Whitney Green Acupuncture
7405 SW Beveland Rd| Tigard, OR 97223
(503) 746-6095 | fax: (503) 746-6405
info@whitneygreenacupuncture.com

ACUPUNCTURE INTAKE

General Information **Date:**

NAME			GOES BY:	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE	WORK PHONE	CELL PHONE		GENDER
DATE OF BIRTH	AGE	EMAIL ADDRESS		

IF WE ARE UNABLE TO REACH YOU, DO WE HAVE PERMISSION TO LEAVE A MESSAGE WITH THE PERSON WHO WILL ANSWER THE PHONE?			☐ YES ☐ NO
EMERGENCY CONTACT	NAME	RELATIONSHIP	PHONE
HOW DID YOU HEAR ABOUT OUR CLINIC? ☐ INSURANCE ☐ ONLINE ☐ COMMUNITY EVENT ☐ REFERRAL FROM: ________________ ☐ OTHER: ______________			
OCCUPATION	HOW MANY HOURS/WEEK DO YOU WORK?		

MARITAL STATUS:	☐ NEVER MARRIED ☐ MARRIED ☐ DIVORCED ☐ PARTNERED/SIGNIFICANT OTHER
LIVING SITUATION:	☐ ALONE ☐ W/ PARTNER/SPOUSE ☐ W/ROOMMATES ☐ W/ CHILDREN ☐ W/PETS

HAVE YOU HAD ACUPUNCTURE TREATMENT BEFORE? ☐ YES ☐ NO	DO YOU BRUISE EASILY? ☐ YES ☐ NO
DO YOU HAVE ANY OF THE FOLLOWING? ☐ PACEMAKER ☐ INSULIN PUMP ☐ SEIZURE DISORDERS ☐ BLEEDING DISORDER ☐ ELECTRONIC DEVICES IMPLANTED IN BODY ☐ N/A	
ARE YOU PREGNANT?	☐ YES ☐ NO ☐ N/A

WHAT ARE YOUR CURRENT EXPECTATIONS IN SEEKING TREATMENT?
WHAT ARE YOUR MOST IMPORTANT HEALTH CONCERNS?

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HEALTHCARE PROVIDERS

PLEASE LIST ANY MEDICAL CARE PROVIDERS CURRENTLY TREATING YOU (Specialist, Naturopath, Chiropractor)

PRIMARY CARE PROVIDER		PHONE
DATE LAST SEEN	REASON	
PROVIDER	PHONE	DATE LAST SEEN
PROVIDER	PHONE	DATE LAST SEEN
MAY I CONTACT YOUR PROVIDERS REGARDING YOUR TREATMENT FOR YOU?	☐ YES ☐ NO	

ADDITIONAL INFORMATION

HEIGHT	WEIGHT	MAX WEIGHT/MINIMUM AND WHEN	WEIGHT CHANGE IN PAST YEAR GAIN/(LOSS) AMOUNT

MEDICATIONS

PLEASE LIST ALL MEDICATION, OVER-THE-COUNTER MEDICATION, VITAMINS, SUPPLEMENTS AND HERBS:

NAME	DOSE (STRENGTH/QUANTITY/DAY)	SINCE WHEN?	REASON
1.			
2.			
3.			

ALLERGIES

PLEASE LIST ANY ALLERGIES OR SENSITIVITIES:

MEDICATIONS:
FOODS:
ENVIRONMENTAL (PLANTS, PETS, CHEMICALS):
LATEX:

SURGERIES

PLEASE LIST ALL SURGERIES:

YEAR	SURGERY	REASON
1.		
2.		
3.		

