Acupuncturist
Cynthia Conlin, LAc.,MSTOM
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 on Insurance ____ Height ________ Weight _____
Birth Date___________________ Age________
Have you experienced Acupuncture before? ________
Medications and Supplements:

____
____
____
____
____

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:
____
____

Please list hospitalizations, surgeries or accidents

____

____

____

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

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

Please indicate usage and frequency of the following:

	Yes	No	How Often
Coffee			
Alcohol			
Recreational Drugs			
Tobacco			
Soda			
Water Intake			

Prostate/Urine Questions:
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___________

Uterine/Menstrual Questions:
Are you pregnant? Y N Age of 1st 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:
____
____
____
____

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 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

nature's touch healing center

Please assist us in maintaining the accuracy of your medical record by sharing your gender identity and pronouns.

Pronouns (ex. she/her/hers):______________________________

Please circle your gender identity below:

Female

Male

FTM - Transgender Female to Male

MTF - Transgender Male to Female

Genderqueer

Non-Binary

Other*

Choose not to disclose

*If none of the above describe your gender identity, please advise us.

Female-to-Male (FTM) or Transgender Man: A person born with female genitalia who feels they are male/ a man and lives as a male/ a man. Some will use the term male.

Male-to-Female (MTF) or Transgender Female: A person born with male genitalia who feels they are female/ a woman and lives as a female/ a woman. Some will use the term female.

Genderqueer: Used by some individuals who do not identify as either male or female, or identify as both male and female. “Questioning” may be the term used by some individuals.

Non-Binary: A term for individuals who do not fit within the gender binary. Individuals who do not identify as only female or only male all the time.