Dawn-Starr Crowther, L.Ac., L.M.T. • Amara Narten, L.Ac.
Jade River Healing Arts Center Acupuncture, 7303 SW Beaverton-Hillsdale Hwy, Portland OR 97225
Office: 503-297-3825 / Fax 503-297-3827 / www.JadeRiverPdx.com

CONFIDENTIAL PATIENT INFORMATION

Please complete all parts of this form prior to your visit. Oriental Medicine is holistic; therefore, a complete medical history is very important. Please be thorough so you can receive the best care possible.

Name _____ Today's Date _____

Street Address _____

City _____ State _____ Zip _____

Mailing Address if different: _____

Home phone _____ Cell phone _____

Date of Birth _____ ❑Male ❑Female Place of Birth _____

Soc Sec # _____ Driver's License # _____ State _____

E-mail _____ OK for appt reminders? ❑ Yes ❑ No

Employer _____

Employer's address _____

City _____ State _____ Zip _____

Work phone _____ Extension _____

Type of work performed/position _____ How Long? _____

If patient is a minor, signature of parent or guardian _____

Living Situation: ❑ alone ❑ w/partner or spouse ❑ w/friends ❑ w/children # _____ ❑ w/pet(s) # _____

Spouse/Partner Name _____ Phone _____

Emergency contact _____ Relationship to you _____

Work phone _____ Cell _____ Home _____

Who can we thank for referring you to our practice? _____

Insurance Information *Insurance billing is a courtesy we extend to our patients. However, our relationship is with you, and you have a relationship with your insurance company. If your claim is denied, you are financially responsible for the bill in full, and we expect payment in a timely manner. Please see our Financial Policies Agreement (a copy which has been provided to you) for details of our policies.*

Ins Company _____

Insured's Name _____ Insured's Date of Birth _____

Relationship to insured if other than self _____

Policy Number _____ Group Number _____

Date Policy in Effect _____ Annual Renewal Date _____

Deductible _____ Deductible met this year? _____

Guarantor (if different than patient) _____

Guarantor's Address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Work phone _____

Major area(s) of concern

1. _____ Is it getting ❑ Better ❑Worse ❑ Unchanged

Past treatment received for this concern _____

Has past treatment been effective? _____

How does this affect you? _____

What makes it better? _____

What makes it worse? _____

What time of day is the problem worse?
❑ Morning ❑ Mid-day ❑ Afternoon ❑ Evening ❑ Night time ❑ Constant

2. _____ Is it getting ❑ Better ❑Worse ❑ Unchanged

Past treatment received for this concern _____

Has past treatment been effective? _____

How does this affect you? _____

What makes it better? _____

What makes it worse? _____

What time of day is the problem worse?
❑ Morning ❑ Mid-day ❑ Afternoon ❑ Evening ❑ Night time ❑ Constant

3. _____ Is it getting ❑ Better ❑Worse ❑ Unchanged

Past treatment received for this concern _____

Has past treatment been effective? _____

How does this affect you? _____

What makes it better? _____

What makes it worse? _____

What time of day is the problem worse?
❑ Morning ❑ Mid-day ❑ Afternoon ❑ Evening ❑ Night time ❑ Constant

Anything else that is important to know about your above problem(s)? _____

_____

Are any of the previous health concerns related to a ❑ Work Injury? ❑ Personal Injury? ❑ Car accident?

Date of injury _____ Name of your attorney _____

Are you currently receiving medical care for any of the above problems? ❑ Yes ❑ No

1. Primary Care Provider _____ Phone _____
2. Provider _____ Phone _____
3. Provider _____ Phone _____

May I contact the above provider(s) regarding my treatment plan for you? ❑ Yes ❑ No

Have you received health care in the past year? ❑ Yes ❑ No Reason _____

When was your last complete medical exam?_____

Do you have any mobility issues we should be aware of? ❑ No ❑ Yes_____

Women: Is there any possibility that you may be pregnant? ❑ No ❑ Yes

ALLERGIES (medicine, food, other)	**Reaction**

PLEASE LIST *ALL* MEDICATIONS & SUPPLEMENTS YOU CURRENTLY TAKE include prescriptions, over-the-counter medicines, vitamins, supplements, and herbs.		
Item	Dose / Frequency	Reason

Have you previously sought other complimentary health care?