REV 11/16

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Name/Initials ________________ **HEALTH CONCERNS/CONDITIONS (Reason for coming in)**

Condition (complete this page for each area of concern) **Date Condition Started:**___________

AREA

DESCRIBE THE PAIN (select all the apply)
☐ TIGHT ☐ SORE ☐ DULL ☐ ACHY ☐ THROBBING ☐ PINCHING ☐ PRESSURE ☐ STABBING
☐ SHARP ☐ TINGLING ☐ NUMB ☐ ELECTRICAL ☐ RADIATING ☐ OTHER: ________________

INTENSITY (1-10 SCALE)	**AT WORST** YOUR SYMPTOM/PAIN IS: 1=LOW 10=WORST	**ON AVERAGE** YOUR SYMPTOM/PAIN IS: 1=LOW 10=WORST

FREQUENCY	☐ DAILY ☐ __ DAY(S) PER WEEK ☐ __ DAY(S) PER MONTH ☐ OTHER:________________________ ☐ 0-25% of the time ☐ 26-50% of the time ☐ 51-75% of the time ☐ 76-100% of the time
TIMING	☐ MORNING ☐ MID-DAY ☐ AFTERNOON ☐ EVENING ☐ NIGHTTIME ☐ CONSTANT

CONDITIONS	HEAT	COLD	REST	ACTIVITY	MASSAGE	OTHER: (DESCRIBE)
	☐BETTER ☐ WORSE	☐BETTER ☐ WORSE	☐BETTER ☐ WORSE	☐ BETTER ☐ WORSE	☐ BETTER ☐ WORSE	☐BETTER ☐ WORSE

IS IT AGGRAVATED BY:	☐ STANDING ☐ SITTING ☐ DRIVING ☐ STRESS ☐ WORK ☐ LAYING DOWN
DOES IT BOTHER YOUR:	☐ SLEEP ☐ WORK ☐ EXERCISE ☐ OTHER:
HAS THE CONCERN BEEN:	☐ IMPROVING ☐ WORSENING ☐ STAYING THE SAME

HOW DO THE ABOVE HEALTH CONCERNS/CONDITIONS IMPAIR OR LIMIT YOUR DAILY ACTIVITIES?

ADDITIONAL NOTES:

INDICATE SYMPTOM AREA IN THE BODY CHART

Past Treatment for This Concern:

TYPE OF TREATMENT	DATE BEGAN	HAVE PAST TREATMENTS BEEN EFFECTIVE? ☐ YES ☐ NO
TYPE OF TREATMENT	DATE BEGAN	HAVE PAST TREATMENTS BEEN EFFECTIVE? ☐ YES ☐ NO

