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**Rose City Acupuncture**  
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**Ste 530**  
**Beaverton, OR 97005**  
**(503) 964-3422**



This is a CONFIDENTIAL questionnaire to help determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

**Personal Information**

Name \_\_\_\_\_ Date \_\_\_\_\_

Gender \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Wireless Phone \_\_\_\_\_

Email \_\_\_\_\_

If under 18, person responsible for your account \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

Occupation \_\_\_\_\_

Hobbies \_\_\_\_\_

Living situation \_\_\_\_\_

How did you hear about me? \_\_\_\_\_

Have you had acupuncture therapy before? How was it? \_\_\_\_\_

What would you like to achieve with acupuncture treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please CIRCLE if any of the following pertain to you (marking “yes” does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):**

Hepatitis B/C    HIV/AIDS    High Blood Pressure    Seizures    Blood-Thinning Medication  
Pacemaker    Current Pregnancy

**Please indicate the use and frequency of the following:**

Coffee \_\_\_\_\_ Soda \_\_\_\_\_ Tea \_\_\_\_\_ Water \_\_\_\_\_

Alcohol \_\_\_\_\_

Recreational drugs \_\_\_\_\_

Tobacco (include history) \_\_\_\_\_

Exercise \_\_\_\_\_

Name and phone number of primary care physician: \_\_\_\_\_

\_\_\_\_\_

**Please list any prescription or over-the-counter medications you are presently taking:**

Medication & Dosage (incl. Supplements)	Reason / How long
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_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Health History**

Please list your health concerns in order of priority:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please give answers about your primary complaint: When did it start?

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What was happening in your life then?

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What other forms of treatment have you sought?

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What helps your condition?

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What aggravates your condition?

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How severe is it? Does it interfere with your daily life?

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Is it worse or better at a particular time of day? \_\_\_\_\_

Please list any surgeries or major health incidents (accidents, etc.) in your life

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Childhood illnesses

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Adult illnesses

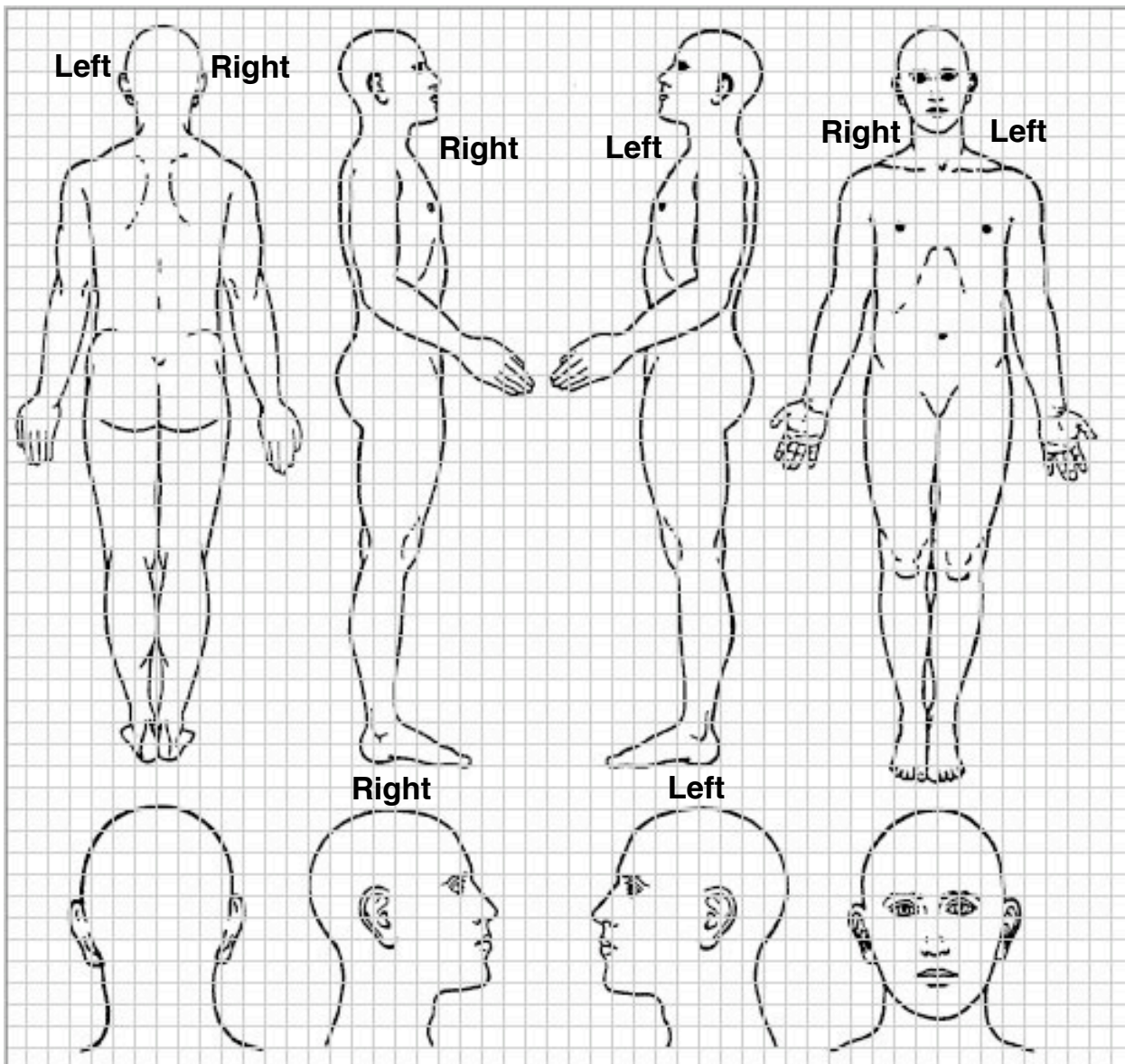
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What do you believe is causing your most important health concerns?