❑ Acupuncture ❑ Chiropractic ❑ Naturopathy ❑ Massage ❑ Other _____

Reason(s) _____

Was the care helpful? _____

Medical History

Height_____ Current Weight _____ Recent ❑Gain ❑Loss Amount _____

Past Maximum / Minimum Weight_____ /_____ When_____

What was your most recent blood pressure reading?_____ /_____ When _____

Surgeries	
Year	**Reason** (please be specific)

Family Medical History (complete any that apply)						
	Mother	Father	Sisters	Brothers	Grandparents	Children
Age (if living)						
Age at death						
Cause of death						
Cancer (type)						
Diabetes						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Stroke						
Allergies / Asthma						
Arthritis						
Auto-immune Illness						
Digestive Problems						
Celiac Disease						
HIV / AIDS						
Alcoholism / Drugs						
Mental Health Probs						
Suicide						
Other:						

My ethnic heritage is (be specific): _____

❑ Unknown / Adopted _____

Personal Medical History (complete any that apply)								
Condition	**Now**	**Past**	**Condition**	**Now**	**Past**	**Condition**	**Now**	**Past**
HIV / AIDS			Asthma			Severe Allergic Reaction		
Hepatitis A B C Other			Pneumonia			MRSA		
Tuberculosis			Bronchitis			Fibromyalgia		
Blood Transfusion			Emphysema			Chronic Fatigue		
Hemophilia			Pneumothorax (lung collapse)			Sleep Apnea		
Other Blood Disorder			Valley Fever			Artificial Implants		
Angina (chest pain)			Kidney Disorder / Disease			Artificial Joints/hardware		
Heart Attack / Disease			Thyroid Disease / Problems			Mononucleosis		
Heart Murmur			Goiter			Malaria		
Rheumatic Fever			Liver Disease / Cirrhosis			Measles		
Scarlet Fever			Jaundice			Mumps		
Artificial Heart Valve			Appendicitis			Whooping Cough		
Pacemaker for Heart			Glaucoma			Chicken Pox		
Heart Surgery			Cataract			Shingles		
Heart Palpitations			Macular Degeneration			Herpes: oral / genital		
High / Low Blood Pressure			Eye Surgery			Sexually Transmitted		
High Cholesterol			Head / Spinal Injury			Migraine Headache		
Diabetes			Multiple Sclerosis			Osteoporosis		
Stroke			Other Neurological Issue			Osteo Arthritis		
Epilepsy or Seizures			Cancer			Rheumatic Arthritis		
Brain Surgery or Shunt			Surgery for Cancer			Depression		
Confusion / Forgetfulness			Chemotherapy			Anxiety		
Dizziness / Fainting			Radiation Therapy			Bipolar Disorder		
Blood Clots in Legs			Celiac Disease			Thoughts of Suicide		
Varicose Veins			Crohn's / Ulcerative Colitis			Alcoholism		
Bruise or Bleed Easily			Ulcers			Drug Addiction		
Anemia			Anorexia / Bulimia			Attend 12-Step?		

Do you have any disease, condition or medical problem not listed above? ❑ No ❑ Yes—**list below**:

_____

Have you experienced trauma? (physical, emotional or mental abuse as child or adult; served in or survived war or other civil unrest; sexual assault; acts of violence; severe accidents; personal loss) ❑ Yes ❑ No

_____

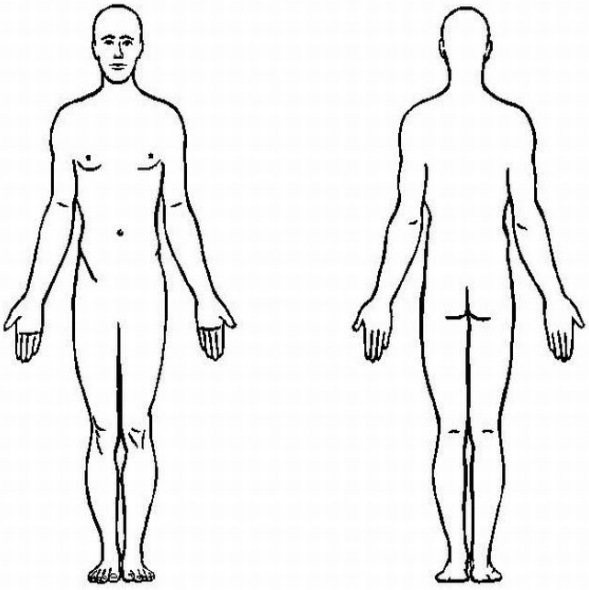
Are you or have you been: ❑ Police Officer ❑ Fire Fighter ❑ EMT ❑ Other_____