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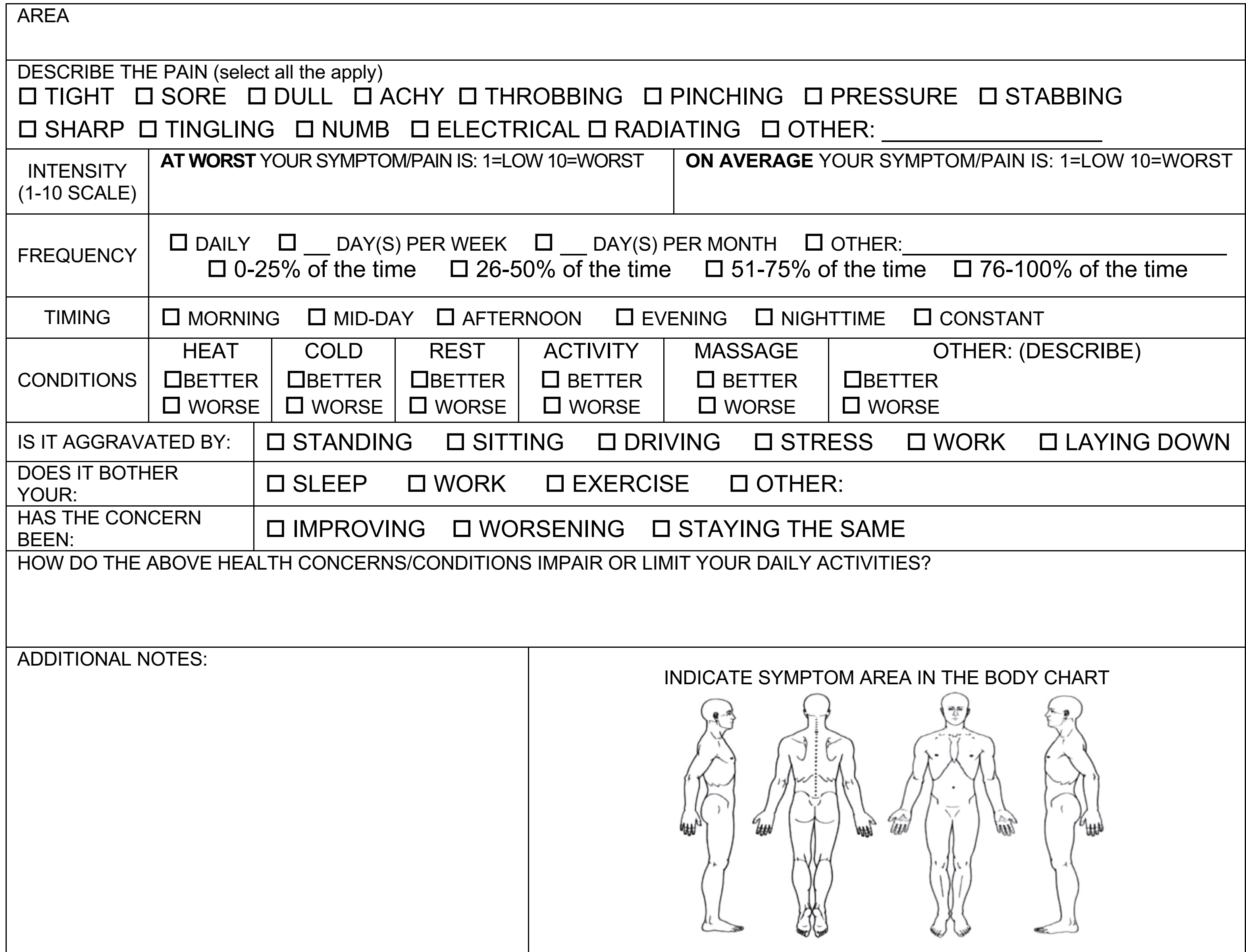
Condition (complete this page for each area of concern) **Date Condition Started:** ___________



AREA		
DESCRIBE THE PAIN (select all the apply) ☐ TIGHT ☐ SORE ☐ DULL ☐ ACHY ☐ THROBBING ☐ PINCHING ☐ PRESSURE ☐ STABBING ☐ SHARP ☐ TINGLING ☐ NUMB ☐ ELECTRICAL ☐ RADIATING ☐ OTHER: ________________		
INTENSITY (1-10 SCALE)	**AT WORST** YOUR SYMPTOM/PAIN IS: 1=LOW 10=WORST	**ON AVERAGE** YOUR SYMPTOM/PAIN IS: 1=LOW 10=WORST
FREQUENCY	☐ DAILY ☐ __ DAY(S) PER WEEK ☐ __ DAY(S) PER MONTH ☐ OTHER:________________________ ☐ 0-25% of the time ☐ 26-50% of the time ☐ 51-75% of the time ☐ 76-100% of the time	
TIMING	☐ MORNING ☐ MID-DAY ☐ AFTERNOON ☐ EVENING ☐ NIGHTTIME ☐ CONSTANT	

CONDITIONS	HEAT	COLD	REST	ACTIVITY	MASSAGE	OTHER: (DESCRIBE)
	☐BETTER ☐ WORSE	☐BETTER ☐ WORSE	☐BETTER ☐ WORSE	☐ BETTER ☐ WORSE	☐ BETTER ☐ WORSE	☐BETTER ☐ WORSE

IS IT AGGRAVATED BY:	☐ STANDING ☐ SITTING ☐ DRIVING ☐ STRESS ☐ WORK ☐ LAYING DOWN
DOES IT BOTHER YOUR:	☐ SLEEP ☐ WORK ☐ EXERCISE ☐ OTHER:
HAS THE CONCERN BEEN:	☐ IMPROVING ☐ WORSENING ☐ STAYING THE SAME

