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Portland, OR 97229
(503) 841-2000

Welcome to my acupuncture clinic, I look forward to working with you to improve your health and wellness.
Please take some time to complete this form and we will talk about your concerns during your visit.
Some patients are sensitive to perfumes, colognes, etc. Please don't use them when you visit the clinic.

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M / F Marital status: S M D W

Address_____

City_____ State_____ Zip_____

Mobile Phone _____ E-Mail Address_____

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. Thanks!

- ***Whom may we thank for this referral?*** _____

Please identify the health concern(s) that have brought you to this clinic in order of importance below:

Condition	**Past Treatment**
A. _____	_____
How does this condition affect you? _____	
B. _____	_____
How does this condition affect you? _____	

Please Read and Sign

I authorize the Licensed Acupuncturist to administer acupuncture for treatment of my disorders. ***I understand that appointment times are reserved especially for me and that the full fee is charged for missed appointments and the half-fee for same-day cancellations****. I understand that payment is due at the end of each visit unless otherwise arranged. If my private insurance covers acupuncture, I am responsible for full payment at the time of the visit.*

The practitioners in this building rent space here, but each individual operates a totally separate and independent business entity. As well, each practitioner is solely responsible for the health care services that he/she provides. If you have any questions, please speak with your practitioner. My signature below indicates that I have read and understand the above.

*Signature*_____ *Date*_____

Health History

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

Do you have any infectious diseases? Y / N If yes, please identify: _____

Family History:	Father	Mother	Brothers	Sisters	Spouse	Children
Check those applicable:						
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

Height: _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

Blood Pressure: What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

Hospitalizations and Surgeries:

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

Health History

Menstrual/Birthing History:

Age of First Menses: _____ Birth Control Type: _____ # of Abortions: _____

# of Days of Menses: _____ # of Pregnancies: _____ # of Live Births: _____

Length of Cycle: _____ # of Miscarriages: _____

Lifestyle:

Do you typically eat 2-3 square meals per day? Y / N If no, how many? _____

Exercise routine: _____

Spiritual practice: _____

How many hours per night do you sleep? _____ Do you wake rested? Y / N

Level of education completed: High School Bachelors Masters Doctorate Other

Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y / N Why/Why not? _____

Nicotine/Alcohol/Caffeine/THC use: _____

Have you experienced any major traumas? Y / N Explain: _____

_____

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Interests and hobbies: _____

_____