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 acupuncture before? Y N If so, when: _____

Primary Care Physician Information:

Name | Office Address | Telephone Number

Date of your last check up with your Primary Care Physician? _____

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 Characteristics

Please check all that apply.

Dull	☐	Sharp	☐	Stabbing	☐	Severe	☐
Moderate	☐	Sore	☐	Cramping	☐	Throbbing	☐
Burning	☐	Radiates	☐	Fixed	☐	Moves About	☐

Pain radiates to: _____

Describe the onset of the pain: _____
_____
_____

Pain is relieved by: _____

Pain is worsened with: _____

Are there any movements that aggravate the pain? _____

How does exercise affect your pain? _____

Do any medications help alleviate the pain? If so, please list: _____

Other treatment you have had for the pain? _____

Patient Diagnostic Test Results

Please answer as completely and accurately as possible.

	Date	Results
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 apply.

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 medications and/or supplements you are currently taking:

Type/Name Dosage Reason Prescribed Date/OTC

_____
_____
_____
_____
_____
_____
_____

**continue on reverse if 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	
Snacks	
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.

Pattern A:

Symptom Type	Often Usually	Occasionally Sometimes
Cough	☐	☐
Phlegm	☐	☐
Wheezing	☐	☐
Shortness of breath	☐	☐
Hoarseness of voice	☐	☐
Vocal problems	☐	☐
Sneezing	☐	☐
Loss of smell	☐	☐
Nasal discharge	☐	☐
Asthma	☐	☐
Allergies	☐	☐
Hayfever	☐	☐
Itching eyes	☐	☐
Sinus headache	☐	☐
Acne	☐	☐
Perspire easily	☐	☐
Itchy skin	☐	☐
Swollen glands	☐	☐
Sore throat	☐	☐
Painful Lymph nodes	☐	☐
Dry skin	☐	☐
Dry/brittle hair	☐	☐
Fatigued after perspiring	☐	☐
Catches cold easily	☐	☐
Grieving over lost ones	☐	☐
Melancholy or Sadness	☐	☐
Crave spicy foods	☐	☐
Dislikes dry weather	☐	☐
Dislikes wind	☐	☐
Dislikes damp weather	☐	☐

Pattern B:

Symptom Type	Often Usually	Occasionally Sometimes
Drooping eyelid(s)	☐	☐
Prolapsed uterus	Y	
Prolapsed stomach	Y	
Gums bleed easily	☐	☐
Nose bleeds	☐	☐
Ulcers	☐	☐
Stomach pain	☐	☐
Excess Gas/Flatulence	☐	☐
Abdominal bloating	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Belching/Burping	☐	☐
Heartburn	☐	☐
"Butterfly" sensation in stomach	☐	☐
Intestinal rumbling	☐	☐
Fatigue after eating	☐	☐
Discomfort after eating	☐	☐
Hernia	Y	
Bruise easily	Y	
Slow wound healing	☐	☐
Craves sweets	☐	☐
Loss of taste	☐	☐
Poor short-term memory	☐	☐
Poor long-term memory	☐	☐
Bad breath	☐	☐

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.

Pattern C:

Symptom Type	Often Usually	Occasionally Sometimes
Blurred vision	☐	☐
Sensitivity to light	☐	☐
Spots before eyes	☐	☐
Tired eyes	☐	☐
Sore eyes	☐	☐
Red eyes	☐	☐
Yellow eyes	☐	☐
Yellow skin	☐	☐
Tight/constricted chest	☐	☐
Hiccough/hiccups	☐	☐
Acid reflux	☐	☐
Rib-side pain	☐	☐
Angered easily	☐	☐
Irritable	☐	☐
Depressed	☐	☐
Frustrated	☐	☐
Clear throat often	☐	☐
Feeling of something in throat	☐	☐
High cholesterol	☐	☐
High triglycerides	☐	☐
History of hepatitis	☐	☐
Pains increased with stress	☐	☐
High blood pressure	☐	☐
Last reading:	s#_____ d#	
Vertigo	☐	☐
Migraines	☐	☐
Headaches	☐	☐

Where on your head?