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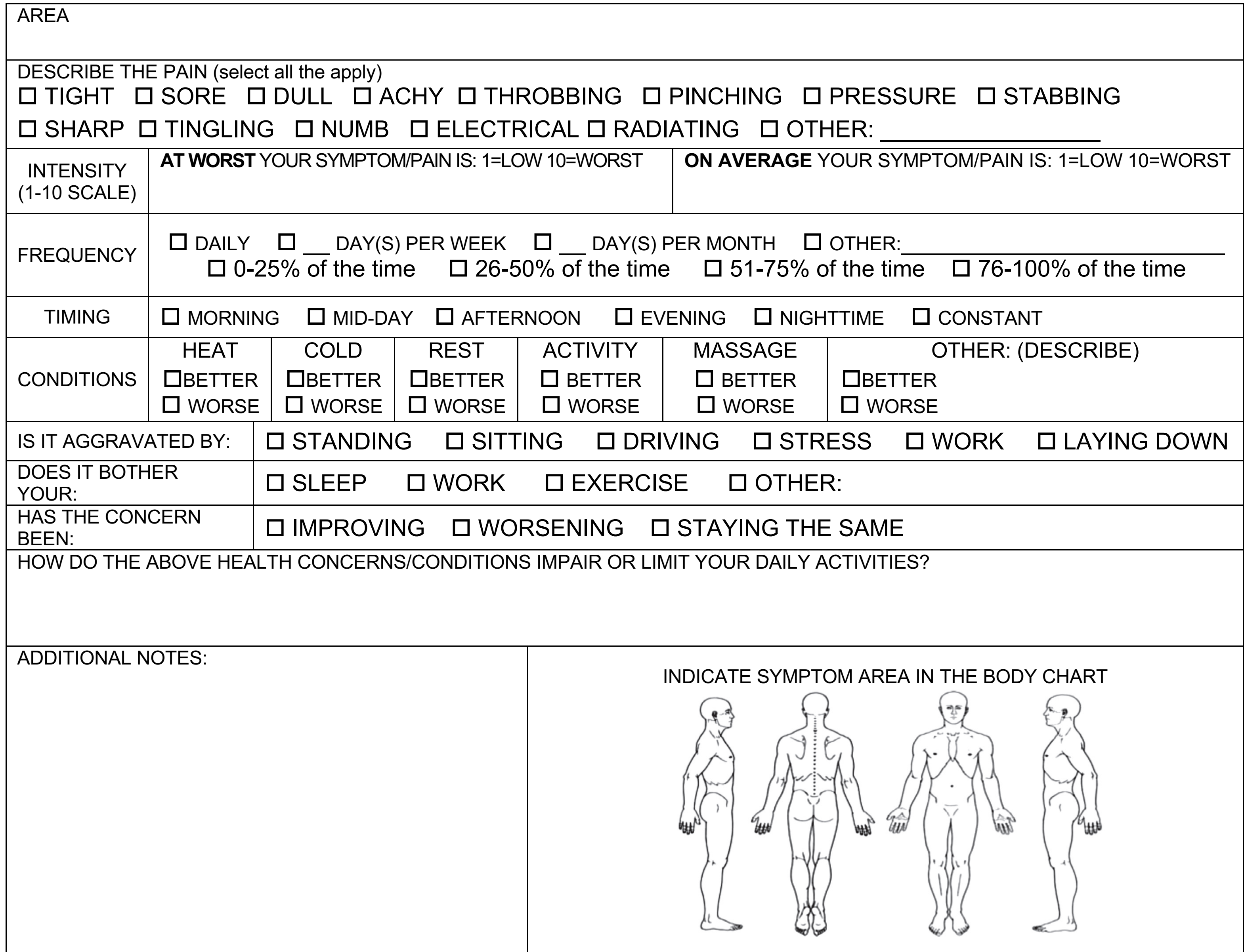
Name/Initials __________________ HEALTH CONCERNS/CONDITIONS (Reason for coming in)