Immunizations: please check all you have received

❑ Polio ❑ Measles/Mumps/Rubella ❑ Pertussis ❑ Diphtheria ❑ Hepatitis B ❑ Hepatitis A
❑ Varicella/Chicken Pox ❑ Influenza ❑ Pneumonia ❑ Smallpox ❑ Typhoid Fever ❑ Yellow Fever
❑ Meningococcal ❑ Human Papillomavirus ❑ Rabies ❑ Other
Do you get an annual influenza vaccination? ❑ Yes ❑ No_____

Chemical Exposure: please indicate past exposure (p) and /or current exposure (c)

p	**c**	Insecticides	**p**	**c**	Radon	**p**	**c**	Use plastic dishes or wrap in microwave
p	**c**	Weed Killers	**p**	**c**	Mold	**p**	**c**	Use plastic water bottles
p	**c**	Fertilizers	**p**	**c**	Asbestos	**p**	**c**	New carpets, vinyl flooring, vinyl windows
p	**c**	Oil-based paints	**p**	**c**	Lead	**p**	**c**	Live in home built prior to 1970
p	**c**	Bleach (Clorox)	**p**	**c**	Solvents	**p**	**c**	Other

Body Pain		
Shade in or mark your area(s) of pain:	**Check all that apply**	
	❑ Sore ❑ Dull ❑ Achy ❑ Throbbing ❑ Pinching ❑ Pressure ❑ Boring ❑ Stabbing ❑ Sharp ❑ Cramping ❑ Tingling ❑ Numb ❑ Prickling ❑ Electrical ❑ Burning ❑	❑ Radiating ❑ Spreading ❑ Shooting ❑ Tearing ❑ Tight ❑ Clicking ❑ Popping ❑ Better with Pressure ❑ Worse with Pressure ❑ Better / Worse with Cold ❑ Better / Worse with Heat ❑ Feels Empty ❑ Feels Full, Distending ❑ Constant ❑ Intermittent ❑

Indicate your most troubling areas of pain by describing below. Please mark area(s) on drawing by number.

1. _____

2. _____

3. _____

Heart/Lungs ❑ Pressure in chest ❑ Irregular heartbeat ❑ Racing heartbeat ❑ Skipped heartbeat
❑ Wheezing ❑ Frequent Cough ❑ Pain with breathing ❑ Ankle swelling
❑ Cold Hands / Feet ❑ Shortness of breath not equal to exertion

❑ Other: _____

Nose/Throat ❑ Sore Throat ❑ Hoarseness ❑ Frequent throat clearing ❑ Difficulty swallowing
❑ Seasonal Allergies ❑ Sinusitis ❑ Frequent colds ❑ Loss of smell
❑ Phlegm (circle): clear yellow dark yellow green bloody thin thick sticky

❑ Other: _____

Ears ❑ Ringing in ears ❑ Excess wax ❑ Frequent infections ❑ Ear pain ❑ Drainage
❑ Dry/itching ears ❑ Hearing Loss ❑ Other _____

Eyes ❑ Excess tearing ❑ Dry eyes ❑ Red / irritated eyes ❑ "Floaters" in vision
❑ Itching eyes ❑ Pain in eyes ❑ Pressure in eye(s) ❑ Change in vision
❑ Glasses ❑ Contacts ❑ Lasik or other surgery ❑ Visual impairment

