

Alethea Acupuncture Clinic
Jonathan Schell L.Ac.



1017 SW Morrison #307A
Portland, OR 97205
503.314.8686

ICD9 Code: _____

Name: _____ Date: _____

Street Address: _____ City: _____ State: _____ Zip: _____ Social Security # - -

Home Phone () Work Phone () May we call you and leave messages about appointments? _____

Sex: _____ DOB: ____ / ____ / ____ Marital Status: _____ Occupation: _____

Emergency Contact _____ Telephone _____ Relationship _____

How did you hear about the Clinic? _____

Please identify the Health concerns that have brought you to the Alethea Acupuncture Clinic Below.

Please list concerns in order of Importance.

A) Condition: _____ Past Treatment: _____

How Does this Condition affect you?: _____

B) Condition: _____ Past Treatment: _____

How Does this Condition affect you?: _____

C) Condition: _____ Past Treatment: _____

How Does this Condition affect you?: _____

D) Condition: _____ Past Treatment: _____

Are you Currently Receiving Health Care? Y N If yes, where and from whom? _____

If no, when and where did you last receive Health Care? _____ For what reason? _____

Has your case ever been referred to an attorney? Y N

Do you have any reason to believe that you are pregnant? Y N If yes, please explain _____

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How Does this Condition affect you?: _____

Height _____ **Weight** _____ **Past Maximum Weight** _____ **When?** _____

Childhood Illnesses (Please circle any that you have had)

Scarlet Fever Diptheria Rheumatic Fever Mumps Measels German Measels Chicken Pox

Immunizations (Please circle any that you have had)

Polio Tetanus Measels/ Mumps/ Rubella Pertusis Diptheria Others _____

Family History	Mother	Father	Brothers	Sisters	Spouse	Children
Age if Living?						
Health (G = Good, P= Poor)						
Age of Death (if Deceased)						
Cause of Death						

Check any disease that members of your family have had below:

Cancer (which type?)						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						

Circle & explain any that apply:

Name: _____ Date: _____

X-Rays/ CAT Scans/ MRI's/ MMR's/ Special Studies: (Reason & When) _____

Severe Illnesses/ Western Diagnosis's _____

Chronic or Continuing Conditions or Illnesses: _____

Injuries: _____

Surgeries/ Hospitalizations (Reason & when) : _____

Any Contagious/ Chronic Infectious Diseases? _____

Other: _____

Allergies: _____

Dryness: (Hair, Mouth, Throat, etc.) _____

Head Aches/ Dizziness: (How Often, Location, Duration, Severity, etc.) _____

Heart: (Palpitations, Irregular Beat, Murmur, Heart Disease, Chest Pain, Stroke, Ankle Swelling, High Blood Pressure, Rheumatic Fever, Varicose Veins. Etc.) _____

Lung:(Cough, Shortness of Breath, Phlegm, Congestion, Pneumonia, Frequent Common Colds, Pleurisy, Difficulty Breathing. Asthma, Emphysema, Tuberculosis, etc.) _____

Energy/ Immunity (Have you or do you have): Fatigue, Slow Wound Healing, Chronic Infections, Chronic Fatigue Syndrome
Energy Level: (Scale of 1-10, 10 being the Most Energy) _____

Sudden Energy Drop at _____ (Time)

Sleep: (# of Hours, Time go to Bed, Insomnia, Restfulness, Dreams) _____

Name: _____ Date: _____

Emotional Status (Mood Swings, Irritability, Nervousness, Stress, Mania, Depression, Rage): _____

Current Medications: _____

Eyes: (Blurriness, Night Vision, Dryness, Redness, Floaters, Pain or Strain, Glaucoma, Glasses/ Contacts, Tearing) _____

Ears: (Sensitivity to Cold/ Heat, Ringing, Deafness, R or L, Ear Aches) _____

Nose: (Nasal Congestion w/ Color & Prevalence of Congestion, Polyps, Hay Fever, Nose Bleeds, etc.) _____