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**PAIN PATIENTS,** Please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain?

\_\_\_dull/achy \_\_\_sharp/stabbing \_\_\_burning \_\_\_tingling \_\_\_numbness \_\_\_electrical

On a scale of 0-10, 0 being no pain, and 10 being the worst pain imaginable, how do you feel?

\_\_\_\_\_

## Family History

(indicate age at death, circled, if deceased)

### Siblings / Children

	Mother	Father	Partner		
Age					
diabetes					
tuberculosis					
heart disease					
high/low BP					
stroke					
kidney disease					
cancer					
arthritis					
anemia					
headaches					
mental illness					
neurological problems					
other issues					

### General:

Height \_\_\_\_\_ Weight \_\_\_\_\_ Recent weight changes \_\_\_\_\_

Energy level 1-10 \_\_\_ Do you tend to feel hot or cold compared to everyone else? \_\_\_\_\_

### Nutrition:

What is your diet like? Do you have any allergies or sensitivities that you know about?

\_\_\_\_\_

\_\_\_\_\_

breakfast \_\_\_\_\_

lunch \_\_\_\_\_

dinner \_\_\_\_\_

snacks \_\_\_\_\_

## For Women

Age of first period \_\_\_\_\_ Date of last period \_\_\_\_\_  
Are you currently experiencing any gynecological symptoms or problems? \_\_\_\_  
Are you currently sexually active? \_\_\_\_ Partner(s) is/are \_\_ Male \_\_ Female  
If sexually active, do you perform safe sex practices? \_\_\_\_\_  
Any problems with sexual desire or function? \_\_\_\_\_  
History of sexually transmitted diseases? \_\_\_\_\_  
Number of pregnancies? \_\_ Births? \_\_\_\_\_ Abortions? \_\_\_\_\_ Miscarriages? \_\_\_\_\_  
Any complications or female surgeries \_\_\_\_\_  
Date of last Pap Smear? \_\_\_\_\_ Abnormal Pap? \_\_\_\_\_ P \_\_\_\_\_  
How frequent do you have a gyn exam/ pap smears? \_\_\_\_\_ Any  
cervical cancer history? \_\_\_\_\_ if yes, when: \_\_\_\_\_  
Any ovarian cancer history? \_\_\_\_\_ if yes, when: \_\_\_\_\_  
Do you perform regular breast self exams? \_\_ yes \_\_\_\_\_ no  
If menopausal or perimenopausal: List symptoms and concerns: \_\_\_\_\_  
When regular periods stopped? \_\_\_\_\_  
Any personal history of breast cancer? \_\_\_\_\_  
Number of days between periods (your cycle) \_\_\_\_\_ Number of days of flow \_\_\_\_\_  
Discharge (describe) \_\_\_\_\_

Circle if you have/ have had the following: PMS - swollen breasts - uterine fibroids - PID  
endometriosis - ovarian cysts - polycystic ovary syndrome (PCOS) - fibrocystic breasts

### Color of flow:

pale/light red  
 red  
 bright red  
 dark red  
 brown  
 clots  
 severe

### Amount

spotting  
 light  
 even throughout  
 moderate  
 heavy

### Pain and cramping:

None  
 before flow  
 after flow  
 during flow  
 mild

## For Men

Are you currently sexually active? \_\_\_\_\_ Partner(s) is/are \_\_ Male \_\_ Female  
If sexually active, do you perform safe sex practices? \_\_\_\_\_  
History of sexually transmitted diseases ? \_\_\_\_\_  
Date of last prostate exam? \_\_\_\_\_  
Trouble with sexual function/libido? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

**CIRCLE any current complaint and UNDERLINE any past complaints, then provide details on the line below.**

**Sleep:**

Amount per night? \_\_\_\_\_ Fall asleep easily? \_\_\_\_\_ Wake easily during the night? \_\_\_\_\_

