Medical History Questionnaire

This is an outline for recording your medical history. **This information as well as the results of any Physical examinations, conversations, special procedures and laboratory test is confidential. Reports will be furnished only with your request and permission.**

You are asked to fill out this record and bring it with you to your first appointment. Please complete each page. Remember to take you time. It will help us help you.

Many of our patients are chemically sensitive. Please avoid the use of fragrances or perfumes when visiting out office. Thank you.

East-West Acupuncture Clinic
Steve Snyder, L.Ac.
(503)-231-4101
3703 SE 39th Ave.
Portland, OR 97202

www.east-westacupuncture.com

Your appointment will be
Date_____
Time_____

There is a large demand for appointments and specific appointment times and limited number of spaces available. We do our best to try and accommodate patient's needs. We are also very careful about our schedule so patients do not have to wait.

Please read and sign below:
"I understand that appointment times are reserved especially for me. 24 hours notice of any changes is appreciated. Full fee will be charged for missed appointments and half fee for same day cancellations. Unless other arrangements have been made, I understand the payment is due at the end of each visit."

Signed_____
Date_____

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Date_____

DOB:_____
Marital Status:_____

Patient Record

Name_____
Address_____
Home Phone_____ Email _____
Employer_____
How did you hear about this Clinic?_____
Do you have a current/pending Worker's Comp Claim? _____
Describe the disorder which is bothering you most_____
_____
Duration of Disorder_____
Other Health Problems? _____
_____
Previous Treatment_____
Disorders & Surgeries (give dates if possible)_____
_____
Current & Recent Medications_____
_____

Usual Intake of

Tobacco	○ Y ○ N	Coffee	○ Y ○ N
Alcohol	○ Y ○ N	Sweets	○ Y ○ N
Marijuana	○ Y ○ N	Other	○ Y ○ N

If Yes, Please List_____
_____

Current or previous problems in the following areas

Muscles, Bones & Joints	○ Y ○ N	Nervous System	○ Y ○ N
Heart	○ Y ○ N	Psychological	○ Y ○ N
Circulation	○ Y ○ N	Hormonal	○ Y ○ N
Digestion	○ Y ○ N	Blood/Lymph Nodes	○ Y ○ N
Lungs, Nose & Throat	○ Y ○ N	Skin	○ Y ○ N
Kidney & Bladder	○ Y ○ N	Other	○ Y ○ N
Reproductive & Genital	○ Y ○ N		

If Yes, Please List_____
_____

Do you have or had you had

Diabetes, Immunity problems, Nosebleeds, Excessive Bleeding from Cuts/Wounds ○Y ○N
Are you or could you be Pregnant ○Y ○ N
Other Issues ○Y ○N
If Yes, Please List_____