Lisa Pate

Licensed Acupuncturist, Registered Dietitian

1222 SE Division St. Portland OR 97202 ph: 503.880.2785

Initial Intake Form

Please answer these questions as thoughtfully as possible. Chinese medicine is a holistic medicine that seeks to individualize each treatment plan. Many of the questions that follow may seem unrelated to your main complaint or reason for seeking care. However, the information you provide here & during your visit will help me to determine the best approach for your treatment. All the information in this questionnaire is STRICTLY CONFIDENTIAL by law. Thank you! I look forward to working with you.

Personal information

Name _____ Date _____

Address _____

City _____ State _____ Zip code _____

Phone: *(home)* _____ *(work)* _____

E-mail _____ Age _____ Date of birth _____

Occupation _____ Social Security # _____

Gender: ❑ Male ❑ Female

Relationships: ❑ Married ❑ Partnership ❑ Single ❑ Separated ❑ Divorced ❑ Widowed

Live with: ❑ Spouse or partner ❑ Parents ❑ Children ❑ Friends ❑ Alone

Emergency contact: _____ Relationship: _____

Address _____

Phone: *(home)* _____ *(work)* _____

How did you hear about our clinic? _____

Insurance information

Do you have health insurance that covers acupuncture? ❑ Yes ❑ No ❑ Unsure

Insurance company name: _____

Address _____

City _____ State _____ Zip code _____

Phone: _____

Policy / Group # _____ Identification # _____

Health History Questionnaire

Are you currently receiving healthcare? ❑ Yes ❑ No

If yes, where and from whom?

If no, when and where did you last receive medical or healthcare?

For what reason?

What are your most important health concerns that you are seeking treatment for?
List as many as you can in order of importance:

Do you have any known contagious diseases at this time? ❑ Yes ❑ No

If yes, what?

Family History

	Father	Mother	Brothers	Sisters	Spouse	Child(ren)
Age *(if living)*						
Health *(G-good / F-fair / P-poor)*						

Are there any health conditions that are known to run in your family? If so, what?

Hospitalization and Surgery

What hospitalizations and/or surgeries have you had?

Reason: Year:

Reason: Year:

Reason: Year:

X-Rays and Special Studies

X-rays, CAT scans, MRIs, or other studies you have had:

→

Allergies

If applicable, please list food, drug, chemical, animal or environmentals that you are allergic or hypersensitive to:

Current Medications

Please check all of the following medications that you are currently using:

- ❑ Laxatives
- ❑ Pain relievers
- ❑ Antacids
- ❑ Cortisone
- ❑ Appetite suppressents
- ❑ Antibiotics
- ❑ Tranquilizers
- ❑ Thyroid medication
- ❑ Sleeping pills
- ❑ Other

Please list any prescription medications, over-the-counter medications, vitamins, or other supplements you are currently taking:

1) 2)

3) 4)

5) 6)

Height: Weight: Max weight: when? Lowest weight: when?

Typical Food Intake

Breakfast:

Lunch:

Dinner:

Snacks:

To Drink:

Which food do you prefer? ❑ warm ❑ cold ❑ spicy Which drinks do you prefer? ❑ warm ❑ cold

Do you strongly desire any particular food or flavor?

Do you strongly dislike any particular food or flavor?

Please list any foods which make you feel bad/aggravate symptoms:

→

HABITS

What are your main interests and hobbies?

Do you exercise? ❑ Yes ❑ No

If yes, what kind? How often?