If so, is it to urinate? \_\_\_\_\_ If wake, fall back asleep easily? \_\_\_\_\_

Wake easily? \_\_\_\_\_ Feel rested in morning? \_\_\_\_\_ Sleep propped up? \_\_\_\_\_

Vivid dreams    Nightmares    Naps needed    Night sweats /chills    Painful to lie down    Apnea

**Psychological:**

Depression    Anger    Anxiety    Stress    Irritability    Other emotional upset \_\_\_\_\_

**Neurological:**

Headache    Migraine                      Head injury                      Loss of Consciousness    Stroke

Fainting/Dizziness    Blackout    Seizures                      Paralysis    Local weakness    Numbness

Tingling    Tremors    Difficulty thinking/ confusion                      Difficulty with memory

**Skin:**

Rashes    Lumps    Itching    Dryness    Slow healing    Easy / unexplained bruising

Hair loss    Color change    Nail problems    \_\_\_\_\_

**Eyes:**

Last eye exam \_\_\_\_\_

Glasses/ Contact lenses    Pain    Redness    Tearing    Double Vision    Glaucoma    Cataract

**Ears:**

Hearing problems    Tinnitus    Vertigo    Balance    Earaches    Infection    Discharge

**Nose & Sinus:**

Sinus congestion    Nose running    Hay fever/ allergies    Nosebleeds    Loss of smell

**Mouth & Throat:**

Last dental exam \_\_\_\_\_

Bleeding gums    Sore tongue    Frequent sore throat    Speech disorder    Chronic halitosis

**Neck:**

Lumps Swollen glands Goiter Neck pain

**Breasts:**

Lumps Tenderness Nipple Discharge Change in size/shape

**Respiratory:**

Last chest X-ray \_\_\_\_\_ Sputum (color, quantity): \_

Cough Difficulty breathing Shortness of breath Wheezing Asthma Bronchitis

Emphysema Pneumonia Tuberculosis Pleurisy

**Cardiac:**

Chest pain Palpitations Lightheaded / dizziness Heart Attack High /low blood pressure

Heart murmur Edema

**Gastrointestinal:**

Low appetite Excess hunger Nausea Vomiting Difficulty swallowing Gastric pain

Abdominal pain Constipation Diarrhea Food allergies IBS Excess belching / gas

Bowel incontinence Rectal bleeding Indigestion Heartburn / Reflux Hemorrhoids

Gall bladder disease Gall stones Jaundice Liver disease Hepatitis

Freq of bowel movements: \_\_\_\_\_ Color \_\_\_\_\_

Formed / loose / soft / hard Recent change in BM \_\_\_\_\_

**Urinary:**

Frequency \_\_\_\_\_ Color \_\_\_\_\_

Cloudy Bloody Frequent urination At night Painful Burning Urgency Hesitancy

Trouble stopping Incontinence Urinary tract infection Kidney stones

**Musculoskeletal:**

Pain Stiffness Swelling Redness Weakness Limited range of motion Arthritis Gout

Neck Shoulders Arms Hands Upper back Middle back Lower back Ribs Hips

Legs Knees Ankles Feet



**Peripheral vascular:**

Pain with exercise    Cramps    Hot/cold extremities    Varicose veins

**Endocrine:**

Thyroid disease    Heat/cold intolerance    Excess sweating    Diabetes / hypoglycemia  
Excess thirst

**Hematologic:**

Anemia    Easy bruising / bleeding    Transfusion history

**Immunity:**

Frequent colds/flu    HIV /AIDS    Autoimmune disease    Exposure to toxins

**Anything else?**

## **INFORMED CONSENT**

I understand that although all efforts will be made to ensure that my treatment is as painless and side-effect-free as possible, sometimes life is not perfect.

I understand that although the acupuncture needles are sterile, and my skin will be cleaned, there is a small risk of infection.

I understand that there is a risk of bleeding, bruising, or pain with needling.

I understand there are a few serious risks associated with acupuncture, such as pneumothorax (punctured lung) or nerve irritation.

I understand that therapeutic bodywork (medical massage) may result in soreness or bruising.

I understand that there are no guarantees with regard to treatment outcome, and that symptoms may become worse after treatment.

I understand that I am free to withdraw this consent and stop treatments at any time.

With this knowledge, I voluntarily consent to acupuncture, moxibustion, cupping, and therapeutic bodywork, and agree to release Sharon Rose from any liability that may occur in connection with the above procedures, except for failure to perform the procedures with appropriate medical care.

## **CANCELLATION POLICY**

I understand that if I cannot keep an appointment I need to call as soon as possible. I understand that cancellation within 24 hours of the appointment creates a hardship for both Rose City Acupuncture and for patients who may have wanted that time slot, and that I may be charged a \$35 cancellation fee for that appointment.

Date \_\_\_\_\_

Patient name (printed) \_\_\_\_\_

Patient signature \_\_\_\_\_

Parent / Legal Guardian's name (if applicable) \_\_\_\_\_

Parent / Legal Guardian's signature \_\_\_\_\_