Condition (complete this page for each area of concern) **Date Condition Started: ____________**



AREA

DESCRIBE THE PAIN (select all the apply)
☐ TIGHT ☐ SORE ☐ DULL ☐ ACHY ☐ THROBBING ☐ PINCHING ☐ PRESSURE ☐ STABBING
☐ SHARP ☐ TINGLING ☐ NUMB ☐ ELECTRICAL ☐ RADIATING ☐ OTHER: __________________

INTENSITY (1-10 SCALE)	**AT WORST** YOUR SYMPTOM/PAIN IS: 1=LOW 10=WORST	**ON AVERAGE** YOUR SYMPTOM/PAIN IS: 1=LOW 10=WORST
FREQUENCY	☐ DAILY ☐ __ DAY(S) PER WEEK ☐ __ DAY(S) PER MONTH ☐ OTHER:__________________ ☐ 0-25% of the time ☐ 26-50% of the time ☐ 51-75% of the time ☐ 76-100% of the time	
TIMING	☐ MORNING ☐ MID-DAY ☐ AFTERNOON ☐ EVENING ☐ NIGHTTIME ☐ CONSTANT	

CONDITIONS	HEAT	COLD	REST	ACTIVITY	MASSAGE	OTHER: (DESCRIBE)
	☐BETTER ☐ WORSE	☐BETTER ☐ WORSE	☐BETTER ☐ WORSE	☐ BETTER ☐ WORSE	☐ BETTER ☐ WORSE	☐BETTER ☐ WORSE

IS IT AGGRAVATED BY:	☐ STANDING ☐ SITTING ☐ DRIVING ☐ STRESS ☐ WORK ☐ LAYING DOWN
DOES IT BOTHER YOUR:	☐ SLEEP ☐ WORK ☐ EXERCISE ☐ OTHER:
HAS THE CONCERN BEEN:	☐ IMPROVING ☐ WORSENING ☐ STAYING THE SAME

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ADDITIONAL NOTES:	INDICATE SYMPTOM AREA IN THE BODY CHART

Past Treatment for This Concern:

TYPE OF TREATMENT	DATE BEGAN	HAVE PAST TREATMENTS BEEN EFFECTIVE? ☐ YES ☐ NO
TYPE OF TREATMENT	DATE BEGAN	HAVE PAST TREATMENTS BEEN EFFECTIVE? ☐ YES ☐ NO

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HEALTH HISTORY

CARDIOVASCULAR

Please indicate whether condition is ***current*** *(C) or* ***past*** *(P)* ☐NONE

C P	C P	C P	C P
☐☐ HIGH BLOOD PRESSURE	☐☐ DIZZINESS	☐☐ CHEST PAIN	☐☐ SWELLING IN HANDS/FEET
☐☐ LOW BLOOD PRESSURE	☐☐ FAINTING	☐☐ IRREGULAR HEART	☐☐ COLD HANDS/FEET
☐☐ BLOOD CLOTS	☐☐ PHLEBITIS	☐☐ PALPITATIONS	☐☐ OTHER:_____________

RESPIRATORY

Please indicate whether condition is ***current*** *(C) or* ***past*** *(P)* ☐NONE

C P	C P	C P	C P
☐☐ SHORTNESS OF BREATH	☐☐ ASTHMA	☐☐ TIGHT CHEST	☐☐ PRODUCTION OF PHLEGM
☐☐ DIFFICULTY BREATHING	☐☐ WHEEZING	☐☐ PRESSURE IN CHEST	☐☐ COUGHING BLOOD
☐☐ DIFFICULTY BREATHING/LYING DOWN		☐☐ FREQUENT COUGH	

