

Please Print clearly:

today's date _____

Name _____ male ___ female ___ date of birth _____

Address _____ married ___ separated ___ divorced ___ widowed ___ single ___

_____ education years elementary ___ years high school _____

telephone home _____ work _____ cell _____ years college, etc _____

Occupation: _____ email _____

Insurance: _____ policy # _____ group # _____ Contact# _____

Name of person holding the policy and their relationship to you: _____ their date of birth: _____

Why have you come for acupuncture? Briefly describe what you hope to gain through treatment:

Please circle any of the numbers below that apply to you and then circle any of the subcategories applicable to you listed to the right. If your condition is not listed or you know the specific medical name, please write your symptom on the line.

1. general well being (please briefly describe) _____

2. mood and emotional care stress anxiety fatigue depression other _____

3. head and neck headache neck pain other _____

4. face eyes ears nose mouth jaw other _____

5. throat and respiratory system asthma pneumonia sore throat other _____

6. heart and circulatory system high blood pressure chest pains edema anemia other _____

7. Infections hepatitis yeast/candida HIV frequent colds mono t.b. sexually transmitted disease
other _____

8. cancer chemotherapy radiotherapy location: _____

9. allergies (please list) _____

10. addictions drugs alcohol sugar other _____

11. musculoskeletal problems bones joints muscle – location: _____

12. skin eczema hives rashes scars (where) other _____

13. digestive system pain acid reflux other _____

14. Bowel diarrhea constipation diverticulosis hemorrhoids IBS other _____

15. urinary system difficulty urinating prostate enlargement other _____

16. reproductive system female cramps PMS menopause infertility other _____
male prostate infertility impotence other _____

17. autoimmune disorders MS lupus r. arthritis other _____

18. endocrine disorders thyroid problem diabetes hypoglycemia other _____

19. nerves and brain numbness tingling psychiatric diagnosis other _____

20. other sleep difficulty weight problem _____

21. bones & ligaments osteoporosis broken bone (which) sprains _____

22. childhood hyperactivity chicken pox German measles scarlet fever measles mumps polio rheumatic fever

Please go back over the list and rank your top four complaints from one to four, one being the most important.

From the office of Laura A.Santi, L.Ac. 3939 NE Hancock St. Ste. 208, Portland OR 97232 503-998-8330

Major Hospitalizations: If you have ever been hospitalized for any major medical illness or operation, write in your most recent hospitalizations below.

Year _____ operation or illness _____

1- hospitalization _____

2- hospitalization _____

3- hospitalization _____

4- hospitalization _____

Tests and immunizations: mark and X next to those that you have had. Enter the year when you were last given the tests or "shots"

chest x-ray _____ kidney x-ray _____ GI series _____ colon x-ray _____ gall bladder x-ray _____
 electrocardiogram _____ TB test _____ sigmoidoscopy _____ mammogram _____ tetanus shots _____
 polio series _____ typhoid shots _____ flu shots _____ mumps shots _____ measles shots _____
 hepatitis shots _____ travel immunizations _____ other _____

Medicines/supplements: Mark an X in the box next to any medicines that you are now taking, Antibiotics _____

Penicillin _____ opiates/codeine _____ sedatives _____ stimulants _____ blood pressure medication _____
 aspirin _____ Tylenol/advil _____ diet pills _____ antacids _____ laxatives _____ supplements _____

Vital Signs:

Height _____ weight _____ any recent weight gain or loss over 10 lbs? _____ how much? _____

Please give general location of any Scars: _____

<p>FAMILY HISTORY: For each member of your family, follow the grey or white line across the page and check the boxes for: 1. Their present state of health 2. Any illnesses they have had</p> <p>(Note: except for <i>spouse</i>, Family refers to <i>blood</i> or <i>natural</i> relatives.)</p> <p>Write in age and cause of death. Include fatal accidents and suicides.</p>				Good health	Poor health	Deceased	Allergies or asthma	Anemia	Blood clotting problems	Diabetes	Cancer or tumor	Epilepsy	Glaucoma	Genetic disease	Alcoholism	Kidney or bladder trouble	Stomach/duodenal ulcer	Nervous breakdown	Rheumatism or arthritis	High blood pressure	Heart trouble	Gout
Father:																						
Mother:																						
Brothers/Sisters:																						
Spouse:																						
Child:																						
Child:																						
Child:																						
Child:																						
Paternal relatives (in each box, write how many affected with) →																						
Maternal relatives (in each box, write how many affected with) →																						
→ Begin YOUR HEALTH HISTORY here. Have you had: →																						

Name and phone number of regular physician: _____ date of last visit _____

Reason for that appointment? _____

Name(s) and type of practice of other health care providers seen: _____

May I contact these providers if I have questions? Please circle the names you give permission to contact and sign your name to grant permission: _____ date _____