❑ Other: _____

Bowel Habits Frequency of bowel movements: _____ times per day / per week (circle)
Do your bowel movements feel complete? ❑ Yes ❑ No _____
Are you fatigued after having a bowel movement? ❑ Yes ❑ No _____
Do you have: ❑ Blood w/ stool ❑ Black or "tarry" stools ❑ Mucus w/ stool
❑ Constipation ❑ Hard, pellet-like stools ❑ Diarrhea
❑ Alternating Diarrhea & Constipation ❑ Frequent gas/flatulence
❑ Hemorrhoids ❑ Anal Fissure ❑ Abdominal Cramps
❑ Use Laxatives Frequency _____
If 50 or older: ❑ Date of last Colonoscopy_____ ❑ Normal ❑ Abnormal

Bladder Any problems with ❑ Urgency ❑ Frequency (how often)_____
❑ Blood in Urine ❑ Cloudy Urine ❑ Frequent Infections
❑ Painful Urination ❑ Hesitant Urination ❑ Burning
❑ Incontinence / Leakage _____
❑ Frequent waking at night to urinate (# of times/night)_____

Upper G/I Any problems with ❑ Poor Appetite ❑ Excess Appetite ❑ Binge Eating
❑ Nausea ❑ Vomiting ❑ Belching
❑ Acid Reflux/Heartburn/Indigestion ❑ Bad Breath
❑ Excess Thirst ❑ Dental problems ❑ Other _____
❑ Abdominal Pain Location: _____

Reproductive
Sexual Orientation: ❑ Hetero ❑ Gay / Lesbian ❑ Bi ❑ Transgender **Sexually Active?** ❑ No ❑ Yes

Female
Method of Birth Control _____
Age Menstruation Started _____
Days between Cycle _____
Usual Days of Flow _____
Maximum Pads / Tampons on heaviest day _____
First Day of Last Period _____ ❑ **Post Menopausal**
Quality of Blood ❑ Dark red ❑ Bright red ❑ Light or Watery
❑ Clots (color): _____

❑ Menstrual Irregularity	❑ Menstrual Cramping	❑ PMS
❑ Breast Pain	❑ Breast Lumps	❑ Pain with Ovulation
❑ Bloating before period	❑ Headaches w/ menses	❑ Spotting
❑ Vaginal infections	❑ Vaginal pain	❑ Vaginal dryness
❑ Pain with sex	❑ Loss of sex drive	❑ Pain or sores on labia

Any Recent shift toward ❑ Heavier flow ❑ Longer Flow ❑ More clots ❑ More cramping
❑ Lighter flow ❑ Missed periods ❑ Longer / Shorter Cycle

Any trouble conceiving? ❑ No ❑ Yes ❑ Don't know Number of pregnancies_____
Number of living babies _____ Number of miscarriages _____
❑ Caesarian ❑ Hysterectomy (date) _____ Number of abortions _____
❑ History of abnormal PAP? ❑ No ❑ Yes Number of D & C _____
Date last PAP smear:_____ Date last Mammogram _____
Any Other Issues / Difficulties? _____

Male ❑ Prostate issues ❑ Reduced urine flow ❑ Hesitant urine flow ❑ Pain in testes / penis
❑ Low sperm count/motility ❑ Loss of sex drive ❑ Sexual dysfunction
Last prostate exam: _____

Skin and Hair

❑ Rash ❑ Hives ❑ Eczema ❑ Psoriasis
❑ Itch without eruption ❑ Brittle Nails ❑ Nail Fungus
❑ Dandruff ❑ Hair Loss ❑ Thinning Hair ❑ Hair is Brittle
❑ Changes in mole(s) ❑ Change in pigment / color of skin

General

❑ Frequent sweating / perspiration ❑ Worse at night
❑ Have to change bed clothes or bedding at night due to sweating
❑ Feel cold / hot all the time
❑ Feel tired or fatigued ❑ Poor immune function

Diet / Meals Are there any foods you avoid? _____

Do you typically eat 3 meals / day? ❑ Yes ❑ No If no, how many? _____
❑ Vegan ❑ Vegetarian ❑ Ovo-Lacto Vegetarian ❑ Eat Fish ❑ Eat Chicken / Turkey
❑ Eat all types of foods ❑ Special diet issues _____

Please list your **typical food intake** below. Please note the **typical time** you eat each meal.

