Sherwood Acupuncture, LLC
20510 SW Roy Rogers Rd, Ste 100
Sherwood, OR 97140-0001

New Patient Intake Sherwood Acupuncture

Patient Information

Personal Details

First Name * _____

Last Name * _____

Date of Birth * / / (MM/DD/YYYY)

Gender *
- ☐ Male
- ☐ Female
- ☐ Unknown

Gender Identity
- ☐ Male
- ☐ Female
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Genderqueer
- ☐ Other

Blood Group _____

Language _____

Race
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Employment Status
- ☐ Employed
- ☐ Full-Time Student
- ☐ Part-Time Student
- ☐ Unemployed
- ☐ Retired

Marital Status
- ☐ Single
- ☐ Married
- ☐ Others

Smoking Status
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former Smoker
- ☐ Never Smoker
- ☐ Smoker, current status unknown
- ☐ Unknown if ever smoked

Primary Contact Details

Email * _____

Home Phone _____

Mobile Phone _____

Work Phone _____

Extn _____

Fax _____

Primary Phone ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 * _____

Address Line2 _____

City * _____

Country * _____

State * _____

Zip code * _____

Postbox No _____

Emergency Contact Name _____

Emergency Contact Number _____

Extn _____

Gender Preference: _____

Occupation: _____

Primary Insurance Details

Insurance Type * ☐ MEDICARE ☐ MEDICAID ☐ TRICARE CHAMPUS ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER _____

Insurance Plan Name or Program Name * _____

ID * _____

Insurance Company Name (Payer Name) * _____

Payer Id * _____

Payer Address _____

Payer City _____

Payer Country _____

Payer State _____

Payer ZipCode _____

Valid From / / (MM/DD/YYYY)

Valid Until / / (MM/DD/YYYY)

Payer ZipCode _____

Copay _____

Deductible _____

Employer/School Name _____

Comments _____

_____

_____

_____

Insured Person Details

Patient Relationship * ☐ Self ☐ Spouse ☐ Child ☐ Other

First Name * _____

Last Name * _____

Date of Birth * / / (MM/DD/YYYY)

Gender * ☐ Male ☐ Female

Address Line 1 _____

Address Line 2 _____

City _____

Country _____

State _____

Zip Code _____

Home Phone _____

Mobile Phone _____

How did you hear about us? * _____

PATIENT SIGNATURE : _____

First Main Complaint/Goal: * _____

How long have you had this complaint/goal? _____

Initial cause of complain/goal _____

Is this condition getting worse? ☐ Yes ☐ No

Please rate the severity of pain (10 being to worst) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please describe the type of pain:

- ☐ sharp
- ☐ tingling
- ☐ throbbing
- ☐ cramps
- ☐ numbness
- ☐ tension
- ☐ shooting
- ☐ Others _____
- ☐ dull
- ☐ burning
- ☐ aching
- ☐ spasms
- ☐ stiffness
- ☐ swelling

How often do you have this pain? _____

Does it interfere with your

- ☐ Work
- ☐ Daily Routine
- ☐ Does not interfere
- ☐ Others _____
- ☐ Sleep
- ☐ Recreation

Activities or movements that are painful to perform:

- ☐ Sitting
- ☐ Walking
- ☐ Lying Down
- ☐ Others _____
- ☐ Standing
- ☐ Bending

What treatment have you already received for your condition? *

- ☐ Medications
- ☐ Physical Therapy
- ☐ None
- ☐ Surgery
- ☐ Chiropractic Services

☐ Others _____

Please describe any injuries/surgeries you have had, including the date of occurrence. _____

_____

_____

_____

Are you under the care of a physician now? ☐ Yes ☐ No

Physician name: _____

Physician Phone Number: _____

Date of last...

Physical Exam: _____

Spinal Exam: _____

Dental X-Ray: _____

Spinal X-Ray: _____

Chest X-Ray: _____

MRI, CT-Scan, Bone Scan: _____

Blood Test: _____

Urine Test: _____

Personal Medical History

Please mark the box to indicate you have had any of the following. If you have not, leave box empty.

- ☐ AIDS/HIV
- ☐ Allergy Shots
- ☐ Anorexia
- ☐ Arthritis
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gonorrhea
- ☐ Heart Disease
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pinched Nerve
- ☐ Polio
- ☐ Prosthesis
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Asthma
- ☐ Breast Lump
- ☐ Bulimia
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Emphysema
- ☐ Fractures
- ☐ Goiter
- ☐ Gout
- ☐ Hepatitis
- ☐ Herniated Disk
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ STD

- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Whooping Cough
- ☐ Others _____
- ☐ Suicide Attempt
- ☐ Tonsillitis
- ☐ Tumors, Growths
- ☐ Vaginal Infections

Type of STD _____

Type of Hepititis _____

Skin and Hair

Check all that apply.

- ☐ Acne
- ☐ Rashes
- ☐ Itchy skin
- ☐ Psoriasis
- ☐ Moles
- ☐ Hair loss
- ☐ Dry skin
- ☐ Skin discoloration
- ☐ None
- ☐ Others _____
- ☐ Hives
- ☐ Bed sores
- ☐ Eczema
- ☐ Ulcerations
- ☐ Skin tags
- ☐ Dandruff
- ☐ Moist skin
- ☐ Fungal infections

Sensory

Check all that apply.

