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						

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:_____

_____

_____

Circle & explain any that apply:

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? _____

_____

_____

_____

_____