Acupuncture Intake

Spirit Point Medicine
1910 SE 11th Ave Suite 200
Portland OR 97214

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 □ Partner □ 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?

____

____

Patient Name:
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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? ____

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

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 □ Eye 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
□ 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
□ Problems 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 _______________

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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