Luo Acupuncture and Herbal Clinic
5201 SW Westgate Dr. Ste. 116 Portland, OR 97221
Tel: 503-203-8898 Fax: 503-203-8809 www.luoacupuncture.com

New Patient Intake Form

Name Last _____ Middle _____ First _____ Date _____

Date of Birth _____ Gender M☐ F☐ Marital Status _____Email_____

Street Address _____City _____ State_____ Zip Code_____

Home Phone _____ Cell/Day Time Phone_____

Emergency Contact_____ Telephone _____Relationship_____

How did you hear about us? _____

Successful health care and preventative medicine are only possible with the practitioner has a complete understanding of the patient physically, mentally, and emotionally. This survey will help us to evaluate your health more completely. Please complete this survey as thoroughly as possible. Include all the complaints, which are familiar to you. Print all information and indicate areas of confusion with a question mark. Thank you.

Are you currently receiving health care? ☐Yes ☐No If yes, where and from whom?_____

_____

If no, when and where did you last receive health care? _____for what reason? _____
Has your case been referred to an attorney? Y☐ N☐

Please identify the health concerns that have brought you to the Clinic below:

Condition **Past Treatment**

a. _____ _____

How does this condition affect you?

_____

b. _____ _____

How does this condition affect you?

_____

c. _____ _____

How does this condition affect you?

_____

d. _____ _____

How does this condition affect you?

_____

Do you have any reason to believe that you are pregnant? ☐ Yes ☐ No

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Medicines (prescription and over-the-counter drugs, vitamins, herbs, etc. attach separate page if necessary)

_____
_____
_____

If applicable, please circle any of the following medications that you are currently taking

☐ Laxatives ☐Pain Relievers ☐Antacids ☐Thyroid Medication ☐Appetite Suppressants
☐ Antibiotics ☐Tranquilizers ☐Sleeping Pills ☐Cortisone ☐Blood Pressure Medication

Allergies: please list any foods, drugs, or medications you are hypersensitive or allergic to (include the type of reactions)

_____
_____

Height _____ **Weight** currently _____ Past Maximum Weight _____ When _____

Blood Pressure What is your most recent blood pressure reading_____/_____ When was this reading taken_____

Childhood Illness (please circle any that you have had)

☐Scarlet Fever ☐Diphtheria ☐Rheumatic Fever ☐Mumps ☐Measles ☐German Measles ☐Chicken Pox

Immunizations (please circle any that you have had)

☐Polio ☐Tetanus ☐Measles/Mumps/Rubella ☐Pertussis ☐Diphtheria ☐Other _____

Hospitalizations and Surgeries (attach separate page if necessary)

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

X-Rays/CAT Scans/MRI's/Special Studies (attach separate page if necessary)

Reason	When	Reason	When
_____		_____	
_____		_____	

Family History	Mother	Father	Brothers	Sisters	Children
Age if living	_____	_____	_____	_____	_____
Health (G=good, P=poor)	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____
Cause of death (if deceased)	_____	_____	_____	_____	_____
If applicable, check any conditions that members of your family have had below					
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____

Emotional (please circle any that you experience now and underline any that you have experienced in the past)

☐Mood Swings ☐Nervousness ☐Mental Tension

Energy and Immunity (please circle any you experience now and underline any you have experienced in the past)

☐Fatigue ☐Slow Wound Healing ☐Chronic Infections ☐Chronic Fatigue Syndrome

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Head, Eye, Ear, Nose, and Throat (circle any you experience now/underline any you have experienced in the past)
☐Impaired Vision ☐Eye Pain/Strain ☐Glaucoma ☐Glasses/Contacts ☐Tearing/Dryness
☐Impaired Hearing ☐Ear Ringing ☐Earaches ☐Headaches ☐Sinus Problems
☐Nose Bleeding ☐Frequent Sore Throats ☐Teeth Grinding ☐TMJ/Jaw Problems ☐Hay Fever

Respiratory (please circle any that you experience now and underline any that you have experienced in the past)
☐Pneumonia ☐Frequent Common colds ☐Difficulty Breathing ☐Emphysema
☐Persistent Cough ☐Pleurisy ☐Asthma ☐Tuberculosis
☐Shortness of Breath ☐Other Respiratory Problems: _____

Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past)
☐Heart Disease ☐Chest Pain ☐Swelling of Ankles ☐High Blood Pressure
☐Palpitations/Fluttering ☐Stroke ☐Heart Murmurs ☐Rheumatic Fever ☐Varicose Veins

Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past)
☐Ulcers ☐Changes in Appetite ☐Nausea/Vomiting ☐Epigastric Pain ☐Passing Gas
☐Heartburn ☐Belching ☐Gall Bladder Disease ☐Liver Disease ☐Hepatitis B or C
☐Hemorrhoids ☐Abdominal Pain
Stool: ☐Diarrhea ☐Constipation ☐Undigested Food ☐Mucous ☐Blood In Stool

Genito-Urinary Tract (please circle any you experience now and underline any you have experienced in the past)
☐Kidney Disease ☐Painful Urination ☐Frequent Urinary Tract Infections ☐Frequent Urination
☐Venereal Disease ☐Kidney Stones ☐Impaired Urination ☐Frequent Urination at Night
☐Blood in Urine

Female Reproductive/Breasts (circle any you experience now/underline any you have experienced in the past)
☐Irregular Cycles ☐Breast Lumps/Tenderness ☐Nipple Discharge ☐Heavy Flow
☐Bleeding Between Cycles ☐Vaginal Discharge ☐Clotting ☐Premenstrual Problems
☐Menopausal Symptoms ☐Difficulty Conceiving

Menstrual/Birthing History
Age of First Menses _____ Birth Control_____ # of Abortions _____
# of Days of Menses _____ # of Pregnancies_____ # of Live Births_____
Length of Cycle_____ # of Miscarriages_____

Male Reproductive (please circle any you experience now and underline any that you have experienced in the past)
☐Sexual Difficulties ☐Prostate Problems ☐Testicular Pain/Swelling ☐Penile Discharge

Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past)
☐Neck/Shoulder Pain ☐Muscle Spasms/Cramps Arm Pain ☐Upper Back Pain ☐Mid Back Pain
☐Low Back Pain ☐Leg Pain ☐Joint Pain (if so, where?)_____

Neurologic (please circle any that you experience now and underline any that you have experienced in the past)
☐Vertigo/Dizziness ☐Paralysis ☐Numbness/Tingling ☐Loss of Balance ☐Seizures/Epilepsy

Endocrine (please circle any that you experience now and underline any that you have experienced in the past)
☐Hypothyroid ☐Hypoglycemia ☐Hyperthyroid ☐Diabetes Mellitus ☐Night Sweats ☐Feeling Hot or Cold

Other (please circle any that you experience now and underline any that you have experienced in the past)
☐Anemia ☐Cancer ☐Rashes ☐Eczema/Hives ☐Cold Hands/Feet
Do you have any infectious diseases? Yes ☐ No ☐
If yes please explain _____
Is there anything else we should know? _____

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Life Style

Please indicate typical food intake

Breakfast_____Lunch_____

Dinner _____Snacks _____

Consumption of Liquids _____**Television Habits** _____**Reading Habits** _____

Daily Exercise_____

Sleep Habits _____

Nicotine/Alcohol/Caffeine Use _____

Have you experienced any major traumas? ☐Yes☐No if yes please explain

_____

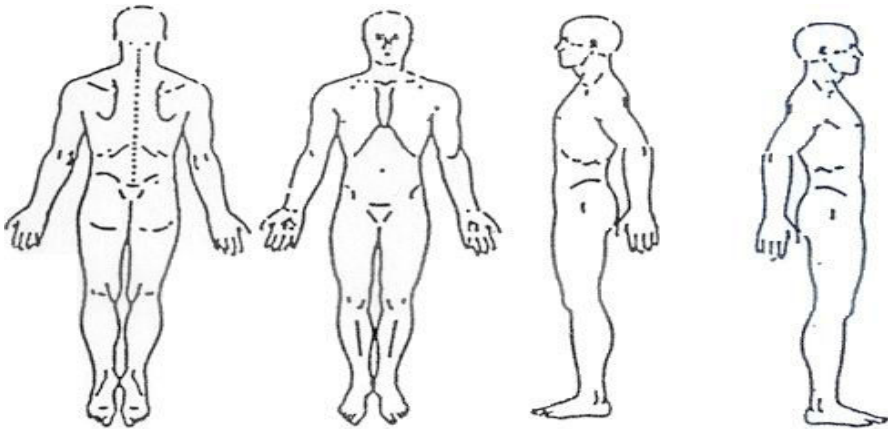
Education _____**Occupation** _____**Employer** _____**Hr/Wk**_____

Do you enjoy work? ☐Yes ☐No Why/Why not?_____

Have you had any unusual stresses recently? Yes☐ **No**☐if yes, please explain_____

Interests, Hobbies, and Recreational Habits_____

Please circle on the diagram any areas of any type of pain or injury.
Please try to describe the type and quality of the pain_____



Are there any other problems you would like to discuss?

_____
_____
_____

_____
Patient/Guardian/Legal Representative Signature