Jen Conjerti, L.Ac.
Acupuncturist & Herbalist
p: (503) 984 4748 e: jen@jenconjerti.com w: jenconjerti.com

PATIENT INTAKE FORM

Name _____ Date _____

Address _____ City/State _____ Zip _____

Contact phone _____ ☐ Home ☐ Work ☐ Mobile

Date of Birth _____ Gender: ☐ Male ☐ Female Marital Status _____

Emergency contact _____ Relationship _____

Emergency contact phone _____ ☐ Home ☐ Work ☐ Mobile

Successful health care and preventative medicine are only possible when the physician has a complete undertanding of the patient - physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Are you receiving health care? ☐ Yes ☐ No

If yes, then where and from whom? _____

If no, then when and where did you last receive health care? _____

Has your case been referred to an attorney? ☐ Yes ☐ No

Whom may I thank for referring you? _____

What health concerns have brought you here. Please indicate condition, past treatment, and how condition affects you.

_____

_____

_____

_____

What are your most important health problems? Please list in order of importance.

_____

_____

_____

Do you have any reason to believe that you are pregnant? ☐ Yes ☐ No

Do you have any chronic infectious diseases? ☐ Yes ☐ No

Do you currently suffer from any chronic illnesses? ☐ Yes ☐ No

Please list any food, drugs or medications to which you are allergic and your reaction to them:

_____

_____

Please circle any of the following medications that you are currently taking:

Laxatives Pain relievers Antacids Thyroid medication Appetite suppressants

Antibiotics Tranquilizers Cortisone Sleeping pills Blood pressure medicaiton

Please list any prescription medications, over-the-counter medications, vitamins, and supplements you take:

_____

_____

Height _____ Weight (current) _____ Weight (past maxiumum) _____ When? _____

BLOOD PRESSURE: What is your most recent blood pressure reading? _____ / _____ When was it taken? _____

CHILDHOOD ILLNESSES: (Please circle any you may have had):

Scarlet fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

IMMUNIZATIONS: (Please circle any you may have had):

Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Others: _____

HOSPITALIZATIONS & SURGERIES:

Reason _____ Date _____

Reason _____ Date _____

Reason _____ Date _____

X-RAYS / CAT SCANS / MRIs / NMRs / SPECIAL STUDIES:

Reason _____ Date _____

Reason _____ Date _____

Reason _____ Date _____

FAMILY HISTORY:

	Mother	Father	Brothers	Sisters	Spouse	Children
Age (if living)						
Health (G = good, P = poor)						
Age at death (if deceased)						
Cause of death						
Check any conditions that members of your family have had, below:						
Cancer						
Diabetes						
Heart disease						
High blood pressure						
Stroke						
Mental illness						

EMOTIONAL (Please circle those you experience now and then and underline those you've experienced in the past:)

Mood swings Nervousness Mental tension

ENERGY & IMMUNITY (Please circle those you experience now and then and underline those you've experienced in the past:)

Fatigue Slow wound healing Chronic infections Chronic Fatigue Syndrome

HEAD, EYE, EAR, NOSE & THROAT (Please circle those you experience now and then and underline those you've experienced in the past:)

Impaired vision Eye pain/strain Glaucoma Glasses/Contacts Tearing/Dryness Impaired hearing

Ear ringing Earaches Headaches Sinus problems Nosebleeds Frequent sore throat

Teeth grinding TMJ/Jaw problems Hay Fever

RESPIRATORY (Please circle those you experience now and then and underline those you've experienced in the past:)

Pneumonia Asthma Tuberculosis Frequent common colds Persistent cough

Pleurisy Emphysema Difficulty breathing Shortness of breath Other _____

CARDIOVASCULAR (Please circle those you experience now and then and underline those you've experienced in the past:)

Heart disease Heart murmurs Chest pain Rheumatic Fever Stroke

Swelling of ankles Palpitations/Fluttering High blood pressure Varicose veins

GASTROINTESTINAL (Please circle those you experience now and then and underline those you've experienced in the past:)

Ulcers	Changes in appetite	Nausea/Vomiting	Epigastric pain	Passing gas
Heartburn	Belching	Gall bladder diseaase	Liver disease	Hepatitis B or C
Abdominal pain	Hemorrhoids	Blood in stool	Undigested food in stool	
Diarrhea	Constipation	Mucous in stool		

GENITO-URINARY TRACT (Please circle those you experience now and then and underline those you've experienced in the past:)

Kidney disease	Painful urination	Impaired urination	Frequent urination	Venereal disease
Kidney stones	Blood in urine	Frequent urination at night	Frequent urinary tract infections	

FEMALE REPRODUCTIVE/BREASTS (Please circle those you experience now and then and underline those you've experienced in the past:)

Irregular cycles	Breat lumps/Tenderness	Nipple discharge	Heavy flow
Bleeding between cycles	Vaginal discharge	Clotting	Premenstrual problems
Menopausal symptoms	Difficulty conceiving		

MENSTRUAL/BIRTHING HISTORY

Age of first menses _____ Birth control _____ No. of abortions _____

No. days of menses _____ No. of pregnancies _____ No. of live births _____

MALE REPRODUCTIVE (Please circle those you experience now and then and underline those you've experienced in the past:)

Sexual difficulties	Prostate problems	Testicular pain/Swelling	Penile discharge	

MUSCULOSKELETAL (Please circle those you experience now and then and underline those you've experienced in the past:)

Neck/Shoulder pain	Muscle spasms/Cramps	Arm pain	Upper back pain	Mid-back pain
Lower back pain	Leg pain	Joint pain (where?) _____		

NEUROLOGICAL (Please circle those you experience now and then and underline those you've experienced in the past:)

Vertigo/Dizziness	Paralysis	Numbness/Tingling	Loss of balance	Seizures/Epilepsy

ENDOCRINE (Please circle those you experience now and then and underline those you've experienced in the past:)

Hypothyroid	Hypoglycemia	Hyperthyroid	Diabetes Mellitus	Night sweats	Feelings of hot or cold

OTHER (Please circle those you experience now and then and underline those you've experienced in the past:)

Anemia	Cancer	Rashes	Cold hands/feet	Eczema/Hives

LIFESTYLE:

Please indicate your typical food intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Consumption of liquids: _____

Caffeine use: _____

Nicotine use: _____

Alcohol use: _____

Daily exercise: _____

Sleep habits: _____

Television habits: _____

Reading habits: _____

Interests and hobbies: _____

_____

Education: _____

Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy your work? ☐ Yes ☐ No Why?/Why not? _____

_____

Have you experienced any major traumas? ☐ Yes ☐ No Please elaborate: _____

_____

_____

_____

_____