EYES/EARS/NOSE/THROAT

Please indicate whether condition is current (C) or past (P) ☐NONE

C P	C P	C P	C P
☐☐ POOR VISION	☐☐ DRY/ITCHY EYES	☐☐ FREQUENT COLDS	☐☐ SORE THROAT
☐☐ BLURRY VISION	☐☐ EAR PAIN	☐☐ SINUSITIS	☐☐ DRY THROAT
☐☐ DECREASED NIGHT VISION	☐☐ EAR INFECTIONS	☐☐ LOSS OF SMELL	☐☐ DIFFICULTY SWALLOWING
☐☐ VISUAL DISTURBANCES	☐☐ HEARING LOSS	☐☐ RUNNY NOSE	☐☐ SEASONAL ALLERGIES
☐☐ EYE FLOATERS	☐☐ RINGING IN EARS	☐☐ POST NASAL DRIP	☐☐ FACIAL PAIN
☐☐ DRY EYES	☐☐ WATERY EYES	☐☐ JAW PAIN	☐☐ GRINDING TEETH
☐☐ JAW CLENCHING			

GASTROINTESTINAL

Please indicate whether condition is ***current*** *(C) or* ***past*** *(P)* ☐NONE

C P	C P	C P	C P
☐☐ DENTAL PROBLEMS	☐☐ POOR APPETITE	☐☐ ACID REFLUX	☐☐ LOOSE STOOLS
☐☐ GRINDING TEETH	☐☐ EXCESSIVE APPETITE	☐☐ BLOATING	☐☐ UNDIGESTED FOOD IN STOOL
☐☐ JAW PROBLEMS	☐☐ GAS	☐☐ INCOMPLETE BOWELS	☐☐ EXCESS THIRST
☐☐ NAUSEA	☐☐ CONSTIPATION	☐☐ TARRY OR BLACK STOOLS	☐☐ BAD BREATH
☐☐ VOMITING	☐☐ DIARRHEA	☐☐ BLOOD IN STOOLS	☐☐ BELCHING

URINARY

How many times per day do you urinate? ______
Do you wake at night to urinate? ☐ YES ____ # of times/night ☐ NO
Color of Urine: ☐ Dark Yellow ☐ Pale Yellow ☐ Clear ☐ Cloudy ☐ Blood in Urine
Urination: ☐ Difficult ☐ Urgency ☐ Profuse/Excessive ☐ Incontinence ☐ Painful ☐ Strong Odor

REPRODUCTIVE

SEXUALLY ACTIVE ☐ YES ☐ NO	LIBIDO ☐ LOW ☐ NORMAL ☐ EXCESSIVE

SKIN AND HAIR

Please indicate whether condition is current (C) or past (P) ☐NONE

C P		C P		C P	
☐☐	ACNE, PIMPLES	☐ ☐	BROWN SPOTS, BROWNING OF SKIN	☐ ☐	SKIN RASHES, HIVES
☐☐	MOLES, WARTS, SKIN TAGS	☐ ☐	SKIN ULCERS OR SORES	☐ ☐	SUNBURN EASILY
☐☐	EASILY FLUSHED	☐ ☐	CUTS HEAL SLOWLY, SCAR BADLY	☐ ☐	HAIR LOSS, THINNING
☐☐	DRYNESS,ROUGHNESS,SCALING	☐ ☐	DRY, COURSE HAIR, SPLIT ENDS	☐ ☐	ATHLETE'S FOOT/TOE FUNGUS
☐☐	BRUISE EASILY				

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HEALTH HISTORY (CONT.)

MEN

☐ N/A

☐ SWOLLEN TESTES ☐ GENITAL PAIN ☐ IMPOTENCE ☐ LOW SPERM COUNT/MOTILITY
☐ PROSTATE ISSUES ☐ TESTICULAR PAIN ☐ PREMATURE EJACULATION ☐ OTHER:_________________________

DATE OF LAST PROSTATE EXAM:

WOMEN

☐ N/A

DO YOU CURRENTLY OR HAVE YOU EVER USED BIRTH CONTROL/IUD? ☐ YES ☐ NO
PLEASE LIST TYPE AND DURATION:

AGE OF 1ST MENSTRUATION:	FIRST DAY OF LAST PERIOD:
NUMBER OF DAYS BETWEEN PERIODS:	NUMBER OF DAYS OF FLOW:

