐	☐	Pollens:____________________________
☐	☐	Insects:____________________________
☐	☐	MSG:______________________________
☐	☐	Chemicals:__________________________
☐	☐	Other:_____________________________

*____
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____

Ever had an anaphylactic response: Y / N
Describe substance & symptom & dates:
____
____
____
____

How did you handle the situation:____________
____
____
____
____

Do you routinely carry an Epi-Pen? Y / N

CHRONIC OR CONTINUING CONDITIONS
Please check or list

OTHERS

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Joint replacement(s)
- ☐ Any implants
- ☐ Cancer
- ☐ High or low thyroid
- ☐ Fibromyalgia
- ☐ Chronic fatigue syn.
- ☐ Asthma

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CURRENT MEDICATIONS
Include any prescriptions, vitamins, supplements & other over-the-counter medications

DRUG	PURPOSE

*____
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For Children **Any history of:**
Learning disabilities
ADHD Y / N treatment
Autism Y / N How addressed

Pediatrician Name: ______________________________

Phone: ____

Address: ______________________________________

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VACCINATIONS / SURGERIES / HOSPITALIZATIONS

Have you had the following vaccinations (X) or diseases (O)?

Yes	No		Yes	No	
☐	☐	Diphtheria	☐	☐	Tetanus
☐	☐	Measles	☐	☐	Polio
☐	☐	Whooping	☐	☐	Smallpox
☐	☐	Typhoid	☐	☐	Mumps
☐	☐	Typhus	☐	☐	Other:__________

Have you had any of the following removed? Date?

☐ Tonsils:_________ ☐ Cysts/Tumors:________
☐ Appendix:________ ☐ Uterus/Ovaries:_______
☐ Gallbladder:______ ☐ Other:_______________

Have you ever been Hospitalized or had a serious Accident or Illness? Please what, when & where:

*____
____
____

GENERAL SYMPTOMS

NOW	PAST	GENERAL SYMPTOMS
☐	☐	Tired, Weak, Lack of energy
☐	☐	Depression, Melancholy, Moodiness
☐	☐	Worry, Anxiety, Nervousness, Irritability
☐	☐	Sleeplessness, Sleeping too much
☐	☐	Frequent colds or Other illness:___________
☐	☐	Headaches
☐	☐	Don't sweat enough
☐	☐	Sweat too much
☐	☐	Night sweats
☐	☐	Dizziness, Fainting, Convulsions
☐	☐	Loss or Gain of weight
☐	☐	Other:_______________________________

Current:
Hgt: ______________ **Wgt:**:_____________
Past Max: __________

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SKIN & HAIR

NOW	PAST	SKIN & HAIR
☐	☐	Acne, Pimples
☐	☐	Skin Rashes, Hives
☐	☐	Stretch marks
☐	☐	Skin ulcers or Sores
☐	☐	Dryness, Roughness, Scaling skin, Scalp, Elbows, Knees, Feet, around the Nose, Ears, Eyebrows
☐	☐	Hair Loss, Thinning
☐	☐	Dry, Coarse hair, Split ends
☐	☐	Bruise easily
☐	☐	Brown spots, Bronzing of skin
☐	☐	Moles, Warts, Skin tags
☐	☐	Easily sun burned
☐	☐	Cuts heal slowly, Scar badly
☐	☐	Flush easily
☐	☐	Hands/Feet numbness or tingling
☐	☐	Feet burn
☐	☐	Athletes foot
☐	☐	Other:_____________________________

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MISCELLANEOUS

Have you traveled outside the USA within the last 2 years?

Yes ☐ No ☐ Where? ___________________________

Have you ever been diagnosed with:

Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Exposed to HIV
☐	☐	HIV	☐	☐	TB

If yes, please give diagnosis/treatment dates:_____________
____

Have you ever been exposed to significant or long term doses of:

Yes	No		Yes	No	
☐	☐	Chemicals	☐	☐	Toxins
☐	☐	Radiation	☐	☐	Other:_______

If so, please explain:_____________________________
→ ____

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NOW	PAST	EYES
☐	☐	Nearsightedness, Farsightedness
☐	☐	Blurred, Failing vision
☐	☐	Dryness, Burning, Itching
☐	☐	Eyes water excessively
☐	☐	Sensitivity to light
☐	☐	Night blindness
☐	☐	Bloodshot, Puffy, dark circles
☐	☐	Glaucoma, Cataracts, Macular degen.

