CARSON ACUPUNCTURE & HERBAL CLINIC, LLC

Acupuncture ~ Herbs ~ Massage

Debbie Carson, L.Ac., Dipl. O.M.
143 NW 4th Avenue
Canby, OR 97013
(503) 266-7999

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph #: _____ Work Ph #: _____ Cell Ph #: _____

At which number would you prefer that we contact you? _____

E-Mail Address: _____ Marital Status: M, S, D, W

Emergency Contact: _____ Relationship: _____ Ph #: _____

Occupation: _____ Employer: _____

How did you hear about our office? _____

Carson Acupuncture is contracted with ODS, Pacific Source and Regence BlueCross BlueShield. For all other insurance carriers, we would be considered an out of network provider. Please check to verify or confirm your insurance benefits for acupuncture.

Primary Health Insurance: _____

Subscribers Name: _____ Date of Birth: _____

Primary ID# _____ Primary Group # _____

Secondary Health Insurance _____

Subscribers Name: _____ Date of Birth: _____

Secondary Insurance ID# _____ Secondary Group # _____

Are you currently receiving health care? □ Yes □ No If yes, please list the following:

Physician Name: _____ Ph #: _____

If no, please indicate the last time that you received health care: _____

Please indicate your primary medical concerns and/or your reason for seeking treatment:

1. _____ 2. _____

3. _____ 4. _____

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

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

If yes, please explain: _____

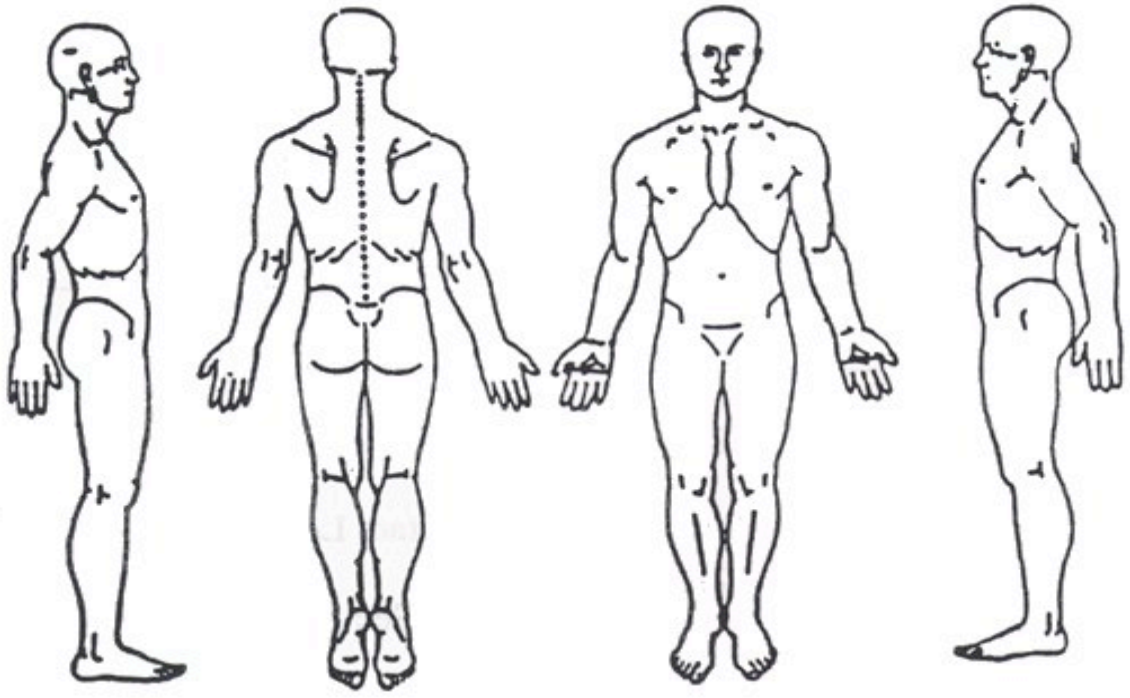
Do you currently suffer from any chronic illnesses? ☐ Yes ☐ No

If yes, please explain: _____

Height: _____ Weight (current): _____ Weight (past maximum): _____

Blood Pressure: What is your most recent blood pressure reading? _____/_____ When: _____

On the diagram below, draw out your primary complaints. Feel free to be creative and complete.



_____

How are you affected by this?

