Antara Acupuncture and Herbal Clinic, LLC Health History Form

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. Thank you!

Date _____

Name _____ Age _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Cell phone _____ Work phone _____

Birthdate _____ Sex M F Marital Status _____

E-mail address _____

Occupation _____ How long? _____

Company Name & Address _____

Spouse's Full Name _____

In Emergency Notify _____ Phone _____

If insurance is to be billed, please present your card/insurance information upon arrival for your visit.

Family Physician _____

Who referred you to this office? _____

Have you ever been treated with acupuncture before? Yes No

Is your condition due to an accident? Yes No Where?_____

1. Main Problem(s) you would like us to help you with:

2. How long ago did this problem begin (be specific)?

3. To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?

4. Have you been given a diagnosis for this problem? If so, what?

5. What kind(s) of treatment have you tried?

Past Medical History (please include date):

Significant Illnesses: Cancer Diabetes Hepatitis HIV/AIDS High Blood Pressure Heart Disease Rheumatic Fever Thyroid Disease Seizures STD Other:_____

Surgeries:

Significant Trauma (auto accidents, falls, etc.):

Allergies (drugs, chemicals, foods.):

Family Medical History:
Cancer Diabetes High Blood Pressure Heart Disease Rheumatic Fever Thyroid Disease
Seizures Asthma Allergies

Occupation:
Occupational stress (chemical, physical, psychological, etc.)

Do you have a regular exercise program? If yes, please describe:

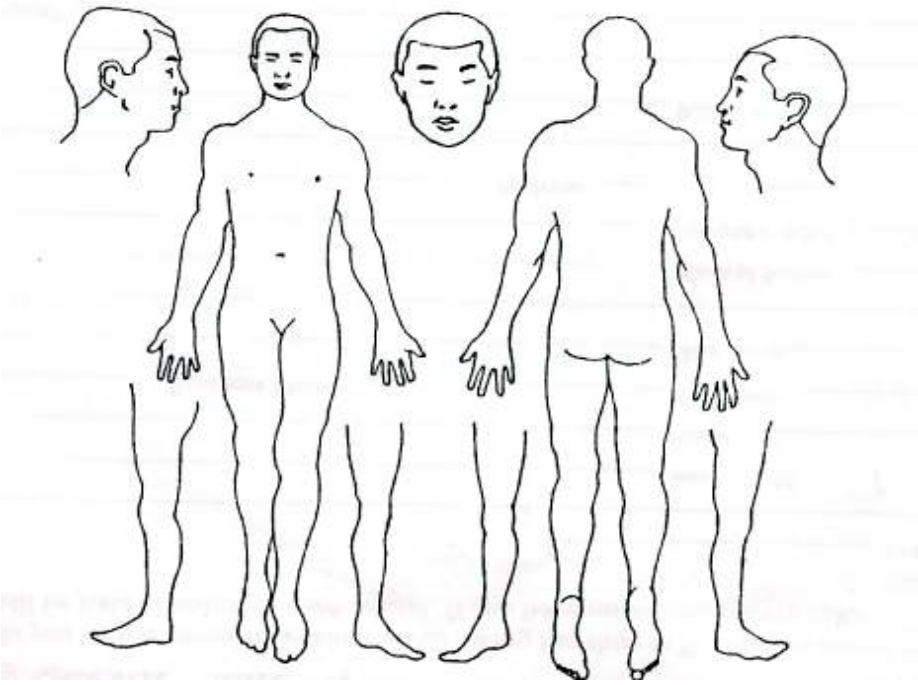
Medicines taken within the last two months: (include vitamins, over-the-counter drugs, herbs, etc)

Are you, or have you ever been, on a restricted diet? What kind?

Please describe your average daily diet:
Morning **Afternoon** **Evening**

Habits:
Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other _____

Indicate painful or distressed areas below:



Please check if you have had any of the following in the last three months OR A chronic tendency towards any of the following:

General

- ☐ Poor appetite
- ☐ Fevers
- ☐ Sweat easily
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Sudden energy drop (What time of day?)
- ☐ Poor sleeping
- ☐ Chills
- ☐ Tremors
- ☐ Poor balance
- ☐ Weight loss
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight gain
- ☐ Strong thirst (hot/cold drinks)

Skin & Hair

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Change in hair or skin texture

Any other hair or skin problems?

Head, Eyes, Ear, Nose & Throat

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Headaches (Where and when?)
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue

Any other head or neck problems?

Cardiovascular

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Swelling of feet
- ☐ Difficulty breathing

Any other heart or blood vessel problems?

Respiratory

- ☐ Cough
- ☐ Bronchitis
- ☐ Coughing blood
- ☐ Production of phlegm? What color?
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain with a deep breath
- ☐ Difficulty breathing when lying down

Any other lung problems?

Gastrointestinal

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Chronic Laxative use
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids

Any other problems with your stomach or intestines?

Genitourinary

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Impotency
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sores on genitals

Do you wake to urinate? How often?
Any particular color to your urine?
Any other problems with your genital or urinary systems?

Pregnancy and Gynecology

- _____ Number of pregnancies
- _____ Miscarriages
- _____ Period between menses
- _____ Number of births
- _____ Abortions
- _____ Duration
- _____ Premature births
- _____ Age at first menses
- _____ First date of last menses
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ Breast lumps
- ☐ Clots
- ☐ Vaginal sores
- ☐ Irregular periods
- ☐ Last PAP
- ☐ Unusual character (heavy / light)
- ☐ Changes in body/psyche prior to menstruation

Do you practice birth control? What type & for how long?

Musculoskeletal

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand/wrist pains
- ☐ Muscle pains
- ☐ Muscle weakness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot/ankle pains
- ☐ Hip pain

Any other joint or bone problems?

Neuropsychological

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Bad temper
- ☐ Dizziness
- ☐ Lack of coordination
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety

Have you been treated for emotional problems?

Any other neurological or psychological problems?

I understand that I am ultimately responsible for any charges for services or products at the Acupuncture Center of Portland and am expected to pay for those charges as they accrue, unless I make prior arrangements to have some of them billed. Any billing of my insurance is done as a courtesy and convenience to me. If for any reason a claim is denied, I understand that I am responsible to pay any unpaid balance at the time of the denial.

_____ _____

Signature or patient/guardian Date