Aculinks Acupuncture Clinic – New Patient Medical History Intake Form

7636 SE FOSTER ROAD, PORTLAND, OR 97206-5225 T: 503-473-3613 F: 503-972-1849

Name: _____ **DOB:** ____/____/____ **Sex:** □M□F **Date:** _____

Place of Birth: _____ **S.S. #:** ____-___-____ **Marital Status:** _____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Email:** _____

Race/Ethnicity: □ American Indian or Alaska Native □ Asian □ Black or African American

□ Hispanic □ Native Hawaiian or Other Pacific Islander □ White or Caucasian □ Other: _____

Highest Education: _____ **Occupation:** _____ **Employer:** _____

Work Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

How did you hear about us? □ Family □ Friend □ Physician □ Web □ Other: _____

Have you ever had acupuncture treatment(s) before today?

□ Yes – many times □ Yes – a few times □ No – never

LIST OF CURRENT MEDICATION: _____

_____

Antacids	Y / N / P	Appetite Suppressants	Y / N / P	Laxatives	Y / N / P	Sleeping Pill	Y / N / P
Antibiotics	Y / N / P	Cortisone	Y / N / P	Pain Relievers	Y / N / P		

CURRENT HEALTH CONDITION

Please circle the following: Y=YES / N=NO / P=PAST

Anemia	Y / N / P	Easy Bleeding or Bruising	Y / N / P	Migraines	Y / N / P
Angina	Y / N / P	Eye Tearing or Dryness	Y / N / P	Mood Swings	Y / N / P
Anxiety or Nervousness	Y / N / P	Fatigue	Y / N / P	Muscle Spasms or Cramps	Y / N / P
Arthritis	Y / N / P	Frequent Sore Throat	Y / N / P	Nausea	Y / N / P
Asthma	Y / N / P	Frequent Urination	Y / N / P	Night Sweats	Y / N / P
Belching or Passing Gas	Y / N / P	Headaches	Y / N / P	Numbness or Tingling	Y / N / P
Blood in Stool	Y / N / P	Heart Disease	Y / N / P	Palpitation/Fluttering	Y / N / P
Blurriness	Y / N / P	Heartburn	Y / N / P	Pneumonia	Y / N / P
Broken Bones	Y / N / P	Hemorrhoids	Y / N / P	Rashes	Y / N / P
Bronchitis	Y / N / P	High/Low Blood Pressure	Y / N / P	Sciatica	Y / N / P
Change in Appetite	Y / N / P	High Fever	Y / N / P	Slow Wound Healing	Y / N / P
Chest Pain	Y / N / P	Impaired Hearing	Y / N / P	Swelling	Y / N / P
Cold Hands/Feet	Y / N / P	Itching	Y / N / P	Tension	Y / N / P
Constipation	Y / N / P	Jaw/TMD Problems	Y / N / P	Ulcer	Y / N / P
Cough	Y / N / P	Joint Pain or Stuffiness	Y / N / P	Varicose Veins	Y / N / P
Depression	Y / N / P	Lumps	Y / N / P	Weakness	Y / N / P

Aculinks Acupuncture Clinic – New Patient Medical History Intake Form

7636 SE FOSTER ROAD, PORTLAND, OR 97206-5225 T: 503-473-3613 F: 503-972-1849

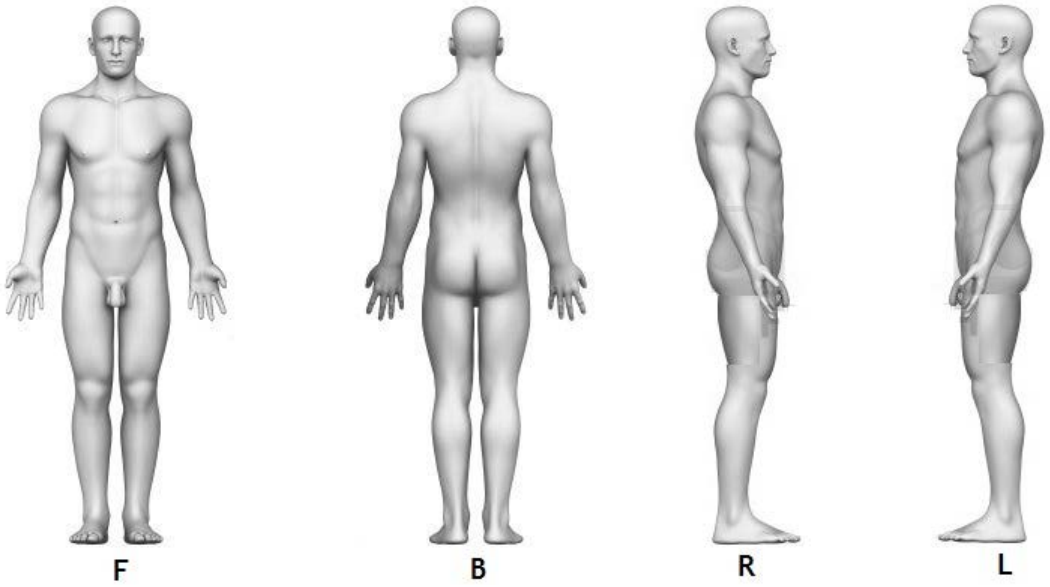
Male Patients:

Prostate Disease	Y / N / P	Premature Ejaculation	Y / N / P	Testicular Pain	Y / N / P	Impotence	Y / N / P

Female Patients:

Length of Cycle	_____ Days	Heavy or Excessive Flow	Y / N / P	Clotting	Y / N / P
Duration of Menses	_____ Days	Regular Cycles	Y / N / P	PMS	Y / N / P
Pregnancies	_____	Difficulty Conceiving	Y / N / P	Breast Pain	Y / N / P
Abortions	_____	Menopausal Symptoms	Y / N / P	Painful Menses	Y / N / P

On figures identify your area of Pain (P), Numbness (N), Spasm (S), Tenderness (T), and intensity (0-10).
no pain = 0 ←1 - - - 2 - - - 3 - - - 4 - - - 5 - - - 6 - - - 7 - - - 8 - - - 9 → 10 = worst pain imaginable
i.e.: Right shoulder pain and arm numbness, circle the right shoulder and indicate P, and arm with an N.



What are your chief health complaints that lead you to visit our clinic? What cause the problem in the first place?

1. _____

2. _____

3. _____

4. _____

The undersigned agrees that the information above is correct.

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____ **DATE:** _____