Helen Spieth LAc, M.Chem
1221 SE Madison St., Portland, OR 97214 ph: (503) 445.7767 fax: (503) 459-4221

Name: ____________________ Date: ____________

Address: ______________________________

City: ____________ State: __________ Zip Code: __________

Phone (h): __________ (c): __________ (w): __________

E-mail address: ______________________________

Quarterly E-Newsletter? ☐Yes ☐No Age: ______ Date of Birth: ____________

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partnership

Live with: ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone

Occupation: ______________ Hours per week: ________ ☐ Retired

Employer: ______________________________

Physician: ______________ Phone: ______________

Address: ______________________________

Who may we thank for referring you? ______________________________

In Emergency Notify: ______________ Relationship to patient: ______________

Phone: ______________

Please list your main health concerns in order of importance to you:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

What is your present level of commitment to address underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0 1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in that you believe are unsupportive of your health?

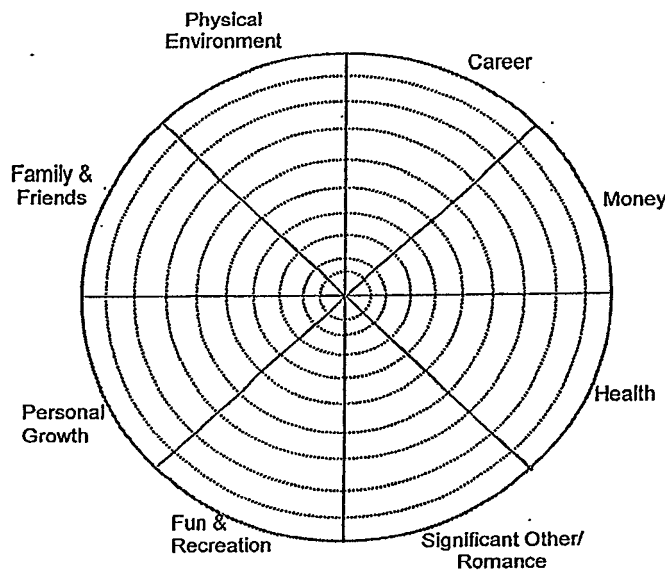
What potential obstacles do you foresee in addressing the lifestyle factors or changes that may be recommended?

Wheel of Balance

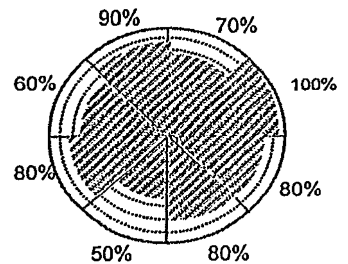
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



Example:



Typical Food Intake

Breakfast: ____________________

Lunch: ____________________

Dinner: ____________________

Snacks: ____________________

Number of caffeinated drinks per day: ________

Number of alcoholic drinks per week: ________

Number of times per week alcohol consumed: ________

How often do you eat out? ________

Do you smoke? ☐Yes ☐No ☐Past Amount: ________

Childhood Illnesses

Please check any condition you had as a child

- ☐ Scarlet fever
- ☐ Mumps
- ☐ Diphtheria
- ☐ Measles
- ☐ Rheumatic fever
- ☐ German measles

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

_______________________________________ Year __________

_______________________________________ Year __________

_______________________________________ Year __________

Allergies

Any drugs? ____

Any foods? ____

Any environmental or chemicals? ____________________________

Current Medications

Please check any of the following medications that you take or use

- ☐ Laxatives
- ☐ Cortisone
- ☐ Tranquilizers
- ☐ Pain relievers
- ☐ Appetite suppressants
- ☐ Thyroid medication
- ☐ Antacids
- ☐ Antibiotics
- ☐ Sleeping pills

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking:

1)______________________

2)______________________

3)______________________

4)______________________

5) ______________________

6) ______________________

7) ______________________

8) ______________________

Exercise

#of days per week:________ Length of workout:________ Type of activity:____________________

Sleep

Bedtime: ____________ Wake time: ____________

Difficulty falling asleep? ❑Yes ❑No

Night time waking? ❑Yes ❑No if yes, what time? ________

Wake up feeling rested? ❑Yes ❑No

General

Height: _________Weight:__________ lbs. Weight 1 year ago: ____________lbs.

