NW Naturopathic Medicine Clinic * 503.639.3777 * 7000 SW Hampton St., Ste. 130 Tigard, OR 97223

NEW PATIENT ACUPUNCTURE INTAKE

How did you hear about us? _____

Main Complaints/Goals	How long?	Initial Cause:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

Are you under the care of a physician now? Yes No (Please circle one)

Physician Name:_____Phone:_____

Family Medical History (check all that apply)

- □ Arteriosclerosis
- □ Stroke
- □ Seizures
- □ Cancer (family member and type)_____
- □ Asthma
- □ Heart Disease
- □ Autoimmune Disease
- □ Alcoholism
- □ Hypertension
- □ Diabetes

Personal Medical History (check all that apply)

- □ ADD/ADHD
- □ Diabetes
- □ Hypertension
- □ Rheumatic Fever
- □ STD_____
- □ Epilepsy
- □ Multiple Sclerosis
- □ Chronic Fatigue
- □ Autoimmune Disease
- □ Emphysema
- □ Hepatitis_____
- □ Polio
- □ Ulcers
- □ Arteriosclerosis
- □ Fibromyalgia
- □ Stroke
- □ Gout
- □ Seizures
- □ Thyroid Disorder
- □ Asthma
- □ Heart Disease
- □ Pneumonia
- □ Tuberculosis
- □ Alcoholism
- □ AIDS/HIV
- □ Pacemaker
- □ Heart Attack

Abuse (optional): Physical, Emotional, Sexual _____

Cancer_____

Major Trauma_____

Surgeries/Hospitalizations_____

Other_____

Allergies_____

List or Attach ALL Prescription Medications	**List ALL Supplements/Herbs**
_____	_____
_____	_____
_____	_____

Print Name:_____ DOB: _____ Date: _____

Skin and Hair (check all that apply)

- □ Acne
- □ Hives
- □ Rashes
- □ Bed sores
- □ Itchy skin
- □ Eczema
- □ Psoriasis
- □ Ulcerations
- □ Moles
- □ Skin tags
- □ Hair loss
- □ Dandruff
- □ Skin: dry or moist?
- □ Skin discoloration (location?)_____
- □ Fungal infections (location?)_____

Sensory (check all that apply)

- □ Glasses
- □ Blurred vision
- □ Sees floaters
- □ Eye strain
- □ Eye pain
- □ Red eyes
- □ Itchy eyes
- □ Excessive tearing
- □ Dry eyes
- □ Night blindness
- □ Glaucoma
- □ Cataracts
- □ Poor hearing
- □ Ringing in ears
- □ Teeth problems
- □ Gum problems
- □ Dry mouth
- □ Excessive saliva
- □ Sores on lips or tongue
- □ Swollen glands
- □ Chronic sore throat
- □ Concussions
- □ Headaches
- □ Migraines
- □ Sinus problems
- □ Nose bleeds
- □ Excess phlegm (color?)_____ _____
- □ Facial pain
- □ Other_____ _____ _____

Respiratory (check all that apply)

- □ Frequent colds
- □ Tight chest
- □ Wheezing
- □ Cough wet or dry
- □ Phlegm color _____
- □ Shortness of breath
- □ Phlegm thick or thin?
- □ Difficulty breathing while lying down

Cardiovascular (check all that apply)

- □ High blood pressure
- □ Chest pain
- □ Low blood pressure
- □ Fainting
- □ Tachycardia
- □ Bradycardia
- □ Irregular heart beats
- □ Palpitations
- □ Phlebitis
- □ Stroke
- □ Blood clots
- □ Vasculitis
- □ Varicose veins
- □ Edema

Gastrointestinal (check all that apply)

- □ Bad breath
- □ Hiccup
- □ Acid reflux/ heartburn
- □ Hiatal hernia
- □ Nausea
- □ Vomiting
- □ Twitching bowels
- □ Gas
- □ Bloating
- □ Rectal pain
- □ Hemorrhoids
- □ Anal fissures
- □ Laxative use
- □ Itchy anus
- □ Burning anus
- □ Diarrhea
- □ Constipation
- □ Intestinal pain
- □ Liver/Gallbladder issues

Bowel Movements:
Frequency _____
Loose or hard _____
Color_____
Odor_____
Mucus (yes or no)
Blood (yes or no)

Genitourinary (check all that apply)

- □ Frequent UTI
- □ Pain on urination
- □ Frequent urination (# per day)_____
- □ Urgent urination
- □ Kidney Disease
- □ Color of Urine _____
- □ Blood in urine
- □ Unable to hold urine
- □ Bedwetting
- □ Enlarged prostate
- □ Kidney stones
- □ Pain with sex
- □ Libido issues
- □ Wake at night to urinate
- □ **Male Only:**
- □ Prostate issues
- □ Erectile dysfunction
- □ Premature ejaculation
- □ Impotence

General Symptoms (check all that apply)

- □ Prefer hot drinks
- □ Prefer cold drinks
- □ Cold hands or feet
- □ Chills
- □ Fever/hot feeling
- □ Weight loss/gain #____lbs.
- □ Poor sleep
- □ Heavy Sleep
- □ Disturbing dreams
- □ Sweats easily
- □ Body heaviness
- □ Fatigue
- □ Bruise/bleed easily
- □ Sleep apnea
- □ Vertigo
- □ Dizziness
- □ Peculiar taste (describe) _____

