Starside Healing Arts LLC

852 SW 21st Avenue Portland Oregon 97205 503 956 0912

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Personal Information

Name______________________________ Age________ Date ______________

Home Address______________________________City________________ State_____ Zip__________

Home Phone____________________ Work Phone____________________ Cell Phone__________________

E-mail______________________________ Status (Married/Single/Divorced/Other) ____________

Birth date______________ If under 18, person responsible for your account__________________________

Height ________ Weight ________ Gender _____ Occupation ______________________________

Emergency Contact: Name______________________________ Contact Phone________________

Whom should we thank for referring you to this office? ______________________________

Have you had acupuncture therapy before? ☐ Yes ☐ No With Whom? ______________________________

Insurance Provider ____________________ Plan Name ______________ Group Number ______________

Policy Number ______________ Employer ______________ Name of Insured ____________________

Please indicate if any of the following pertain to you. (This may affect the type of treatment you receive.)

☐ Hepatitis ☐ HIV ☐ High Blood Pressure ☐ Seizures ☐ Pacemaker ☐ Blood-Thinning Meds ☐ Pregnancy

Please indicate the use and frequency of the following:

Coffee __________________ Soda pop ______________________Water ________________________

Alcohol____________________ Recreational drugs ___________________ Tobacco__________________

Please list any prescription or over-the-counter medications you are presently taking (continue on back if necessary):

Medication	Reason
______________________________	______________________________
______________________________	______________________________

Health History

What are the health problems for which you are seeking treatment? ____

____

How long have you had this condition? ____

What other forms of treatment have you sought? ____

____

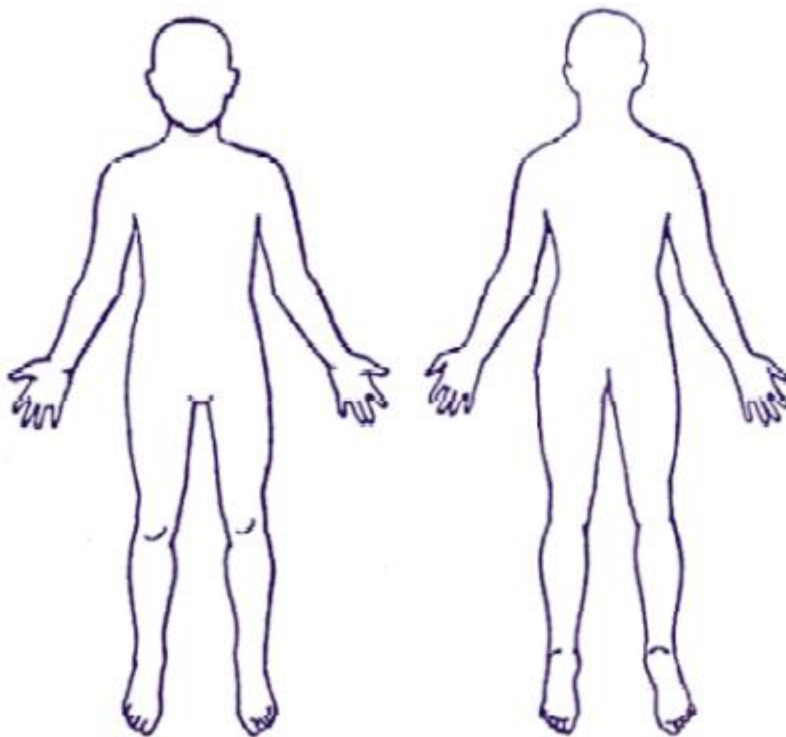
What helps your condition? ____

What aggravates your condition? ____

Please list any surgeries or major health incidents (accidents, etc.) in your life:_____________________________________

____

PAIN PATIENTS, please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain: ☐ dull/achy ☐ sharp/stabbing ☐ burning ☐ tingling ☐ numb ☐ electric

What would you like to achieve with acupuncture treatment? ____

____

Symptom Survey

Please “check” the symptoms or conditions you experience frequently (+) or occasionally (-):

Sp/St	Ht/P	Lu/LI	Ki/UB	Liv/GB
__ excessive appetite	__ insomnia	__ cough	__ low back pain	__ eye problems
__ loose stool/diarrhea	__ palpitations	__ shortness of breath	__ knee problems	__ jaundice
__ digestive problems, indigestion	__ cold hands and feet	__ decreased sense of smell	__ hearing impairment	__ difficulty digesting oily foods
__ vomiting	__ nightmares	__ nasal problems	__ ear ringing	__ gall stones
__ belching, burping	__ mentally restless	__ skin problems	__ kidney stones	__ light-colored stool
__ heartburn/reflux	__ laughing for no reason	__ claustrophobia	__ decreased sex drive	__soft/ brittle nails
__ stomach bloating	__ chest pains	__ colitis/diverticulitis	__ hair loss	__ easily angered
__ obsession in work, relationships, etc.	__ poor memory	__ constipation	__ urinary problems	__ difficulty in making decisions
__ lack of appetite	__ sadness	__ blood in stool	__easily bruised	
		__ hemorrhoids	__ dental problems	__high cholesterol
		__ recent use of antibiotics		__ bitter taste

__ fatigue __edema __asthma __allergies __dizziness __ get sick easily __headaches

__ I usually feel warm __ I usually feel chilled

Other chronic conditions:____

♀For Women

Age of first period ____________ Date of last period ____________ Number of children (live births) ____________

Number of days between periods (your cycle) ________________Number of days of flow__________________

Color of flow:	Amount of flow:	# of pads you use per day:	Pain and cramping:	
□ pale/light red	□ spotting	1st day ___	□ No	
□ red	□ light	2ND day ___	□ Yes	
□ bright red	□ even throughout	3RD day ___	□ before flow	□ mild
□ dark red	□ heavy	4th day ___	□ during flow	□ moderate
□ dark red/brown	□ clots	+days ___	□ after flow	□ severe

♀For Women (cont.)

Other symptoms related to menses: ☐ Discharge ☐ PMS ☐ Headache ☐ Nausea

☐ Constipation ☐ Diarrhea ☐ Swollen Breasts ☐ Mood Swings ☐ Increased Appetite

☐ Decreased Appetite ☐ Insomnia

Fertility Information

# of IVF procedures____________________________ # of IUI procedures__________________________________

Has a physician diagnosed a difficulty with fertility due to: ☐ Female Factor ☐ Male Factor ☐ Unexplained

☐ Other ____

Conclusion

Please check any additional services you would be interested in: ☐ Chinese herbal medicine ☐ Massage

☐ Other ____

Would you like to receive occasional email updates from Starside Healing Arts? ☐ Yes ☐ No

Are there any other concerns that you think I should know about?

____

____

Please read and sign.

I understand that payment is due at the time of treatment unless other arrangements have been made. I agree to give at least 24 hours notice of cancellation of an appointment. Cases of emergency may be considered exceptions to this cancellation policy. I understand the treatment here is not a replacement for medical care. I understand that Charles Grey does not diagnose medical illness, disease or any other physical or mental conditions (unless specified under his professional scope of practice). Mr. Grey does not prescribe pharmaceuticals, nor does he perform spinal manipulations. I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have. I have stated all my known conditions and take it upon myself to keep Mr. Grey updated on my health.

Client signature____Date______________________________

Practitioner signature____Date______________________________