Do you sleep well? ❑ Yes ❑ No Number of hours? _____

Do you Awaken rested? ❑ Yes ❑ No Do you have vivid or disturbing dreams? ❑ Yes ❑ No

Check Yes or No for the following as they relate to your current lifestyle:

Do you enjoy your work?	❑ Yes ❑ No	Drink coffee? Other caffeine?	❑ Yes ❑ No
Take vacations?	❑ Yes ❑ No	How much/often?	
Spend time outside?	❑ Yes ❑ No	Drink alcoholic beverages?	❑ Yes ❑ No
Do you read?	❑ Yes ❑ No	How much/often?	
Watch television?	❑ Yes ❑ No	Use tobacco?	❑ Yes ❑ No
Have a supportive relationship?	❑ Yes ❑ No	How much/often?	
Have a religious or spiritual practice?	❑ Yes ❑ No	Use recreational drugs?	❑ Yes ❑ No
Do you eat three meals a day?	❑ Yes ❑ No	Do you have a history of abuse?	❑ Yes ❑ No
Do you add salt to food?	❑ Yes ❑ No	Any major traumas?	❑ Yes ❑ No

General Characteristics

Check all that apply to you:

In what weather do you feel best? ❑ sun ❑ clouds ❑ rain ❑ heat ❑ cold ❑ wind

In what weather do you feel worse? ❑ sun ❑ clouds ❑ rain ❑ heat ❑ cold ❑ wind

With exercise, you feel: ❑ energized ❑ fatigued

You generally feel: ❑ hot ❑ warm ❑ cool ❑ cold extremities ❑ warm extremities

Your thirst is: ❑ extreme ❑ moderate ❑ little ❑ for cold drinks ❑ for warm drinks

You perspire: ❑ a lot ❑ little/none ❑ at night ❑ easily/without exertion ❑ with anxiety

Other:

Predominant emotion: ❑ Happy/joyful ❑ Sad/depressed ❑ Easily angered/irritable ❑ Fearful

Other:

→

Review Of Systems

***Y**=current condition; **N**=never had; **P**=past condition*

ENDOCRINE

Hypo or hyperthyroid?	❑ Y	❑ N	❑ P
Excessive hunger?	❑ Y	❑ N	❑ P
Hypoglycemia?	❑ Y	❑ N	❑ P
Excessive thirst?	❑ Y	❑ N	❑ P
Diabetes?	❑ Y	❑ N	❑ P
Seasonal depression?	❑ Y	❑ N	❑ P
Heat or cold intolerance?	❑ Y	❑ N	❑ P

Other?

IMMUNE

Fatigue?	❑ Y	❑ N	❑ P
Chronic infections?	❑ Y	❑ N	❑ P
Chronically swollen glands?	❑ Y	❑ N	❑ P
Slow wound healing?	❑ Y	❑ N	❑ P
Chronic Fatigue Syndrome?	❑ Y	❑ N	❑ P

Other?

NEUROLOGIC

Seizures?	❑ Y	❑ N	❑ P
Paralysis?	❑ Y	❑ N	❑ P

If yes, where?

Muscle weakness?	❑ Y	❑ N	❑ P
Numbness or tingling?	❑ Y	❑ N	❑ P
Loss of memory?	❑ Y	❑ N	❑ P
Loss of balance?	❑ Y	❑ N	❑ P
Vertigo or dizziness?	❑ Y	❑ N	❑ P

Other?

MENTAL/EMOTIONAL

Therapy for emotional work?	❑ Y	❑ N	❑ P
Depression?	❑ Y	❑ N	❑ P
Mood swings?	❑ Y	❑ N	❑ P
Considered/attempted suicide?	❑ Y	❑ N	❑ P
Anxiety or nervousness?	❑ Y	❑ N	❑ P

Other?

HEAD

Headaches?	❑ Y	❑ N	❑ P
Head injury?	❑ Y	❑ N	❑ P
Migraines?	❑ Y	❑ N	❑ P
Jaw/TMJ problems?	❑ Y	❑ N	❑ P
Feeling of heaviness in head?	❑ Y	❑ N	❑ P
Hair loss?	❑ Y	❑ N	❑ P
Lite headedness?	❑ Y	❑ N	❑ P

Other?

