Acupuncture Intake

Spirit Point Medicine
1516 SE 43rd Suite 2
Portland OR 97215

NAME:_____Date_____DOB:_____
Address_____
City _____ State _____ Zip _____ Email _____

Telephone # (home) _____ (work) _____(cell)_____
Age _____ Gender _____ Pronouns _____ Weight _____ Height _____

How did you hear about our clinic?
_____

Relationship Status: □ Single □ Married □ Partnership □ Separated □ Divorced □ Widowed
Live with: □ Spouse □ Partner □ Parent/s □ Children □ Friend/s □ Alone □ Roommate/s

Emergency Contact Name _____ Relationship _____
Phone_____

Dominant hand: Right Left

Are you currently under the care of a medical professional? Yes No
If YES, please provide name and contact info:
_____
If NO, when and where did you last receive health care, and for what reason?
_____

What are your most important health concerns? List in order of importance.
1) _____
How does this affect your life?
_____

2) _____
How does this affect your life?
_____

3)_____
How does this affect your life?
_____

4)_____
How does this affect your life?
_____

Any other health issues we should be aware of?
_____
_____

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General Information

Significant traumas or illnesses (auto accidents, falls, etc)

_____

Birth and childhood health (forceps delivery, childhood asthma, etc.

_____

What are the current stressors in your life?

_____

What do you do for exercise and self-care?

_____

Allergies

Drug Allergies: _____

Food Allergies: _____

Environmental Allergies: _____

Medications and Supplements

Please list any prescription medications, over the counter medications, vitamins, or supplements you are currently taking or have taken within the past 2 months:

_____
_____
_____
_____

Hospitalizations and Surgeries/Years

_____
_____
_____

Habits

☐ Coffee ☐ Tea ☐ Soda ☐ Alcohol ☐ Sugar ☐ Salt ☐ Marijuana ☐ Drugs _____
Tobacco use: ☐ Never smoked ☐ Former smoker ☐ Current daily smoker
How many/day_____Number of alcoholic drinks/week_____

Diet

Typical diet and time eaten:
Morning _____
Afternoon _____
Evening _____
Are there foods that you avoid eating? Why? _____

Patient Name:
DOB:

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Please check any that apply to you currently, <u>underline any that you have experienced significantly in the past.</u>

GENERAL

□ Poor sleep □ Heavy sleep □ Insomnia □ Fatigue □ Cold back □ Cold abdomen □ Autoimmune disease □ Frequent colds/low immunity □ Sudden energy drop at _____(time) □ Chronic or contagious disease_____

SKIN AND HAIR

□ Night sweats □ Sweat easily □ Rashes □ Ulcerations □ Hives □ Itching □ Eczema □ Pimples □ Dandruff □ Changes in hair/skin texture □ Loss of hair □ Bleed/bruise easily (where) _____ □ Other hair or skin problems_____

HEAD, EYES, EARS, NOSE AND THROAT

□ Dizziness □ Eye strain □ Eye pain □ Night blindness □ Spots in eyes □ Color blindness □ Cataracts □ Glaucoma □ Changes in vision □ Earaches □ Ringing in ears □ Poor hearing □ Nose bleeds □ Sinus problems □ Mucus □ Dry mouth or throat □ Copious saliva □ Tooth/gum problems □ Jaw problems □ Grinding teeth □ Facial pain □ Recurrent sore throats □ Migraines □ Sores on lips or tongue □ Peculiar tastes/smells □ Headaches (where and when)_____ □ Other head or neck problems_____

CARDIOVASCULAR

□ High blood pressure □ Low blood pressure □ Chest pain □ Irregular heartbeat □ Fainting □ Cold hands/feet □ Swelling in hands/feet □ Anemia □ Blood clots □ Phlebitis □ Difficulty breathing □ Other_____

RESPIRATORY

□ Cough □ Allergies □ Coughing blood □ Fevers □ Chills □ Asthma □ Bronchitis □ Pneumonia □ Difficulty breathing when lying down □ Tight chest □ Production of phlegm (color) _____

GASTROINTESTINAL

Bowel movements: Frequency _____ Color _____ Texture/shape _____ □ Poor appetite □ Heavy appetite □ Change in appetite □ Cravings □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Bad breath □ Gas or burping □ Abdominal pain or cramps □ Rectal pain □ Hemorrhoids □ Foul smelling stools □ Black or bloody stools □ Laxative use ____/week; type _____ □ Strong thirst (cold/hot drinks)

GENITO-URINARY

□ Pain on urination □ Frequent urination □ Blood in urine □ Urgency to urinate □ Unable to hold urine □ Kidney stones □ Sexually transmitted disease □ Prostate trouble □ Wake up to urinate _____/night; time _____

Patient Name:
DOB:

PREGNANCY AND GYNECOLOGY

Age at first menses_____ Date of most recent menses _____
Days of flow_____ Days from one cycle to next _____ Last PAP_____
Number pregnancies_____ Number births_____ □ Miscarriage/termination
□ Heavy flow □ Light flow □ Cramps or clots □ Vaginal discharge □ Breast lumps □ Vaginal sores or pain
□ Irregular periods □ Fertility challenges
Birth control: type and duration_____
Changes in body/psyche prior to menstruation_____

MUSCULSKELETAL

□ Neck pain □ Upper back pain □ Lower back pain □ Sciatica pain □ Arthritis □ Muscle pains (where)
_____ □ Joint pains (where) _____
Old muscle, bone, or joint injuries _____ □ Other joint or bone problems_____

NEUROPSYCHOLOGICAL

□ Tremors □ Vertigo □ Localized weakness □ Areas of numbness □ Poor coordination □ Poor memory □
Brain fog □ Concussion □ Seizures □ Depression □ Anxiety □ Anger □ Trouble managing stress
□ Treated for emotional problems When:_____
□ Considered/attempted suicide □ Other neurological or psychological problems_____

Family History Please indicate if a close relative (parent, grandparent, sibling) has any of the following:

Condition	Relative	Condition	Relative
□ Allergies/Asthma		□ Eczema/Psoriasis	
□ Anemia		□ Food Intolerances	
□ Arthritis		□ Heart Disease	
□ Autoimmune Disease		□ High Blood Pressure	
□ Birth Defects		□ Kidney Disease	
□ Bleeding Disorder		□ Mental Illness	
□ Cancer		□ Seizures	
□ Depression/Anxiety		□ Stroke	
□ Diabetes		□ Tuberculosis	
□ Other:		□ Other:	

□ I don't know the family medical history