

**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><b>FAMILY HISTORY:</b> 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 or natural</i> relatives.)</p> <p>Write in age and cause of death. Include fatal accidents and suicides.</p>				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
PRINT NAMES BELOW	Good health	Poor health	Deceased																
Father:																			
Mother:																			
Brothers/Sisters:																			
Spouse:																			
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 \_\_\_\_\_