Maximum Weight: __________________________ When: ____________________

When during the day is your energy the best? ________________ Worst? ______________

Personal History

Please check any conditions or symptoms you have now

- ❑ Arthritis
- ❑ Heart Disease
- ❑ Kidney Disease
- ❑ Diabetes
- ❑ Ulcer
- ❑ Raynaud's Disease
- ❑ Thyroid Imbalance
- ❑ Lyme Disease
- ❑ Gastritis/Pancreatitis
- ❑ Emphysema
- ❑ Liver/Gallbladder Disease
- ❑ High/low Blood Pressure
- ❑ Elevated Blood Cholesterol
- ❑ Food Allergies/Intolerances
- ❑ Seizures
- ❑ Chronic Fatigue
- ❑ Respiratory Allergies
- ❑ Chronic Pain Condition
- ❑ Asthma
- ❑ Stroke
- ❑ Hypo/Hyperglycemia
- ❑ Cancer
- ❑ Diverticulitis/IBS
- ❑ Hepatitis
- ❑ Anemia
- ❑ Alcoholism
- ❑ Impotence
- ❑ Infertility

Family Medical History

Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice

- ❑ Diabetes ____
- ❑ Stroke ____
- ❑ Cancer ____
- ❑ Seizures ____
- ❑ High Blood Pressure ____
- ❑ Asthma ____
- ❑ Heart Disease ____
- ❑ Allergies ____
- ❑ Other ____________

Please check the ***first box*** if you had this issue in the ***past*** but do not any longer.
Please check the ***second box*** if you ***currently/recently*** have any of these symptoms.

General

❑❑Fevers
❑❑Sweats easily
❑❑Localized weakness
❑❑Bleed/Bruise easily
❑❑Dental/Gum problems
❑❑Strong thirst (hot/cold drinks)
❑❑Poor sleeping
❑❑Chills
❑❑Tremors
❑❑Poor balance
❑❑Weight loss
❑❑Weight gain
❑❑Muscle weakness/fatigue
❑❑Fatigue
❑❑Night sweats
❑❑Cravings
❑❑Peculiar tastes/smells
❑❑Sudden energy drop

Skin and Hair

❑❑Rashes
❑❑Itching
❑❑Loss of hair
❑❑Acne
❑❑Weak or ridged nails
❑❑Dermatitis
❑❑Ulcerations
❑❑Eczema/Psoriasis
❑❑Recent moles
❑❑Warts
❑❑Change in skin/hair texture
❑❑Hives/allergic dermatitis
❑❑Dandruff
❑❑Skin discoloration
❑❑Face flushing
❑❑Fungal infection

Head, Eyes, Ears, Nose and Throat

❑❑Dizziness
❑❑Glasses
❑❑Poor vision
❑❑Cataracts
❑❑Ringing in ears
❑❑Sinus problems
❑❑Grinding teeth
❑❑Dental problems
❑❑Difficulty swallowing
❑❑Eye strain
❑❑Night blindness
❑❑Blurred vision
❑❑Poor hearing
❑❑Nose bleeds
❑❑Facial pain
❑❑Jaw clicks/locks
❑❑Headaches
❑❑Migraines
❑❑Eye pain
❑❑Color blindness
❑❑Earaches
❑❑Spots in front of eyes
❑❑Recurrent sore throat/colds
❑❑Sores on lips/tongue

Cardiovascular

❑❑Chest pain
❑❑Fainting
❑❑ Spontaneous sweating
❑❑Varicose/spider veins
❑❑Low blood pressure
❑❑Irregular heart beat
❑❑Cold hands/feet
❑❑Phlebitis
❑❑Pressure in chest
❑❑Blood clots
❑❑Palpitations at rest
❑❑Swelling of hands/feet
❑❑Shortness of breath
❑❑High blood pressure
❑❑Dizziness