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Do you have strong cravings for certain foods/tastes?_____

Beverages How much water do you consume / day? _____
Source of your water: ❑ tap ❑ filtered ❑ reverse osmosis ❑ bottled ❑ well
I prefer my water: ❑ ice cold ❑ cold ❑ room temperature ❑ warm ❑ hot
Other beverages in typical day _____

Caffeine ❑ None ❑ Coffee ❑ Tea: Green / Black ❑ Cola ❑ Energy Drink
cups / cans per day_____ Time(s) of Day _____

Alcohol ❑ None ❑ Occasional ❑ Weekly ❑ Daily # drinks / week_____
Kind(s) consumed _____

Aerobic Exercise

❑ Sedentary (not much exercise: walk to car; walk in store(s); sit at work all day)
❑ Mild (climb stairs; walk 3 blocks or less; 5-10 minutes/day)
❑ Moderate (occasional vigorous exercise, 3 x/week for 20 minutes)
❑ Regular (vigorous exercise, 4 x/week for 30 minutes)
❑ High (vigorous exercise 6-7 x/week for 30-60 minutes)

Other Exercise

❑ Yoga, Qi Gong, Tai Qi times/week _____ for _____ minutes
❑ Pilates, Core times/week _____ for _____ minutes
❑ Weight training times/week _____ for _____ minutes
❑ Bicycle / Swimming times/week _____ for _____ minutes
❑ Other _____ times/week _____ for _____ minutes

Tobacco ❑ Cigarettes #/day_____ ❑ Chew #/day_____ ❑ Pipe #/day_____ ❑ Cigar #/day_____
❑ Number of years_____ ❑ Quit tobacco, but used for _____ # of years (note kind above)
❑ Never used ❑ Grew up in smoking household, for _____ # of years

Recreational Drugs ❑ Never used ❑ Used in the past, don't use now ❑ Use now: Frequency _____
❑ Marijuana ❑ Meth ❑ Cocaine ❑ LSD ❑ Mushrooms ❑ Other_____
❑ I've been in a drug treatment program ❑ I need help with drug use

Sleep How many hours/night sleep do you get on a regular basis?_____
How many times/night do you wake? _____ Do you wake rested? ❑ Yes ❑ No
Time to bed_____ Time up _____ TV in bedroom? ❑ Yes ❑ No
What is your bedtime routine?_____
Is your bedroom quiet & restful?_____

Does sleeping partner(s) interfere with your sleep? ❑ No ❑ Yes _____

❑ Insomnia ❑ Difficulty Falling Asleep ❑ Difficulty Staying Asleep ❑ Mind is too busy
❑ Wake due to pain ❑ Bad Dreams ❑ Wake feeling like I can't breathe ❑ Snoring
I sleep: ❑ w/spouse or partner ❑ family bed ❑ w/ pet(s) cat / dog ❑ alone

Work I work outside the home ❑ Yes ❑ No ❑ Retired ❑ Student ❑ Unable to work
Number of hours/week_____ My work is a significant source of stress ❑ Yes ❑ No
I enjoy my work ❑ Yes ❑ No Why or why not?_____

Climate Please indicate any of the following that you feel most affected by:
❑ Cold ❑ Dampness ❑ Heat ❑ Dryness ❑ Wind ❑ High Humidity
❑ Change in Barometric Pressure ❑ New Moon ❑ Full Moon ❑ Other_____

Please indicate your favorite (+) and least favorite (-) seasons
____ Winter ____ Spring ____ Summer ____ Fall

Other Hobbies_____

Interests_____

I have an active spiritual life ❑ Yes ❑ No Faith _____

❑ Prayer ❑ Faith Healing ❑ Fasting ❑ Special Diet ❑ Singing ❑ Meditation ❑ Chanting

❑ Service to others ❑ Time in nature ❑ Mindfulness ❑ Other _____

Is there anything else I should know about you?

_____

_____

Thank you for taking the time to complete this health history. Your care in completing this form will allow me to give you the best care possible.

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify Dawn-Starr Crowther, L.Ac. immediately whenever I have changes in my health condition(s).

_____ _____

Patient Signature **Date**