EYES

Spots in eyes/floaters?	❑ Y	❑ N	❑ P
Cataracts?	❑ Y	❑ N	❑ P
Blurriness?	❑ Y	❑ N	❑ P
Eye pain, burning, strain?	❑ Y	❑ N	❑ P
Redness?	❑ Y	❑ N	❑ P
Tearing or dryness?	❑ Y	❑ N	❑ P
Itchy eyes?	❑ Y	❑ N	❑ P
Glaucoma?	❑ Y	❑ N	❑ P
Glasses or contacts?	❑ Y	❑ N	❑ P

Other?

EARS

Impaired hearing?	❑ Y	❑ N	❑ P
Chronic ear infections?	❑ Y	❑ N	❑ P
Earaches?	❑ Y	❑ N	❑ P
Plugged ears?	❑ Y	❑ N	❑ P
Ringing/noise in ears?	❑ Y	❑ N	❑ P

Other?

NOSE AND SINUSES

Frequent colds?	❑ Y	❑ N	❑ P
Nose bleeds?	❑ Y	❑ N	❑ P
Stuffiness?	❑ Y	❑ N	❑ P
Chronic drippy nose?	❑ Y	❑ N	❑ P

→

Review Of Systems (cont.)

***Y**=current condition; **N**=never had; **P**=past condition*

Sinus problems? ❑ Y ❑ N ❑ P
Loss of smell? ❑ Y ❑ N ❑ P
Hay fever? ❑ Y ❑ N ❑ P
Frequent sneezing? ❑ Y ❑ N ❑ P
Post-nasal drip? ❑ Y ❑ N ❑ P
Other?

MOUTH AND THROAT

Frequent sore throat? ❑ Y ❑ N ❑ P
Choking feeling? ❑ Y ❑ N ❑ P
Gum problems? ❑ Y ❑ N ❑ P
Frequent canker sores? ❑ Y ❑ N ❑ P
Bad breath or bitter taste? ❑ Y ❑ N ❑ P
Chronic dry or cracked lips? ❑ Y ❑ N ❑ P
Tooth sensitivity? ❑ Y ❑ N ❑ P
Loss of teeth? ❑ Y ❑ N ❑ P
Dry mouth/dry throat? ❑ Y ❑ N ❑ P
Other?

RESPIRATORY

Cough? ❑ Y ❑ N ❑ P
Wheezing? ❑ Y ❑ N ❑ P
Asthma? ❑ Y ❑ N ❑ P
Heavy sensation in chest? ❑ Y ❑ N ❑ P
Painful breathing? ❑ Y ❑ N ❑ P
Difficulty breathing? ❑ Y ❑ N ❑ P
Bronchitis? ❑ Y ❑ N ❑ P
Phlegm present? ❑ Y ❑ N ❑ P
Shortness of breath (day/night)? ❑ Y ❑ N ❑ P
Persistent hoarseness? ❑ Y ❑ N ❑ P
Loss of voice? ❑ Y ❑ N ❑ P
Other?

CARDIOVASCULAR

Heart disease? ❑ Y ❑ N ❑ P
Chest pain at rest? ❑ Y ❑ N ❑ P
Ankle or leg swelling? ❑ Y ❑ N ❑ P
Chest pain with exertion? ❑ Y ❑ N ❑ P
High/low blood pressure? ❑ Y ❑ N ❑ P
Heart palpitations? ❑ Y ❑ N ❑ P
Stroke? ❑ Y ❑ N ❑ P
Last blood pressure reading?
Other?

