

Inner Gate Acupuncture and Herbal Clinic

1421 SE Ankeny St

Portland OR 97214

503.284.6996

Patient Health History

Welcome to our Clinic. At Inner Gate Acupuncture & Herbal Clinic it is our goal to help each patient improve their quality of life and to achieve optimum health. Traditional Chinese medicine, which consists primarily of Acupuncture and Chinese Herbs, offers a unique approach to healing that nicely compliments other health care modalities. We work closely with physicians, alternative practitioners and you, our patient, in order to provide the best and most thorough treatment.

In order to serve you best we encourage you to fill out this survey in as much detail as possible. Successful health care is only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. All symptoms that you are experience are relevant and important to us as Chinese Medicine practitioners. All information will be held in strict confidence. **Thank you.**

Name: _____ Date: ____/____/____
(first) (middle) (last)

Date of Birth: ____/____/____ Social Security Number: ____-____-____ Age: ____ Gender: ____ Marital status: S M D W P

Address: _____ City: _____ State: ____ Zip: _____

Phone Number: (____) _____ - _____ Email Address: _____

1. When and where did you last receive health care? _____

For what reason? _____

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you to our clinic in order of importance below:

Condition

Past Treatment

1) _____

How does this condition affect you? _____

2) _____

How does this condition affect you? _____

3) _____

How does this condition affect you? _____

4) _____

How does this condition affect you? _____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

6. Do you have any reason to believe you may be pregnant? Y / N If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

9. **Blood Pressure:** What is your most recent blood pressure reading? ____/____ When was this reading taken? _____

10. **Childhood Illness:** (Please check any that you have had)

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

11. **Immunizations** (please check any that you have had):

Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Hepatitis A & B Others: _____

12. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. **Family History:**

Check those applicable:

	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

15. **Lifestyle:**

- a. Do you typically eat at least three meals per day? Y N If no, how many? _____
- b. Do you feel you have a healthy diet? Y N
- c. Do you have any particular food cravings? _____
- d. Exercise routine: _____
- e. Spiritual practice: _____
- f. How many hours per night do you sleep? _____ Do you wake rested? Y N
- g. Level of education completed: High School Bachelors Masters Doctorate Other
- h. Occupation: _____ Employer: _____ Hours/Week: _____
Do you enjoy work? Y/N Why/Why not? _____
- i. Nicotine/Alcohol/Caffeine Use: _____
- j. Have you experienced any major traumas? Y N Explain: _____

- k. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____
- l. Television habits: _____ Reading habits: _____
- m. Interests and hobbies: _____

Below, please CHECK any that you have now, and UNDERLINE any that you have experienced in the past

- | | | | |
|---|---|--|---|
| <p>16. <u>Respiratory</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Pneumonia <input type="checkbox"/> Frequent Common Cold <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Emphysema <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Pleurisy <input type="checkbox"/> Asthma <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Other Respiratory Problems <p>17. <u>Head, Eye, Ear, Nose, & Throat</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Impaired Vision <input type="checkbox"/> Eye Pain/Strain <input type="checkbox"/> Glaucoma <input type="checkbox"/> Glasses/Contacts <input type="checkbox"/> Tearing/Dryness <input type="checkbox"/> Impaired Hearing <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Earaches <input type="checkbox"/> Headaches <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Frequent Sore Throats <input type="checkbox"/> Teeth Grinding <input type="checkbox"/> TMJ/Jaw Problems <input type="checkbox"/> Hay Fever <p>18. <u>Neurological</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Vertigo/Dizziness | <ul style="list-style-type: none"> <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Seizures/Epilepsy <p>19. <u>Energy and Immunity</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Fatigue <input type="checkbox"/> Slow Wound Healing <input type="checkbox"/> Chronic Infections <input type="checkbox"/> Chronic Fatigue Syndrome <p>20. <u>Cardiovascular</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Heart Disease <input type="checkbox"/> Chest Pain <input type="checkbox"/> Swelling of Ankles <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Palpitations/Fluttering <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Murmurs <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Varicose Veins <p>21. <u>Musculoskeletal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Neck/Shoulder Pain <input type="checkbox"/> Muscle Spasms/Cramp <input type="checkbox"/> Arm Pain <input type="checkbox"/> Upper Back Pain <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Leg Pain <input type="checkbox"/> Joint Pain (if so, where?): _____ | <p>22. <u>Endocrine</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Night Sweats <input type="checkbox"/> Feeling Hot or Cold <p>23. <u>Gastrointestinal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Ulcers <input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Epigastric Pain <input type="checkbox"/> Passing Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Belching <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Abdominal Pain <p>24. <u>Genito-Urinary Tract</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Painful Urination <input type="checkbox"/> Frequent UTI <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Impaired Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Frequent Urination at Night | <p>25. <u>Emotional</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Mood Swings <input type="checkbox"/> Nervousness <input type="checkbox"/> Mental Tension <p>26. <u>Female Reproductive/Breasts</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Irregular Cycles <input type="checkbox"/> Breast Lumps/Tenderness <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Heavy Flow <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Premenstrual Problems <input type="checkbox"/> Clotting <input type="checkbox"/> Bleeding Between Cycles <input type="checkbox"/> Menopausal Symptoms <input type="checkbox"/> Difficulty Conceiving <input type="checkbox"/> Painful Periods <p>27. <u>Male Reproductive</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Sexual Difficulties <input type="checkbox"/> Prostrate Problems <input type="checkbox"/> Testicular Pain/Swelling <input type="checkbox"/> Penile Discharge <p>28. <u>Other</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer <input type="checkbox"/> Rashes <input type="checkbox"/> Eczema/Hives <input type="checkbox"/> Cold Hands/Feet |
|---|---|--|---|

29. **Menstrual/Birthing History:** a. Age of First Menses: _____ b. # of Days of Menses: _____ c. Length of Cycle: _____
- d. Birth Control Type: _____ e. # of Pregnancies: _____ f. # of Miscarriages: _____ g. # of Abortions: _____
- h. # of Live Births: _____

Is there anything else we should know? _____

How did you hear about us? _____