Print Name:_____ DOB: _____ Date: _____

Psychological (check all that apply)

- □ Anxious
- □ Fearful
- □ Irritable
- □ Rage
- □ Cries often
- □ Depressed
- □ Suicidal thoughts
- □ Poor memory
- □ Attempted suicide
- □ OCD
- □ Anorexia
- □ Bulimia

Female Only (check all that apply)

- □ Date of last period _____
- □ Length of cycle _____
- □ Duration of flow _____
- □ Color of blood _____
- □ Amenorrhea
- □ Irregular periods
- □ Heavy periods
- □ Painful periods
- □ Clots
- □ Spotting (time during cycle?)_____
- □ Breast tenderness
- □ Breast lumps
- □ Vaginal pain
- □ Vaginal itching
- □ Vaginal dryness
- □ Vaginal sores
- □ Vaginal odor
- □ Vaginal discharge (color)_____
- □ Endometriosis
- □ Ovarian cysts
- □ PMS (describe) _____ _____
- □ Age menses began _____
- □ Age at menopause _____
- □ Pregnancies_____
- □ Miscarriages_____
- □ Abortions _____
- □ Fertility issues (explain) _____ _____
- □ Are you currently pregnant (yes or no) # of weeks _____
- □ Trauma at your birth _____
- □ Trauma while giving birth _____
- □ Date of last PAP: _____ Normal: Yes No
- □ Date of last Mammogram: _____ Normal: Yes No

Neurological/Musculoskeletal (check all that apply)

- □ Tremors
- □ Tics
- □ Seizures
- □ Muscle twitching
- □ Muscle spasms
- □ Muscle atrophy
- □ Restless Leg
- □ Limb weakness
- □ Muscle pain
- □ Radiating pain
- □ Rib side pain
- □ Neck pain
- □ Shoulder pain
- □ Elbow pain
- □ Wrist pain
- □ Hip pain
- □ Knee pain
- □ Ankle pain
- □ Foot pain
- □ Hand Pain
- □ Finger pain
- □ Toe pain
- □ Stiffness
- □ Upper back pain
- □ Lower back pain
- □ Joint pain
- □ Joint swelling
- □ Numbness
- □ Tingling
- □ Arthritis
- □ Rheumatoid arthritis
- □ Osteoarthritis
- □ Spinal stenosis
- □ Spondylopathy
- □ Disc herniation _____ _____
- □ Bulging disc _____ _____
- □ Other_____ _____

Habits/Diet (check all that apply)

Appetite
- □ Low
- □ High
- □ Normal

Thirst
- □ Low
- □ High
- □ Normal

Cravings
- □ Salty Food
- □ Greasy Food
- □ Fried Food
- □ Sweets

Other

Alcoholic Drinks #____ per day/week

Tobacco #____pack per day #____ years

Drug Use (type) _____

Coffee #_____ cups/day

Water #_____ cups/day

Soda #_____ cups/day

Average Daily Menu

Morning _____

_____

Afternoon _____

_____

Evening _____

_____

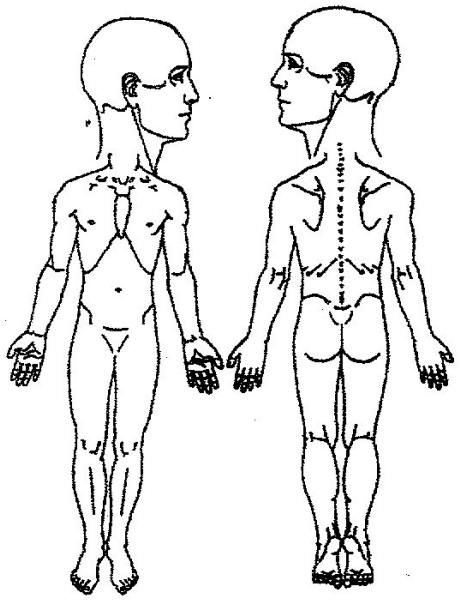
Snacks _____

Exercise _____

Print Name:_____ DOB: _____ Date: _____

Check the column to indicate the level of your pain for each word, or leave blank if it does not apply to you.__

		Mild	Moderate	Severe
1	Throbbing	____	____	____
2	Shooting	____	____	____
3	Stabbing	____	____	____
4	Sharp	____	____	____
5	Cramping	____	____	____
6	Gnawing	____	____	____
7	Hot-burning	____	____	____
8	Aching	____	____	____
9	Heavy	____	____	____
10	Tender	____	____	____
11	Splitting	____	____	____
12	Tiring-Exhausting	____	____	____
13	Sickening	____	____	____
14	Fearful	____	____	____
15	Cruel-Punishing	____	____	



Mark or comment on the above figure where you have your pain or problems.

Indicate on this line how bad your pain is—at the left end of line means no pain at all, at right end means worst pain possible.

No Pain		Worst Possible Pain

Print Name:_____ DOB: _____ Date: _____