

# Medical Health History Patient Information

InSpire Wellness, LLC 7319 N. John Ave Suite 101, Portland, OR 97203

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have any problem, questions or concerns, please bring them to the attention of your InSpire Wellness, LLC practitioner. Thank you for your cooperation, and welcome to InSpire.

		Today's Date				
Last Name	First Name		Middle Name			
Home Address	City/Town	State	Zip Code			
Telephone Numbers (Home)	(Work/Business	;)	Email Address			
Emergency Contact Person	Relation		Telephone Number(s)			
Legal Guardian (If under 18	years of age)		Telephone Number(s)			
Date of Birth Age	Height	Weight	Sex(male/female)			
Marital Status (please circle)	: Married/Committed	Single	Divorced Widowed			
Have you ever received acup	uncture before? Y N	lf so,	when:			
Primary Care Physician Information:						
Name	Office Address		Telephone Number			
Date of your last check up w	vith your Primary Care Phys	ician?				

## Patient Chief Complaint or Health Issue

Please describe your main health issue or complaint which has resulted in you seeking acupuncture treatments (be as specific as possible):

## Types of Pain

Please describe location of aches and pains (if applicable):

Pain Character Please check all	ristics				
Dull Moderate Burning	Sharp   Sore   Radiates		Stabbing Cramping Fixed		Severe Throbbing Moves About
Pain radiates to:					
Describe the ons	set of the pain: _				
Pain is relieved	by:				
Pain is worsened	d with:				
Are there any m	novements that ag	gravate the	pain?		
How does exerc	ise affect your pa	in?			
Do any medicati	ons help alleviate	the pain?	lf so, please list	:	
Other treatment	you have had for	the pain?			

## Patient Diagnostic Test Results

Patient Diagnostic Test Results					
Please answer a	as completely an	d accurately as pos	sible.		
	<u>Date</u>	<u>Results</u>			
Blood Work					
X-Rays					
MRI					
CT Scan					
EMG					

Please list any surgeries that you have had. If so, when and where on the body was surgery performed? Continue on reverse if necessary.

#### Patient and Relative Health History

Please indicate which illness/disease you or your blood relatives have experienced: \*Blood relatives constitute your Grandparents, Parent, Siblings and Children.

Illness/Disease	Who	Approximate Date
Anemia		
Appendicitis		
Cancer		
Diabetes		
Emotional Disorders		
Heart Disease		
Hepatitis		
High Blood Pressure		
Infectious Disease		
Rheumatic Fever		
Seizures		
Tuberculosis		

Do you currently or have you ever had a sexually transmitted disease? Please circle those that apply and include approximate date contracted:

AIDS/HIV	Chlamydia	Gonorrhea	Herpes	HPV	Syphilis

# Patient Medication and Supplement Record

Please check all that a	pply.			
Antacids	Tylenol or Advil		Oral Contraceptives	
Antidepressants	Laxatives		Probiotics / Prebiotics	
Antibiotics	Daily Vitamins		Glucose or Insulin	
Antifungals	Heart medications		Relaxants or Regulators	
Anti-Inflammatory 🗌	Thyroid Medication		Blood Pressure Medications	
Aspirin	Sleeping pills		Recreational or Illegal Drugs	
Please list any medicat	ions and/or supplements	you are	currently taking:	
Type/Name	Dosage	Reason	Prescribed	Date/OTC
*continue on reverse in	f necessary			
Other(s) discontinued	within the past three (3)	) months	:	

\*continue on reverse if necessary

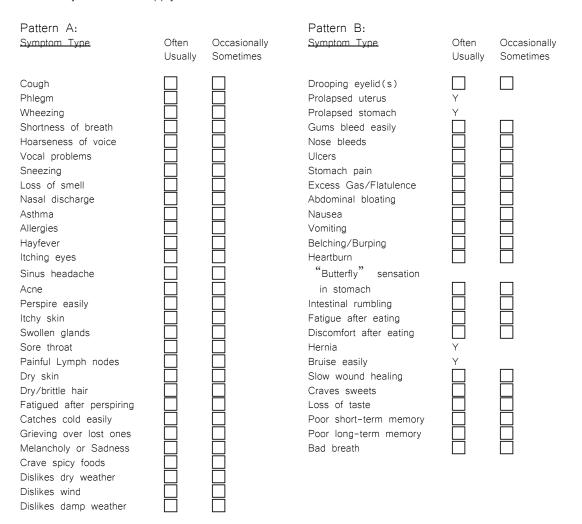
## Patient Dietary Routine

Please be as specific as possible, by listing the typical intake of foods and dietary supplements.

Breakfast			
Lunch			
Dinner			
<u>Snacks</u>			
Supplements			

## Patient Patterns of Health and Symptoms

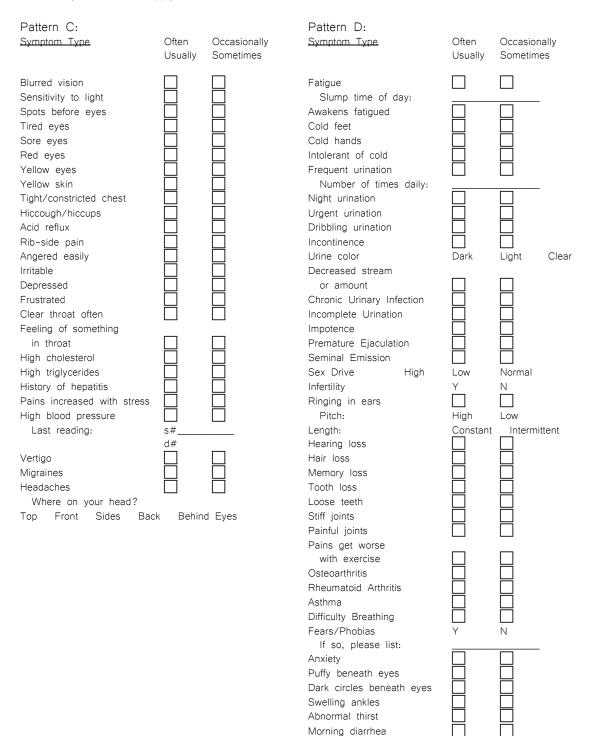
Please indicate which of the following symptoms you experience and there frequency. Check or circle only those that apply.



Please list any known allergies and/or sensitivities:

## Patient Patterns of Health and Symptoms: Continued

Please indicate which of the following symptoms you experience and there frequency. Check or circle only those that apply.



## Patient Patterns of Health and Symptoms: Continued

Please indicate which of the following symptoms you experience and there frequency. Check or circle only those that apply.