Respiratory

❑❑Cough/Wheezing
❑❑Bronchitis
❑❑Asthma
❑❑Coughing blood
❑❑Pneumonia
❑❑Difficult inhale/exhale
❑❑Tight sensation in chest
❑❑Pain with deep inhalation
❑❑Difficulty breathing when lying down
❑❑Production of phlegm: What color? ____________________

Gastrointestinal

❑❑Nausea
❑❑Gas
❑❑Indigestion
❑❑Bloating
❑❑Bad breath
❑❑Acid reflux/GERD
❑❑Belching
❑❑Hernia

❑❑Abdominal pain/cramps
❑❑Constipation
❑❑Black stools
❑❑Blood in stools
❑❑Excessive appetite
❑❑Poor appetite
❑❑Changes in appetite
❑❑IBS/Crohn's disease

❑❑Vomiting
❑❑Diarrhea
❑❑Loose stools (>2 per day)
❑❑Rectal pain
❑❑Hemorrhoids
❑❑Chronic laxative use
❑❑Significant thirst

Genito-Urinary

❑❑Frequent urination
❑❑Painful urination
❑❑Urgent urination
❑❑Unable to hold urine
❑❑Copious flow
❑❑Scanty flow
❑❑Dribbling after urination

❑❑Urinary tract infection
❑❑Blood in urine
❑❑Sores on genitals
❑❑Herpes
❑❑STD's
❑❑Decreased libido
❑❑Excessive libido

❑❑Kidney stones
❑❑Premature ejaculation
❑❑Nocturnal emission
❑❑Impotence
❑❑Pain in testicles
❑❑Prostatitis

❑❑Night urination: What time?_______________ How often?________________

Gynecological/Reproductive - Females

❑❑Difficult/painful intercourse
❑❑Vaginal dryness
❑❑Vaginal sores
❑❑Vaginal discharge
❑❑Irregular menstruation
❑❑Painful menstruation
❑❑PMS

❑❑Ovarian cysts
❑❑Endometriosis
❑❑Uterine fibroids
❑❑Fibrocystic breast tissue
❑❑Polycystic ovarian disease
❑❑Infertility

- Age of first menses______
- Date of last menses______
- Date of last PAP/Pelvic______
- # of pregnancies______
- # of ectopic pregnancies______
- # of live births ______
- # of miscarriages______
- # of abortions ______

Do you practice birth control? _________
What type? ____________________ How long? ____________________

Musculoskeletal

❑❑Neck pain
❑❑Knee pain
❑❑Hip pain
❑❑Foot/ankle pain
❑❑Rotator cuff pain
❑❑Back pain: Low___ Middle___ Upper___

❑❑Shoulder pain
❑❑Hand/wrist pain
❑❑Carpal Tunnel
❑❑Tendonitis
❑❑Sprains/strains

❑❑Muscle pain
❑❑Muscle weakness
❑❑Sciatica
❑❑Bursitis
❑❑Soreness/weakness in lower body (back, knee, hip, ankle, foot)

Neuropsychological

❑❑Seizures
❑❑Areas of numbness
❑❑Loss of balance
❑❑Vertigo/Dizziness
❑❑Lack of coordination

❑❑Concussion
❑❑ADD/ADHD
❑❑Bad temper/irritable
❑❑Poor memory
❑❑Easily susceptible to stress

❑❑Nervousness
❑❑Anxiety/Panic attacks
❑❑Depression
❑❑Manic depression
❑❑Seasonal Affective Disorder

Acupuncture Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below name licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, and nutritional counseling.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately.*

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above- named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.
_________ initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _________ initials

Patient's Name:

Patient's Signature:

Date Signed:

Practitioner: Helen Spieth L.Ac