_____

_____

_____

Please indicate current treatment for these concerns (This may include medical treatments as well as home treatment such as over the counter medications)_____

_____

_____

FAMILY HISTORY

Please list any medical concerns your parents, grandparents, and siblings may have or have had. Please list current age or age of death. Health concerns may include: diabetes, hypertension, high cholesterol, cancer. Please indicate the age at time of condition

	Mother	Father	Grandmother/ Maternal	Grandfather/ Maternal	Grandmother/ Paternal	Grandfather/ Paternal	Sibling	Child
Diabetes/ Type								
High Blood Pressure								
High Cholesterol								
Heart Disease								
Stroke								
Cancer/ Type								
Addiction								
Digestive Issues								

ENERGY LEVEL

Please rate your energy level throughout the day, using the graph below.

High	•	•	•	•
Medium	•	•	•	•
Low	•	•	•	•
	Morning	Noon	Afternoon	Night

EXERCISE

Please check the appropriate level

_____Sedentary

_____Mild Exercise

_____Occasional Vigorous Exercise (1 – 3X/Week)

_____Vigorous Exercise (4x/week)

Caffeine

_____Chocolate

_____Coffee

_____Tea

_____Other (please specify)

Alcohol

_____# Of Drinks per Week

Tobacco

Type and Quantity: _____

Typical Diet: (Please include some of the main foods that you eat)

_____

_____

_____

Current Medications: (Please list current medications that you are taking (including over-the-counter medications)

_____

_____

Do you have any infectious diseases? _____**Yes** _____**No** Please explain**:**

_____

_____

Do you currently suffer from any chronic diseases? _____**Yes** _____**No** Please explain:

_____

_____

SYMPTOM IDENTIFICATION

Please rate the following on a scale of 0 – 4

(0 = never, 1 = occasionally, 2 = sometimes, 3 = frequently, 4 = always)

Please rate any of the following if you are currently experiencing or have experienced them in the past:

Musculoskeletal:

_____Injuries	_____Back Pain	_____Muscle Pain
_____Post-Operative Pain	_____Tendonitis	_____Neck Pain
_____Knee Pain	_____Arthritis	_____Bursitis
_____Carpal Tunnel Syndrome	_____Tennis Elbow	_____TMD (TMJ)
_____Jaw Tension/Teeth Grinding	_____Plantar Fasciitis	

Neurological:

_____Headaches	_____ Migraines	_____Sciatica Pain
_____Dizziness	_____Numbness Seizures	

Gastrointestinal:

_____Loss of Appetite	_____Acid Reflux	_____Abdominal Pain
_____Diarrhea	_____Irritable Bowel Disease	_____Diverticulitis
_____Crohns' Disease	_____Ulcerative Colitis	_____Constipation
_____Ulcers	_____Hemorrhoids	_____Hepatitis
_____Gallstones	_____Gall Bladder Removal	

Dermatological:

_____Eczema	_____Acne	_____Skin Rashes
_____Rosacea	_____Scars	

Respiratory:

_____Asthma	_____Chronic Bronchitis	_____Pneumonia
_____Sinusitis	_____Frequent Colds	_____Nosebleeds
_____Seasonal Allergies	_____Shortness of Breath	

Circulatory:

_____Hypertension	_____Diagnosed Heart Disease	_____Heart Attack

_____Irregular Heart Beat _____Heart Murmur _____Chest Heaviness

_____Palpitations/Fluttering _____Stroke _____Pace Maker

_____Anemia _____Rheumatic Fever _____Cold Hands & Feet

_____ Varicose Veins _____Swelling of the Ankles

Urogenital:

_____Bladder Infections _____Frequent Urination _____Kidney Stones

_____Urinary &/or Bowel Incontinence _____Low Libido

_____Sexual Dysfunction

Endocrine:

_____Hypothyroidism _____Hyperthyroidism _____Diabetes

_____Hypoglycemia

Gynecological:

_____PMS _____Irregular Menses _____Painful Menses

_____Pregnancy Related Issues _____Infertility _____Endometriosis

_____Ovarian Cysts _____Chronic Pelvic Pain _____Hysterectomy

_____Menopause Related Issues

Eyes:

_____Pain _____Blurry Vision _____Tired Eyes

_____Redness and/or Itching _____Floaters

_____Diagnosed Eye Disease (such as Glaucoma or Macular Degeneration)

Ears:

_____Pain _____Deafness _____Tinnitus

_____Plugged Ears

Sleep:

_____Difficulty Falling Asleep _____Difficulty Staying Asleep

_____Disturbed Dreams _____Vivid Dreams

_____Nighttime Urination That Disturbs Sleep

Emotional:

_____Anxiety Disorder _____Non-Clinical Depression _____Clinical Depression

_____Mood Swings

If you have any other medical diagnoses that are not listed that may be important, please list:

Current Medications:

Please list current medications that you are taking (including over-the-counter meds)

Lifestyle:

Fluid Intake (please indicate what kinds of fluids – water, coffee, tea, soda – and how much per day):

Typical Diet

Please include some of the main foods that you eat: