Albany Acupuncture Clinic
Mandi Schwendiman, L.Ac., D.Ac
724 Lyon St. SW Albany, Oregon 97321
Phone 541-928-2171 Fax 541-981-2113

Name:_____ Age:_____ Gender: M/F
(first) (middle) (last)

Phone#: (H) (_____)_____-_____ Phone(☐Cell) or (☐Work) (_____)_____-_____

Email:_____ **Preferred Method of Contact:** ☐ Home ☐ Cell ☐ Email

Address:_____

City/State:_____ /_____ Zip:_____

Date of Birth:_____/_____/_____ Social Security Number:_____

Emergency Information (Please indicate who to notify in case of emergency)

Name: _____ Relationship:_____

Phone#: (H) (_____)_____-_____ Phone:(Cell) (_____)_____-_____

General Information Height _____ Weight _____ Marital Status _____

Blood pressure _____ /_____ When was this reading taken _____/_____/_____

Occupation:_____ Employer:_____ Hours/Week:_____
Do you enjoy work? Y/N

How did you hear about our office? _____
Have you had Acupuncture Before? Y/N

Major Compliant(s) Please identify the health concerns that have brought you to Albany Acupuncture Clinic in order of significance to you:

	Severe	Moderate	Slight	Normal	
1.	☐	☐	☐	☐	_____
2.	☐	☐	☐	☐	_____
3.	☐	☐	☐	☐	_____
4.	☐	☐	☐	☐	_____
5.	☐	☐	☐	☐	_____

What kind of treatment and diagnosis have you received? _____

_____

How do these conditions affect your life? _____

_____

Two goals that you would like to work together towards?

1._____ 2._____

List Medications Being Taken

Drug Name & Dosage	For What Purpose/Condition
1.	
2.	
3.	
4.	
5.	

List Supplements/Vitamins Being Taken

Supplement/Vitamin Name & Amount	For What Purpose/Condition
1.	
2.	
3.	
4.	
5.	

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to

(please include reaction):_____

Do you have any infectious diseases? Y/N

If yes, please identify:_____

Have you experienced any major traumas (injuries, surgeries, emotional)? Y/N

Explain:_____

Do you have or are you any of the following?

☐Pacemaker ☐Electric Implants ☐Metal Implants ☐Severe Bleeding Disorder
☐Pregnant ☐HIV Positive ☐Hepatitis A/B/C ☐Herpes ☐Stroke

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

__Scarlet Fever __Diphtheria __Rheumatic Fever __Mumps
__Measles __Chicken Pox __German Measles

Immunizations: (please check any that you have had)

__Polio __Tetanus __Measles __Mumps __Rubella __Pertussis
__Diphtheria __Hepatitis A & B Others:_____

Family History: (please include the relationship)
Father/Mother/Brothers/Sisters/Spouse/Son/ Daughter

Cancer_____ Diabetes_____ Heart Disease_____
High Blood Pressure_____ Stroke_____ Mental Illness_____
Asthma_____ Hay Fever _____ Hives_____
Kidney Disease_____ Migraines_____ Gallstones_____
Arthritis_____ Thyroid Disease_____ Epilepsy_____

Patient Profile

General

☐Anemia ☐Poor Appetite ☐Tremors
☐Fatigue ☐Localized Weakness ☐Poor Balance
☐Fever ☐Bleeding or Bruise Easily ☐Cravings
☐Weight Loss ☐Peculiar Tastes or Smells ☐Weight Gain
☐Sweats ☐Strong Thirst (hot or cold drinks) ☐Alcoholism
☐Chills ☐Sudden Energy Drop ☐Tetanus Shot
☐Drug Addiction ☐Poor Sleep Habits ☐Frequent Cold/Flu

Skin and Hair

☐Rashes ☐Open Sore ☐Recent Moles
☐Itching ☐Acne ☐Loss of Hair
☐Dandruff ☐Corns ☐Hives
☐Warts ☐Nail Problems ☐Ulcerations
☐Psoriasis ☐Dry Skin ☐Eczema

Head, Eyes, Ears, Nose and Throat

☐Dizziness/Vertigo ☐Concussions ☐Migraines
☐Poor Vision ☐Eye Strain ☐Eye Pain
☐Cataracts ☐Night Blindness ☐Color Blindness
☐Ringing in Ears ☐Blurry Vision ☐Earaches
☐Sinus Problems ☐Poor Hearing ☐Spots in Vision
☐Grinding Teeth ☐Nose Bleeds ☐Sore Throats
☐Nasal Congestion ☐Headaches ☐Facial Pain

Cardiovascular

☐High/Low Blood Pressure ☐Myocarditis ☐Coronary Heart Disease
☐Pacemaker ☐Pneumatic Heat Disease ☐Difficulty in Breathing
☐Palpations ☐Chest Pain ☐Hardening of Arteries
☐Irregular Heartbeat ☐Varicose Veins ☐Phlebitis
☐Mitral Stenosis ☐Swelling of Hands/Feet ☐Blood Clots
☐Mitral Prolapse ☐Fainting ☐Cold Hands/Feet

Respiratory

☐Cough ☐Coughing Blood ☐Pain w/ Deep Breath
☐Bronchitis ☐Pneumonia ☐Production of Phlegm
☐Difficulty Breathing Lying Down Yellow/Green/Clear/White
☐Pleurisy ☐Emphysema ☐Asthma

Gastrointestinal

☐Nausea ☐Constipation ☐Diarrhea
☐Vomiting ☐Gas ☐Belching
☐Bad Breath ☐Blood in Stools ☐Black Stools
☐Abdominal Pain or Cramps ☐Rectal Pain ☐Hemorrhoids
☐Indigestion ☐Chronic Laxative Use ☐Acid Reflux
☐Ulcer ☐Colitis

Genitourinary

☐Bed Wetting ☐Blood in Urine ☐Frequent Urination
☐Kidney Infections/Stones ☐Painful Urination ☐Bladder Infections
☐Genital Herpes ☐Venereal Disease ☐Prostate Problems
☐Cystitis ☐Incontinence ☐ Wake up to Urinate
How Many Times _____

Pregnancy and Gynecology

Are you pregnant or trying to get pregnant? Y/N

# of Pregnancies _____	Age at 1st Menses _____	☐Unusual Flow (heavy/light)
# of Abortions _____	Time between Menses _____	☐Vaginal Sores
# of Births _____	Duration of Menses _____	☐Vaginal Discharge
# of Miscarriages _____	Start of Last Menses _____ /_____	☐Breast Lumps
☐Use of Birth Control	☐Irregular Periods	☐Uterine Fibroids
☐Hot Flash/Night Sweats	☐Mood Swings	☐Osteoporosis
☐Menopause	☐Hysterectomy	☐Hormone Replacement

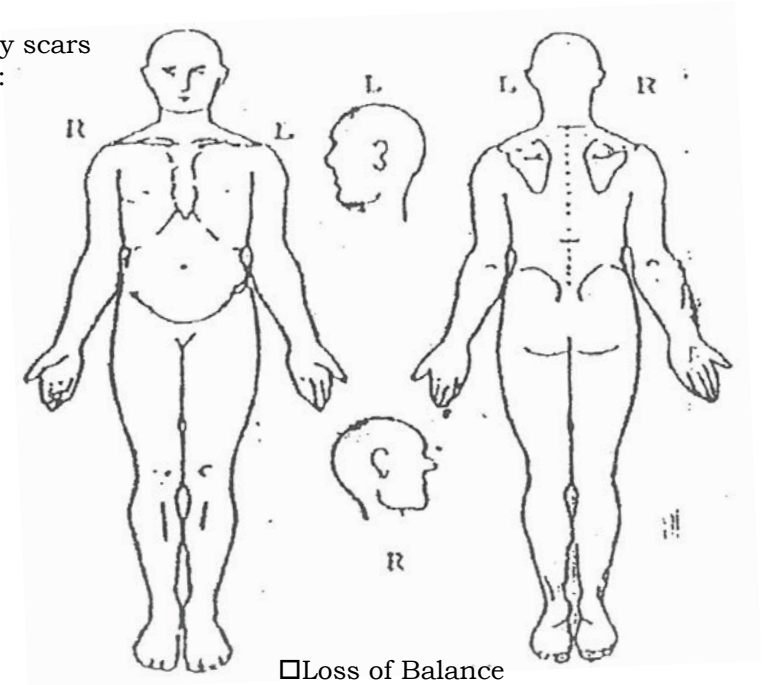
Fertility Information

Issues with Fertility?_____ What treatments have you received? _____

# of IVF procedures _____ # of IUI procedures _____

Musculoskeletal

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):



Is the Pain:

☐Aching	☐Dull	☐Cramping
☐Sharp	☐Electrical	☐Tingling
☐Numbness	☐Burning	☐Moving
☐Fixed	☐Other_____	

Do the Following Lessen the Pain?

☐Pressure	☐Cold	☐Heat
☐Exercise	☐Other_____	

Do the Following Worsen the Pain?

☐Pressure	☐Cold	☐Heat
☐Movement	☐Other_____	

Neuropsychological

☐Seizures	☐Dizziness	☐Loss of Balance
☐Areas of Numbness	☐Lack of Coordination	☐Poor Memory
☐Concussion	☐Depression	☐Anxiety
☐Bad Temper	☐Easily Susceptible to Stress	☐ADD

Infection

☐Measles	☐Mumps	☐Whopping Cough
☐Rheumatic Fever	☐Tuberculosis	☐Typhoid Fever
☐Malaria	☐Chicken Pox	☐Scarlet Fever
☐Small Pox		

Lifestyle:

Do you eat 3 meals per day? Y/N If no, how many?_____ Do you have food cravings? Y/N

What is the best thing about your eating habits?_____

What is the worst thing about your eating habits?_____

Exercise routine:_____

On average, how many hours per night do you sleep?_____

When do you go to bed_____ Wake up_____ Do you wake rested? Y/N

Nicotine/Alcohol/Caffeine Use:_____

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day?_____