

**PDX Acupuncture Inc.
Patient Health History Form**

Please fill this form out to the best of your ability and bring it with you to your first office visit. If you have any questions, please feel free to ask me. Thank You!

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (W) _____

Email _____

Date of Birth _____ Age _____ Sex _____

Occupation _____

How did you hear about us? _____

Emergency Contact _____

Phone _____

I will call patients at times, and wish to ensure your privacy regarding treatment at this clinic. In the event that we are unable to reach you by phone please **indicate where it is appropriate to leave messages for you:**

- Home message machine With family member At work Never leave message

What are your primary health concerns? List as many as you can, in the order of their importance to you.

1. _____

2. _____

3. _____

4. _____

5. _____

What are your expectations you have for your visit today?

General Information:

Height _____ Weight _____ Weight 1 yr ago _____ Max weight _____

Typical Diet:

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Foods you crave _____

Primary Interests & Hobbies

Primary form of exercise, if any

How often?

Family History: Do you have a family history of any of the following diseases or conditions? Please include your parents, brothers/sisters, and grandparents, if known. Check all that apply.

- Anemia Cancer Heart Disease Mental Illness Alzheimer's
- Arthritis Diabetes Hypertension Multiple Sclerosis Stroke
- Asthma Epilepsy Kidney Disease Parkinson's Other

Please list other significant family medical history not listed above

Are you currently receiving healthcare? If so, where and from whom? Please provide contact information (phone and address) if available. If not, when was the last time you received medical care and why?

Which of the following childhood illness have you had?

- Diphtheria Measles Scarlet Fever German measles
- Mumps Rheumatic Fever Chickenpox Other _____

Which immunizations have you had?

- Diphtheria Measles/Mumps/Rubella Meningitis Polio Tetanus
- Chickenpox Hepatitis A/B/C Pertussis Flu Other _____

Which diagnostic studies have you had?

- EKG X-Ray Bone Density Scan CT Scan
- EEG Mammogram MRI Other _____

Do have any allergies?

Please any medications, either by prescription or over-the-counter and all vitamins/supplements/herbs, you are regularly taking or have taken in the past 6 months. Include dosage, if known:

Prescription Drugs:(If you brought this with you on a separate paper just attach)

- 1. _____ Reason for taking _____ Dosage _____
- 2. _____ Reason for taking _____ Dosage _____
- 3. _____ Reason for taking _____ Dosage _____
- 4. _____ Reason for taking _____ Dosage _____
- 5. _____ Reason for taking _____ Dosage _____
- 6. _____ Reason for taking _____ Dosage _____

Over the counter Drugs:

- 7. _____ Reason for taking _____ Dosage _____
- 8. _____ Reason for taking _____ Dosage _____
- 9. _____ Reason for taking _____ Dosage _____
- 10. _____ Reason for taking _____ Dosage _____

Vitamins/Supplements:

- 11. _____ Reason for taking _____ Dosage _____
- 12. _____ Reason for taking _____ Dosage _____
- 13. _____ Reason for taking _____ Dosage _____
- 14. _____ Reason for taking _____ Dosage _____

Herbs:

- 15. _____ Reason for taking _____ Dosage _____
- 16. _____ Reason for taking _____ Dosage _____
- 17. _____ Reason for taking _____ Dosage _____
- 18. _____ Reason for taking _____ Dosage _____

Assessing the Areas of Your Life

In assessing your health, it is helpful to have some sense of the degree of satisfaction you feel in various areas of your life. Using the scales below please rate yourself in terms of satisfaction and dissatisfaction. Number 0 means you are very dissatisfied or stressed. Number 10 means you are very satisfied or comfortable.

Friends & Family	0	1	2	4	5	6	7	8	9	10
Physical Environment	0	1	2	4	5	6	7	8	9	10
Health	0	1	2	4	5	6	7	8	9	10
Career	0	1	2	4	5	6	7	8	9	10
Intimate Relationships	0	1	2	4	5	6	7	8	9	10
Recreation	0	1	2	4	5	6	7	8	9	10
Money	0	1	2	4	5	6	7	8	9	10
Personal Growth/Spirituality	0	1	2	4	5	6	7	8	9	10

Comments, information I should know to further your treatment

Please list any habits you would like me to know about (smoking, alcohol, caffeine, etc.):

Review of Systems: Please fill in the circle if you have the symptom currently or check it if you have experienced it in the past 6 months.

Mental/Emotional:	
<input type="radio"/> Depression	<input type="radio"/> Mood Swings
<input type="radio"/> Tension/Stress	<input type="radio"/> Memory problems
<input type="radio"/> Poor concentration	<input type="radio"/> Anxiety
Endocrine:	
<input type="radio"/> Hair Loss	<input type="radio"/> Brittle Nails
<input type="radio"/> Heat Intolerance	<input type="radio"/> Cold Intolerance
<input type="radio"/> Excessive Thirst	<input type="radio"/> Excessive Hunger
<input type="radio"/> General Fatigue	<input type="radio"/> Fatigue after meals
<input type="radio"/> Seasonal Depression	<input type="radio"/> Night Sweats
Head:	
<input type="radio"/> Headaches	<input type="radio"/> Migraines
<input type="radio"/> Head Injury	<input type="radio"/> Jaw pain/TMJ
Immune:	
<input type="radio"/> Chronic Fatigue Syndrome	<input type="radio"/> Swollen Glands
<input type="radio"/> Slow Wound Healing	<input type="radio"/> Frequent colds/flu
<input type="radio"/> Recurrent Infections	