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NOW	PAST	RESPIRATORY
☐	☐	Frequent coughing
☐	☐	Spitting up Mucus or Blood
☐	☐	Difficulty breathing
☐	☐	Shortness of breath on exertion
☐	☐	Chest pain
☐	☐	Frequent pneumonia
☐	☐	History of TB, COPD, pleurisy, emphysema
☐	☐	Other:______________________

*______________________________________
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NOW	PAST	EARS
☐	☐	Earaches
☐	☐	Noises or Ringing in ears
☐	☐	Ear discharges
☐	☐	Loss of hearing
☐	☐	Lots of wax
☐	☐	Sensitive to hot / cold
☐	☐	Other:______________________
☐	☐	Have ear tubes (if child)

*______________________________________
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NOW	PAST	NOSE & THROAT / MOUTH
☐	☐	Hay fever, Sinusitis, Runny nose
☐	☐	Dry mouth or Nose
☐	☐	Nosebleeds
☐	☐	Cracks in corners of mouth
☐	☐	Dry or Chapped lips
☐	☐	Sore throats, Tonsillitis
☐	☐	Clear throat a lot
☐	☐	Sore, Red, or Cracked tongue
☐	☐	Cold sores, Herpes
☐	☐	Inability to smell or Taste
☐	☐	Lots of cavities
☐	☐	Bleeding gums
☐	☐	Hoarseness
☐	☐	Teeth grinding
☐	☐	TMJ / jaw pain
☐	☐	Other:______________________

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NOW	PAST	NEUROLOGICAL
☐	☐	Dizziness / vertigo
☐	☐	Loss of balance
☐	☐	Seizures / epilepsy
☐	☐	Paralysis
☐	☐	Numbness / tingling
☐	☐	Headaches Location ______________
☐	☐	Memory loss

*______________________________
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NOW	PAST	CARDIOVASCULAR
☐	☐	Heart beats fast or Irregularly
☐	☐	Chest tightness
☐	☐	Discomfort at high altitude
☐	☐	Dizzy or Weak upon standing up
☐	☐	Swollen Feet, Ankles, or Legs
☐	☐	Cold Hands or Feet
☐	☐	Hands or Feet turn blue
☐	☐	Blue fingernails
☐	☐	Leg pains when walking
☐	☐	Varicose veins
☐	☐	Tendency towards anemia
☐	☐	High blood pressure
☐	☐	Murmurs
☐	☐	Stroke
☐	☐	Rheumatic fever
☐	☐	Low blood pressure
☐	☐	Implants to assist heart / pacemaker
☐	☐	Other:______________

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NOW	PAST	GASTROINTESTINAL
☐	☐	Loss of appetite
☐	☐	Gagging
☐	☐	Difficulty swallowing
☐	☐	Nausea, Vomiting
☐	☐	Bad breath
☐	☐	Metallic or Bitter taste in mouth
☐	☐	Food cravings or Strong desires
☐	☐	Can't eat fats
☐	☐	Heartburn
☐	☐	Indigestion or Distress
☐	☐	Heaviness after eating
☐	☐	Gas, Belching
☐	☐	Bloating, Cramps
☐	☐	Stomach or Abdomen tender or painful
☐	☐	Symptoms relieved by eating
☐	☐	Symptoms worse after eating
☐	☐	Avoid certain foods
☐	☐	Headache, Dizziness, Irritability if skip meals
☐	☐	Diarrhea or Loose stools
☐	☐	Constipation
☐	☐	Change in bowel movements
☐	☐	Light colored or Greasy stools
☐	☐	Dark stools
☐	☐	Blood in stools
☐	☐	Feeling of incomplete evacuation
☐	☐	Undigested food in stool
☐	☐	Foul stool odor or Gas
☐	☐	Hernia
☐	☐	Hepatitis, Cirrhosis of the liver
☐	☐	Ulcers
☐	☐	Gall bladder disease, stones
☐	☐	Hemorrhoids
☐	☐	Other:______________

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NOW	PAST	MUSCULO-SKELETAL
☐	☐	Muscle Pain or Stiffness Where?______________________________
☐	☐	Swollen, Painful, Stiff joints
☐	☐	Bone pain
☐	☐	Foot, Ankle, Calf pain
☐	☐	Tremors, Twitches
☐	☐	Loss of strength
☐	☐	Joint replacements
☐	☐	Muscle wasting
☐	☐	Injuries, Fractures
☐	☐	Other:_______________________________

