Therapia
WELLNESS CLINIC

2505 SW Spring Garden St, Ste 100
Portland, OR 97219
P: (503) 841-6222
www.TherapiaClinic.com

Acupuncture Intake Form

General Information

Legal Name:_____ What name do you use (if different)?_____

Assigned Sex: M F I Gender:_____ Pronoun:_____ Date of Birth:____/____/____ Age:____

Address:_____ City:_____ State:_____ Zip:_____

Phone:(_____) _____-_____ Email:_____

Emergency Contact:_____ Relationship:_____ Phone:(_____) _____-_____

Occupation:_____ How did you hear about us? _____

Medical Information

Please describe the main reason for your visit today (chief concern):_____

_____

Other concerns you would like to address:_____

_____

Are you or have you previously received treatment for this problem from any other health professionals? Yes No

If yes, what was your diagnosis?_____

Have you had acupuncture before? Yes No If yes, when?_____

Are you taking any medications or herbal supplements? List with dosage, if known:_____

_____

Are you interested in taking Chinese Herbs? Yes No

Please list any major past or current medical issues or major traumas/diseases in your health history:_____

_____

List any current allergies:_____

Have you ever had any of the following?

	Y	N		Y	N		Y	N
Heart Disease			Chest/Lung Problems			Pregnancy Date of Last _____		
High Blood Pressure			Kidney Disease			Prostate Problems		
Hepatitis/Liver Disease			Cancer _____			Arthritis		
High Cholesterol			Artificial Joints			Headaches/Migraines		
Thyroid Disorder			Broken Bones			Seizures/Convulsions		
Fainting/Dizziness			Mental Health Disorders			Anemia/Clotting Dys.		
Diabetes			Substance Abuse Problems			Pacemaker		

Family History

Please circle if a family member has had any of the following: Diabetes Seizures Stroke Arthritis Lupus

Cancer Heart Disease Hypertension Mental Disorders Other:_____ Comments:_____

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Review of Systems

Please fill this out carefully, even if some of the symptoms don't seem at all connected to your current issue! Place **one check** next to a symptom you have experienced, **two checks** next to a frequently occuring symptom, and **three checks** next to a symptom that is particularly distressing to you.

Head and Face
Headaches
Dizziness
Memory Loss
Other:_____

Eyes
Blurry Vision
Eyelid Twitching
Floaters
Pain
Other:_____

Nose
Frequent Colds
Sinus Trouble
Bleeding
Other:_____

Mouth
Dental Problems
Gum Problems
Teeth Grinding/TMJ
Unusual Tastes
Other:_____

Throat
Sore Throat
Hoarseness
Diffculty Swallowing
Dryness
Other:_____

Respiration
Difficulty Inhaling
Difficulty Exhaling
Pain
Cough
Congestion
Shortness of Breath
Other:_____

Heart and Chest
High Blood Pressure
Low Blood Pressure
Chest Pain
Chest Tightness
Difficulty Lying Down
Other:_____

Circulation
Easy Bruising
Easy Bleeding
Cold Limbs—Hands or Feet
Reynaud's Syndrome
Other:_____

Gastrointestinal
Always Thirsty
Never Thirsty
Excessive Appetite
Low Appetite
Gas/Bloating
Stomach or Abdominal Pain
Nausea
Diarrhea/Loose Stools
Constipation
Rectal Bleeding
Colon Problems
Other:_____

Urination
Frequent
Difficult
Painful
Nocturnal
Bleeding
Other:_____

Skin
Acne
Dryness
Moles that Change
Lumps
Excessive Sweating
Night Sweats
Rarely Sweat
Other:_____

Neurological
Nervousness/Anxiety
Tremors
Numbness or Tingling
Lack of Coordination
Nerve Pain
Other:_____

Sleep
Insomnia
Drowsiness
Excessive Dreaming
Waking Easily
Other:_____

Pain—please describe:

_____
_____
_____
_____

Are there any other health concerns you'd like to address?

_____
_____
_____
_____

Patient/Guardian Signature:_____ **Date:**_____/_____/_____

Printed Patient Name:_____