Top Front Sides Back Behind Eyes

Pattern D:

Symptom Type	Often Usually	Occasionally Sometimes
Fatigue	☐	☐
Slump time of day:	_____	
Awakens fatigued	☐	☐
Cold feet	☐	☐
Cold hands	☐	☐
Intolerant of cold	☐	☐
Frequent urination	☐	☐
Number of times daily:	_____	
Night urination	☐	☐
Urgent urination	☐	☐
Dribbling urination	☐	☐
Incontinence	☐	☐
Urine color	Dark	Light Clear
Decreased stream or amount	☐	☐
Chronic Urinary Infection	☐	☐
Incomplete Urination	☐	☐
Impotence	☐	☐
Premature Ejaculation	☐	☐
Seminal Emission	☐	☐
Sex Drive High	Low	Normal
Infertility	Y	N
Ringing in ears	☐	☐
Pitch:	High	Low
Length:	Constant	Intermittent
Hearing loss	☐	☐
Hair loss	☐	☐
Memory loss	☐	☐
Tooth loss	☐	☐
Loose teeth	☐	☐
Stiff joints	☐	☐
Painful joints	☐	☐
Pains get worse with exercise	☐	☐
Osteoarthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Asthma	☐	☐
Difficulty Breathing	☐	☐
Fears/Phobias	Y	N
If so, please list:	_____	
Anxiety	☐	☐
Puffy beneath eyes	☐	☐
Dark circles beneath eyes	☐	☐
Swelling ankles	☐	☐
Abnormal thirst	☐	☐
Morning diarrhea	☐	☐

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.

Pattern E:

Symptom Type	Often Usually	Occasionally Sometimes
Palpitations	☐	☐
Racing heart beat	☐	☐
Missing pulse beats	☐	☐
Heart murmur	☐	☐
Shortness of breath	☐	☐
Chest congested	☐	☐
Delirium	☐	☐
Jittery	☐	☐
Speech problems	☐	☐
Insomnia	☐	☐
Dream-disturbed sleep	☐	☐
Mouth sores	☐	☐
Tongue sores	☐	☐
Dry mouth	☐	☐
Flushing in afternoon	☐	☐
Night sweats	☐	☐
Pale skin	☐	☐
Numb skin	☐	☐
Scanty, yellow urine	☐	☐

Pattern F:

Symptom Type	Often Usually	Occasionally Sometimes
Sense of heaviness	☐	☐
Favors warm drinks	☐	☐
Physical labor	☐	☐
Sedentary work	☐	☐
Regular exercise	☐	☐
Brittle nails	☐	☐
Muscle cramps	☐	☐
Twitches/spasms	☐	☐
Muscle/weakness	☐	☐
Fever/chills	☐	☐
History of Kidney Stones	☐	☐

Pattern G: Females Only

Symptom Type	Often Usually	Occasionally Sometimes	
Age at first period	_____		
Age of menopause	_____		
Painful menses	☐	☐	
Average duration of cycle (i.e.28 days))	_____		
Irregular cycle	☐	☐	
Average duration of flow (i.e. 4-7)	_____		
Blood clots visible	☐	☐	
Cramps	Before	During	After
Color of flow	Dark	Light	Bright
Breast distention	☐	☐	
Breast pain			
Date of last period	_____		
Recent change in period	☐	☐	
Vaginal pain	☐	☐	
Fibroid tumors	☐	☐	
Fibrocystic breast(s) or ovary(ies)	☐	☐	
Date of last Pap exam	_____		
History of irregular pap exams	☐	☐	
Number of pregnancies	_____		
Miscarriages	Y		
If so, number	_____		
Infertility	Y		

Have you had any Gynecological surgeries?

Please list procedures and approximate dates:

_____

_____

_____

_____

_____

Have you experienced any other premenstrual symptoms?

Please list:

_____

_____

_____

_____

_____