MENSTRUAL FLOW: ☐ DARK RED ☐ BRIGHT RED ☐ RED ☐ PURPLE ☐ CLOTS ☐ HEAVY FLOW ☐ LIGHT FLOW

☐ MENSTRUAL CRAMPS ☐ BLOATING ☐ BREAST SWELLING ☐ BREAST TENDERNESS ☐ ACNE ☐ PMS
☐ VAGINAL DRYNESS ☐ SPOTTING ☐ VAGINAL PAIN ☐ VAGINAL INFECTIONS ☐ HOT FLASHES

DATE OF LAST PAP SMEAR:	DATE OF LAST MAMMOGRAM:

ANY OTHER ISSUES OR DIAGNOSES:

ANY TROUBLE CONCEIVING? ☐ YES ☐ NO	NUMBER OF PREGNANCIES	NUMBER OF MISCARRIAGES	NUMBER OF ABORTIONS/D&C

HABITS AND LIFESTYLE

☐ BREAKFAST- WHAT:

☐ LUNCH- WHAT:

☐ DINNER- WHAT:

FOODS YOU STRONGLY LIKE:

FOODS YOU STRONGLY DISLIKE:

RATE YOUR STRESS LEVEL ON A SCALE OF 1-10 (0 LOWEST, 10 HIGHEST)

DO YOU CONSUME:

☐ CIGARETTES OR TOBACCO	PACKS/DAY:	☐ ALCOHOL	DRINKS/DAY:
☐ COFFEE/TEA/SODA	CUPS/DAY:	☐ CANNABIS	TIMES/DAY:
☐ SUGAR	TIMES/DAY:	☐ OTHER DRUGS___________________	TIMES/DAY:
☐ PROCESSED / FAST FOOD	TIMES/DAY:	☐ WATER	GLASSES/DAY:
☐ EXERCISE	WHAT KIND AND HOW OFTEN:		

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FAMILY HISTORY

SYMPTOM	SELF	MOTHER	FATHER	GRANDPARENTS	SIBLINGS	CHILDREN	OTHER
ADDICTION	☐	☐	☐	☐	☐	☐	☐
ALCOHOLISM	☐	☐	☐	☐	☐	☐	☐
ALLERGIES	☐	☐	☐	☐	☐	☐	☐
ANXIETY	☐	☐	☐	☐	☐	☐	☐
ARTHRITIS	☐	☐	☐	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐	☐	☐	☐
AUTO-IMMUNE DISEASE	☐	☐	☐	☐	☐	☐	☐
BLEEDING DISORDER	☐	☐	☐	☐	☐	☐	☐
CANCER (TYPE)							
______________________	☐	☐	☐	☐	☐	☐	☐
______________________	☐	☐	☐	☐	☐	☐	☐
DEPRESSION	☐	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐	☐
DIGESTIVE PROBLEMS	☐	☐	☐	☐	☐	☐	☐
EATING DISORDERS	☐	☐	☐	☐	☐	☐	☐
FIBROMYALGIA	☐	☐	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐	☐
HIGH CHOLESTEROL	☐	☐	☐	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	☐	☐	☐
KIDNEY DISEASE	☐	☐	☐	☐	☐	☐	☐
MENTAL HEALTH	☐	☐	☐	☐	☐	☐	☐
SEIZURES	☐	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐	☐
SUICIDE	☐	☐	☐	☐	☐	☐	☐
OTHER:	☐	☐	☐	☐	☐	☐	☐
OTHER:	☐	☐	☐	☐	☐	☐	☐
OTHER:	☐	☐	☐	☐	☐	☐	☐

PAIN DISABILITY QUESTIONNAIRE

Patient Name ____ Date ___________________________

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely — Need help with all my personal care
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

4. Does your pain affect your ability to sit or stand?
No problems — Can not sit/stand at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

7. Does your pain affect your ability to walk or run?
No problems — Can not walk/run at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression/tension
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

____
Examiner

OTHER COMMENTS:

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.