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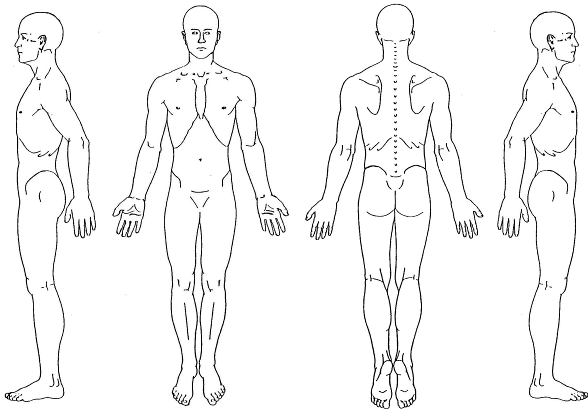
Please shade area or mark with "X" any scars or old injuries.



NOW	PAST	URINARY
☐	☐	Difficulty urinating
☐	☐	Frequent urination at night
☐	☐	Bed wetting
☐	☐	Incomplete urination or Dribbling
☐	☐	Painful urination
☐	☐	Bladder infections
☐	☐	Kidney infections
☐	☐	Kidney stones
☐	☐	Kidney dialysis
☐	☐	Kidney transplant
☐	☐	Sexually transmitted disease
☐	☐	Low back pain
☐	☐	Other:_______________________________

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How much fluid do you drink a day?_______________
How much is plain water? ____________________

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NOW	PAST	MALE
☐	☐	Prostate problems
☐	☐	Difficult or Unusual urination
☐	☐	Pain, Discomfort, Itching in genital area
☐	☐	Diminished or Excessive sexual desire
☐	☐	Penile discharge
☐	☐	Difficulty maintaining an erection
☐	☐	Breast tumors
☐	☐	Other:______________________________

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HABITS—ESTIMATE FREQUENCY OR QUANTITY

- ☐ Cigarettes or Tobacco: ______________packs/day
- ☐ Coffee or Black Tea: ________________cups/day
- ☐ Alcohol: __________________________drinks/week
- ☐ Marijuana or Other drugs: ____________times/week
- ☐ Exercise – type & amt.
- ☐ Hobbies – type & amt
- ☐ Television – hours / wk:
- ☐ Do you skip meals?_______ Which? ____________
- ☐ How many meals do you eat in a day? __________
- ☐ When is your biggest meal? __________________

Additional information / Anything missed:

____

____

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NOW	PAST	FEMALE
☐	☐	Irregular menstruation
☐	☐	Bleeding between cycles
☐	☐	Cramps, Pain prior to or With periods
☐	☐	Depressed, Tense, Irritable with periods
☐	☐	Painful or Swollen breasts
☐	☐	Lumps in breasts
☐	☐	Heavy flow, clots
☐	☐	Symptoms occur in monthly pattern
☐	☐	Diminished or Excessive sexual desire
☐	☐	Difficulty having orgasm
☐	☐	Inability to conceive
☐	☐	Miscarriages, Abortions
☐	☐	Vaginal discharge
☐	☐	Pain, Discomfort, Itching in genital area
☐	☐	Hot flashes
☐	☐	Other:____________________________

Date that last period started:__________________________

# of days period lasted:_________ Length of cycle:________

Date of last PAP smear:_________ Normal? (Y) (N)

Type of birth control:________________________________

Have you ever used Birth control pills or an IUD?_________

What type and for how long?__________________________

Pregnancy history

# of pregnancies ____________ # of live births___________

# of abortions ______________ # on miscarriages ________

Breast Health

NOW	PAST	
☐	☐	Nipple discharge
☐	☐	Lumps, cysts
☐	☐	Biopsy, cancer
		Side ________ When ________
☐	☐	Implants

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	YOUR (Patient's) FATHER	YOUR (Patient's) MOTHER	YOUR SIBLINGS			YOUR CHILDREN		
			1	2	3	1	2	3
Age (if living)								
Age at death								
Cause of death								
Health—G = Good, B = Bad								
Cancer								
Heart Problems								
Digestive Problems								
Respiratory Problems								
Urinary Tract Problems								
Diabetes								
Hypoglycemia								
Thyroid Problems								
Gall Bladder Problems								
High Blood Pressure								
Anemia								
Migraines								
Stroke								
Epilepsy								
Tuberculosis								
Allergies								
Asthma								
Psychological Problems								
Birth Defects								
Other:								

Thank you for your assistance and patience working your way through this form.

____
Patient/ Guardian Signature Date

____

Interviewer Signature Date