<p>Neurological:</p> <ul style="list-style-type: none"> <input type="radio"/> Seizures <input type="radio"/> Muscle Weakness <input type="radio"/> Loss of memory <input type="radio"/> Vertigo/dizziness <input type="radio"/> Paralysis <input type="radio"/> Numbness/Tingling <input type="radio"/> Easily stressed <input type="radio"/> Shaking/Trembling Limbs
<p>Ears:</p> <ul style="list-style-type: none"> <input type="radio"/> Impaired hearing <input type="radio"/> Earaches <input type="radio"/> Ringing <input type="radio"/> Itching <input type="radio"/> Popping
<p>Nose/Sinuses:</p> <ul style="list-style-type: none"> <input type="radio"/> Frequent colds <input type="radio"/> Stuffiness <input type="radio"/> Sinus Pain <input type="radio"/> Nose Bleeds <input type="radio"/> Hay Fever <input type="radio"/> Loss of Smell
<p>Eyes:</p> <ul style="list-style-type: none"> <input type="radio"/> Floaters/spots <input type="radio"/> Blurriness <input type="radio"/> Color Blindness <input type="radio"/> Double Vision <input type="radio"/> Cataracts <input type="radio"/> Eye Pain/Strain <input type="radio"/> Excessive tearing/Dryness <input type="radio"/> Glaucoma
<p>Neck:</p> <ul style="list-style-type: none"> <input type="radio"/> Lumps <input type="radio"/> Goiter/enlargement of throat <input type="radio"/> Pain/Stiffness
<p>Skin:</p> <ul style="list-style-type: none"> <input type="radio"/> Rashes <input type="radio"/> Acne/Boils <input type="radio"/> Color Changes <input type="radio"/> Lumps <input type="radio"/> Eczema <input type="radio"/> Hives <input type="radio"/> Itching
<p>Urinary:</p> <ul style="list-style-type: none"> <input type="radio"/> Pain <input type="radio"/> Frequency <input type="radio"/> Frequent Infections <input type="radio"/> Incontinence <input type="radio"/> Kidney Stones
<p>Respiratory:</p> <ul style="list-style-type: none"> <input type="radio"/> Cough <input type="radio"/> Cough w/ Blood <input type="radio"/> Asthma <input type="radio"/> Pneumonia <input type="radio"/> Emphysema <input type="radio"/> Painful Breath <input type="radio"/> Shortness of Breath <input type="radio"/> Congestion <input type="radio"/> Wheezing <input type="radio"/> Bronchitis <input type="radio"/> Pleurisy <input type="radio"/> Difficulty Breathing
<p>Cardiovascular:</p> <ul style="list-style-type: none"> <input type="radio"/> Heart Disease <input type="radio"/> High Blood Pressure <input type="radio"/> Low Blood Pressure <input type="radio"/> Blood Clots <input type="radio"/> Phlebitis <input type="radio"/> Rheumatic Fever <input type="radio"/> Ankle Swelling <input type="radio"/> Angina/Chest Pain <input type="radio"/> Heart <input type="radio"/> Palpitations/Fluttering
<p>Intestinal:</p> <ul style="list-style-type: none"> <input type="radio"/> Trouble Swallowing <input type="radio"/> Change in Appetite <input type="radio"/> Nausea/Vomiting <input type="radio"/> Burning Pain in Stomach <input type="radio"/> Jaundice <input type="radio"/> Gallbladder Disease <input type="radio"/> Liver Disease <input type="radio"/> Hemorrhoids <input type="radio"/> Heartburn <input type="radio"/> Abdominal Pain <input type="radio"/> Excess Gas <input type="radio"/> Constipation <input type="radio"/> Diarrhea <input type="radio"/> Black Stools <input type="radio"/> Blood in the Stools
<p>Musculoskeletal:</p> <ul style="list-style-type: none"> <input type="radio"/> Joint Pain/Stiffness <input type="radio"/> Broken Bones <input type="radio"/> Spasms/Cramps <input type="radio"/> Arthritis <input type="radio"/> Weakness <input type="radio"/> Sciatica
<p>Blood/Peripheral Vascular:</p> <ul style="list-style-type: none"> <input type="radio"/> Easily Bruise/Bleed <input type="radio"/> Deep Leg Pain <input type="radio"/> Varicose Veins <input type="radio"/> Anemia <input type="radio"/> Cold hands/feet

Male Reproductive (applies to lifetime):

- Hernias
- Prostate Disease
- STD's
- Impotence
- Premature Ejaculation
- Testicular masses/Pain
- Discharge/sores of Penis

Female Reproductive (applies to lifetime):

Age of first menses (period) _____ Age of last menses _____

How many days between menses? _____

How many days do you menstruate for? _____

Are you currently taking birth control? _____

What is your history of birth control? _____

- Irregular cycles
- Painful menses
- Heavy flow
- Light flow
- Bleeding/spotting between periods
- Clotting
- Discharge
- PMS
- Menopausal Symptoms
- Endometriosis
- Ovarian cysts

Date of last annual exam/Pap/Results: _____

- Sexually active
- Pain during intercourse
- Difficulty conceiving
- Cervical dysplasia
- Sexual difficulties
- STD
- Breast Pain/Tenderness
- Breast lumps

Pregnancies _____

Births _____

Complications _____

Are there any other health concerns that you have which have not been covered in this questionnaire?

Signature _____

Date _____

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