GASTROINTESTINAL

Poor appetite? ❑ Y ❑ N ❑ P
Blood or mucous in stools? ❑ Y ❑ N ❑ P
Peculiar taste? ❑ Y ❑ N ❑ P
Acid reflux? ❑ Y ❑ N ❑ P
Difficulty swallowing? ❑ Y ❑ N ❑ P
Increased appetite? ❑ Y ❑ N ❑ P
Bloating? ❑ Y ❑ N ❑ P
Loss of taste? ❑ Y ❑ N ❑ P
Nausea/vomiting? ❑ Y ❑ N ❑ P
Frequent belching? ❑ Y ❑ N ❑ P
Frequent flatulence? ❑ Y ❑ N ❑ P
Abdominal or stomach pain? ❑ Y ❑ N ❑ P
Constipation? ❑ Y ❑ N ❑ P
Difficulty passing stool? ❑ Y ❑ N ❑ P
Pain with elimination? ❑ Y ❑ N ❑ P
Diarrhea? ❑ Y ❑ N ❑ P
Undigested food in stools? ❑ Y ❑ N ❑ P
Hemorrhoids? ❑ Y ❑ N ❑ P
Ulcer? ❑ Y ❑ N ❑ P
Gall bladder disease? ❑ Y ❑ N ❑ P
Hepatitis B or C ❑ Y ❑ N ❑ P
How often are your bowel movements?

Other?

→

Review Of Systems (cont.)

***Y**=current condition; **N**=never had; **P**=past condition*

MUSCULOSKELETAL

Pain?	❑ Y ❑ N ❑ P	where?
Swelling?	❑ Y ❑ N ❑ P	where?
Weakness?	❑ Y ❑ N ❑ P	where?
Stiffness?	❑ Y ❑ N ❑ P	where?
Heaviness?	❑ Y ❑ N ❑ P	where?
Tremors?	❑ Y ❑ N ❑ P	where?
Numbness?	❑ Y ❑ N ❑ P	where?
Shooting pain?	❑ Y ❑ N ❑ P	where?
Coldness?	❑ Y ❑ N ❑ P	where?
Burning?	❑ Y ❑ N ❑ P	where?

SKIN

Rashes?	❑ Y ❑ N ❑ P	where?
Eczema/hives?	❑ Y ❑ N ❑ P	where?
Acne, boils?	❑ Y ❑ N ❑ P	where?
Discoloration?	❑ Y ❑ N ❑ P	where?
Easy bruising?	❑ Y ❑ N ❑ P	where?
Psoriasis?	❑ Y ❑ N ❑ P	where?

URINARY

Frequent urination (day/night)?	❑ Y ❑ N ❑ P
Urgency?	❑ Y ❑ N ❑ P
Difficulty urinating?	❑ Y ❑ N ❑ P
Inability to hold urine?	❑ Y ❑ N ❑ P
Painful urination?	❑ Y ❑ N ❑ P
Strong smelling urine?	❑ Y ❑ N ❑ P
Blood in urine?	❑ Y ❑ N ❑ P

Other?

REPRODUCTIVE

Women:

Age at first menses?

Age at last menses (if applicable)?

Length of cycle:

Duration of menses (days)?

pregnancies?

live births?

miscarriages?

abortions?

Date of last PAP?

Abnormalities?

Are cycles regular?	❑ Y ❑ N ❑ P
Large clots?	❑ Y ❑ N ❑ P
PMS?	❑ Y ❑ N ❑ P
Endometriosis?	❑ Y ❑ N ❑ P
Uterine fibroids?	❑ Y ❑ N ❑ P
Ovarian cysts?	❑ Y ❑ N ❑ P
Difficulty conceiving?	❑ Y ❑ N ❑ P
Vaginal discharge/infections?	❑ Y ❑ N ❑ P
On birth control or hormones?	❑ Y ❑ N ❑ P
Menopausal symptoms?	❑ Y ❑ N ❑ P

Date of last period?

Men:

Hernias?	❑ Y ❑ N ❑ P
Testicular pain?	❑ Y ❑ N ❑ P
Lump or swelling in testicles?	❑ Y ❑ N ❑ P
Difficult or loss of erection?	❑ Y ❑ N ❑ P
Prostate disease?	❑ Y ❑ N ❑ P
Infertility?	❑ Y ❑ N ❑ P

Other?

Thank You! I appreciate the time you spent to complete this.

Lisa Pate, LAc, RD • 1222 SE Division St. Portland OR 97202 • phone: 503.880.2785