

**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) \_\_\_\_\_ (C) \_\_\_\_\_

Email \_\_\_\_\_

Insurance Information:

Carrier \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Social Security Number \_\_\_\_\_

Occupation \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? Friend \_\_\_\_\_ Northwest Networking Professional \_\_\_\_\_

CitySearch \_\_\_\_\_ Acufinder \_\_\_\_\_ Health Professional's \_\_\_\_\_

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 and 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 and briefly describe why?

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

Do have any allergies?

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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

Is there any additional comments or 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"/> Poor concentration <input type="radio"/> Anxiety <input type="radio"/> Tension/Stress <input type="radio"/> Memory problems
Endocrine: <input type="radio"/> Hair Loss <input type="radio"/> Brittle Nails <input type="radio"/> Excessive Thirst <input type="radio"/> General Fatigue <input type="radio"/> Fatigue after meals <input type="radio"/> Heat Intolerance <input type="radio"/> Cold Intolerance <input type="radio"/> Excessive Hunger <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

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

Musculoskeletal:

- Joint Pain/Stiffness       Broken Bones       Spasms/Cramps       Arthritis        
Weakness       Sciatica

Blood/Peripheral Vascular:

- Easily Bruise/Bleed       Deep Leg Pain       Varicose Veins       Anemia       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