

**Acupuncturist**  
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915 NE 2nd St  
Gresham, OR 97030  
503-661-1302



**Acupuncture Health History Intake**

Name (Last, First) \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

City/State, Zip Code \_\_\_\_\_

Phone Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Is it ok to leave a message on an answering machine? \_\_\_\_\_

Email Address \_\_\_\_\_

May I contact you via email? \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Phone \_\_\_\_\_

How did you find out about the clinic? \_\_\_\_\_

**Health Information:**

Sex \_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_

Have you experienced Acupuncture before? \_\_\_\_\_

**Medications and Supplements:**

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Are you under another practitioner's care? \_\_\_\_\_

For what condition(s) \_\_\_\_\_

What is our focus for today? \_\_\_\_\_

What other forms of treatment have you sought? \_\_\_\_\_

List any allergies: \_\_\_\_\_

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**Please list hospitalizations, surgeries or accidents**

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**Please indicate any diseases you or a blood relative have or have had in the past.**

<b>Illness</b>	<b>You</b>	<b>Relative</b>
<b>Cancer</b>		
<b>Hepatitis</b>		
<b>High Blood Pressure</b>		
<b>Rheumatic Fever</b>		
<b>Diabetes</b>		
<b>Heart Disease</b>		
<b>Seizures</b>		
<b>Emotional Disorders</b>		
<b>Tuberculosis</b>		
<b>STD's</b>		
<b>Herpes</b>		
<b>HIV/Aids</b>		
<b>Bleeding Disorder</b>		

**Please indicate usage and frequency of the following:**

	<b>Yes</b>	<b>No</b>	<b>How Often</b>
<b>Coffee</b>			
<b>Alcohol</b>			
<b>Recreational Drugs</b>			
<b>Tobacco</b>			
<b>Soda</b>			
<b>Water Intake</b>			

**For Men:**

Date of last prostate exam\_\_\_\_\_ PSA Results\_\_\_\_\_  
Frequency of Urination: Daytime \_\_\_\_\_ Night time\_\_\_\_\_  
Color of Urine\_\_\_\_\_ Is there a strong odor?\_\_\_\_\_  
Circle any prostate symptoms you are experiencing:  
Rectal dysfunction Back pain Groin pain Delayed Stream  
Dribbling Incontinence Urine retention Impotence  
Premature Ejaculation Testicular pain Other\_\_\_\_\_

**For Women:**

Are you pregnant? Y N Age of 1<sup>st</sup> Period\_\_\_\_  
Age of last Period \_\_\_\_\_ # of Pregnancies\_\_# of live births\_\_  
# of abortions \_\_ # of miscarriages \_\_ #days between periods\_\_  
#of days of flow\_\_ Color of flow\_\_\_\_\_  
Clots Y N Flow is Light Medium Heavy  
Date of Last Pap \_\_\_\_\_ Date of Mammogram\_\_ Bone Density \_\_  
Irregular results\_\_\_\_\_

**Circle any that apply:**

Fibroids Fibrocystic Breasts Ovarian Cysts PID Endometriosis

**Circle symptoms experienced related to your menstrual cycle:**

Discharge	Vaginal Dryness	Headache	Nausea
Constipation	Diarrhea	Swollen Breasts	Tender Breasts
Mood Swings	Inc Appetite	Dec. Appetite	Hot Flashes
Night Sweats	Inc Libido	Dec. Libido	Insomnia
Bloating	Cramping	Bearing down sensation	

**Any other not listed:**

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## Symptom Survey for Everyone:

The following is a list of symptoms that you may or may not experience. Please indicate a check mark next to the symptoms you sometimes experience and a + sign by the symptoms you experience frequently. These groupings are broken up into elements. This will help us together find out which elements are out of balance and to create a treatment plan for you.

### Earth

lack of appetite  excessive appetite  vomiting  loose stool/diarrhea  
 nausea  heartburn/reflux  burping  food "sits" in stomach   
 hemorrhoids  bruising  fatigue after eating  foggy thinking  
 tendency to obsession in work/relationships

### Fire

insomnia  heart palpitations  nightmares  mental restlessness  
 angina  chest tightness  anxiety  laughing for no reason  Vivid dreams

### Metal

cough  grief  decreased sense of smell  nasal congestion  rashes  
 bronchitis  diverticulitis  colitis  claustrophobia  anxiety  asthma  
 shortness of breath  constipation

### Water

low back pain  knee problems  ear ringing  hearing loss  kidney stones  
 hair loss  decreased sex drive  urinary problems  incontinence  
 osteoporosis  hot flashes  night sweats  early morning diarrhea

### Wood

eye problems  jaundice  gall stones  soft nails  brittle nails  sighing  
 light colored stools  easily angered  liver disease  spasms or twitching   
 tics  high blood pressure  migraines  hiccups  high cholesterol  anger  
 difficulty digesting oily foods  difficulty making decisions

### Blood and Qi

fatigue  edema  blood in stool  black stool  bruising  dizziness  
 allergies  hay fever  frequent colds  sudden weight loss  dry skin  
 dry hair  hair thinning/falling out  poor memory  floaters in vision  
 intolerance to weather changes  cold hands and feet