Throat: (Soreness, Swollen Lymph Nodes, Able to Swallow) _____

Mouth: (Cavities, Prevalence of Fillings, Mouth/ Tongue/ Lip Sores, Teeth Grinding, TMJ/ Jaw Problems) _____

Skin: (Lesions, Acne, Carbuncle/ Furuncles, Dry, Flaking, Oily, Notable Scars, Eczema, Dandruff, Bruises, Loss of Hair) _____

Appetite:(Scale of 1-10, 10 being Ravenous, Feel Sated after Eating, Eating doesn't Satisfy, Not Hungry in Morning, etc.) _____

GI: (Ulcers, Belching, Changes in Appetite, Gall Bladder Disease, Liver Disease, Epigastric Pain, Hepatitis B or C, Passing Gas, Hemorrhoids, Heartburn, Abdominal Pain, Bad Breath) _____

Thirst: (Time which Thirst is Greatest, Thirsty but no desire to Drink, Can't seem to drink enough to quench thirst, etc.) _____

Digestion: (Gas, Bloating, Nausea/ Vomiting) _____

Pain: (Severity Scale 1-10, 10 being Most, When, Where & How did it happen, How affected is the Range of Motion, etc.) _____

Musculoskeletal: (Neck/ Shoulder Pain, Low Back Pain, Muscle Spasms/ Cramps, Leg Pain, Arm Pain, Upper Back Pain, Mid Back Pain, Joint Pain (If So When?) _____

Neurological: (Vertigo/ Dizziness, Paralysis, Numbness/ Tingling, Loss of Balance, Seizures/ Epilepsy) _____

Name: _____ Date: _____

Temperature: (Do you run Hot or Cold, Cold Hands & Feet, Hot Itchy Feet, Hands &/ or Chest, etc.) _____

Sweats: (Day/ Night/ Spontaneous) _____

Male Reproduction/ Sex: (Sexual Difficulties, Prostate Problems, Testicular Pain/ Swelling, Penile Discharge, etc) _____

Menses:

Age Began _____ Menopause _____

Length of Monthly Cycle; Regularity _____

No. of Days of Flow _____ (Color, Amount, Quality of Pain, Clotting, Emotions, etc.) _____

Female Reproductive/ Breasts: (Irregular Cycles, Breast Lumps/ Tenderness, Nipple Discharge, Heavy Flow, Bleeding between cycles, Vaginal Discharge, Clotting, Premenstrual problems, Menopausal Symptoms, Difficulty Conceiving, etc.) _____

Date of Last PAP _____ Any Abnormalities? _____

Birth Control (Include History) _____

Pregnancies:

No. of Pregnancies _____ No. of Abortions _____

No. of Births _____ No. of Miscarriages _____

Complications _____

Endocrine: (Hypothyroid, Hypoglycemia, Hyperthyroid, Diabetes Mellitus, Night Sweats, Feeling Hot or Cold) _____

Elimination: (Times, Quantity, Consistency, Color, Smell, Blood)

Stool (Diarrhea, Constipation, Undigested Food, Mucous, Blood in Stool):-

Urination: (Kidney Disease, Kidney Stones, Painful Urination, Impaired Urination, Frequent Urinary Tract Infections, Frequent Urination at night, Frequent Urination, Blood in the Urine, Venereal Disease) _____

Other: (Anemia, Cancer, Rashes, Eczema/ Hives, Cold Hands/ Feet) _____

Name: _____ Date: _____

Life Style:

Education: _____

Occupation: _____ Employer: _____

Hours/ Week: _____ Do you enjoy your work? Y N

Why/ or Why not? _____

Exercise:(How Much? How Often? What do you do, Cardio/ Non-Cardio?)

Typical Diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Tastes that you crave? _____

Tastes that you can't stand? _____

Is there anything else we should know? _____