- ☐ Glasses
- ☐ Sees floaters
- ☐ Eye pain
- ☐ Itchy eyes
- ☐ Dry eyes
- ☐ Glaucoma
- ☐ Poor hearing
- ☐ Teeth problems
- ☐ Dry mouth
- ☐ Sores on lips or tongue
- ☐ Chronic sore throat
- ☐ Headaches
- ☐ Sinus problems
- ☐ Excess phlegm
- ☐ None
- ☐ Blurred vision
- ☐ Eye strain
- ☐ Red eyes
- ☐ Excessive tearing
- ☐ Night blindness
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Gum problems
- ☐ Excessive saliva
- ☐ Swollen glands
- ☐ Concussions
- ☐ Migraines
- ☐ Nose bleeds
- ☐ Facial pain

Respitory

Check all that apply.

- ☐ Frequent colds
- ☐ Wheezing
- ☐ Dry cough
- ☐ Shortness of breath
- ☐ Thin phlegm
- ☐ None
- ☐ Tight chest
- ☐ Wet cough
- ☐ Post nasal drip
- ☐ Thick phlegm
- ☐ Difficulty breathing while lying down

Cardiovascular

Check all that apply.

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Tachycardia
- ☐ Irregular heart beats
- ☐ Phlebitis
- ☐ Vasculitis
- ☐ Edema
- ☐ Chest pain
- ☐ Fainting
- ☐ Bradycardia
- ☐ Palpitations
- ☐ Blood clots
- ☐ Varicose veins
- ☐ None

Gastrointestinal

Check all that apply.

- ☐ Bad breath
- ☐ Acid reflux/heartburn
- ☐ Nausea
- ☐ Twitching bowels
- ☐ Bloating
- ☐ Hemorrhoids
- ☐ Itchy anus
- ☐ Diarrhea
- ☐ Laxative use
- ☐ None
- ☐ Hiccup
- ☐ Hiatal hernia
- ☐ Vomiting
- ☐ Gas
- ☐ Rectal pain
- ☐ Anal fissures
- ☐ Burning anus
- ☐ Constipation
- ☐ Intestinal pain

Blood in stool? ☐ Yes ☐ No

Genitourinary

Check all that apply

- ☐ Frequent UTI
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Bed wetting
- ☐ Kidney stones
- ☐ Decreased libido
- ☐ Premature ejaculation
- ☐ Pain with sex
- ☐ Pain on urination
- ☐ Urgent urination
- ☐ Unable to hold urine
- ☐ Enlarged prostate
- ☐ Erectile dysfunction
- ☐ Increased libido
- ☐ Impotence
- ☐ None

Color of urine: _____

General Symptoms

Check all that apply.

- ☐ Prefer hot drinks
- ☐ Cold hands or feet
- ☐ Fever/hot feeling
- ☐ Poor sleep
- ☐ Disturbing dreams
- ☐ Body heaviness
- ☐ Bruise/bleed easily
- ☐ Vertigo
- ☐ Peculiar taste
- ☐ Prefer cold drinks
- ☐ Chills
- ☐ Weight loss/gain
- ☐ Heavy sleep
- ☐ Sweats easily
- ☐ Fatigue
- ☐ Sleep apnea
- ☐ Dizziness
- ☐ None

Psychological

Check all that apply.

- ☐ Anxious
- ☐ Irritable
- ☐ Cries often
- ☐ Suicidal thoughts
- ☐ Attempted suicide
- ☐ Anorexia
- ☐ None
- ☐ Fearful
- ☐ Rage
- ☐ Depression
- ☐ Poor memory
- ☐ OCD
- ☐ Bulimia

Neurological/Musculoskeletal

Check all that apply.

- ☐ Tremors
- ☐ Seizures
- ☐ muscle spasms
- ☐ Restless leg
- ☐ Muscle pain
- ☐ Rib side pain
- ☐ Shoulder pain
- ☐ Wrist pain
- ☐ Knee pain
- ☐ Foot pain
- ☐ Finger pain
- ☐ Stiffness
- ☐ Tics
- ☐ Muscle twitching
- ☐ Muscle atrophy
- ☐ Limb weakness
- ☐ Radiating pain
- ☐ Neck pain
- ☐ Elbow pain
- ☐ Hip pain
- ☐ Ankle pain
- ☐ Hand pain
- ☐ Toe pain
- ☐ Upper back pain

- ☐ Lower back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Numbness
- ☐ Tingling
- ☐ Arthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Spinal stenosis
- ☐ Spondylopathy
- ☐ Disc herniation
- ☐ Bulging disc
- ☐ None

Please describe for all that apply

Have you been abused? (Physical, Emotional, Sexual) _____

Have you had cancer? _____

Female Only

Check all that apply.

- ☐ Amenorrhea
- ☐ Irregular periods
- ☐ Heavy periods
- ☐ Painful periods
- ☐ Clots
- ☐ Spotting
- ☐ Breast tenderness
- ☐ Vaginal pain
- ☐ Vaginal itching
- ☐ Vaginal dryness
- ☐ Vaginal sores
- ☐ Vaginal discharge
- ☐ Endometriosis
- ☐ Ovarian Cysts
- ☐ None

Date of last period _____

Length of cycle _____

Age menses began _____

Age menopause began _____

Number of pregnancies _____

Fertility issues? _____

Are you pregnant? If yes, number of weeks. _____

Date of last PAP _____

Date of last mammogram _____

Medications _____

_____

_____

Allergies

Drug Allergy _____

_____

_____

Food Allergy _____

Environmental Allergy

Supplements

Family Medical History

Check all the apply

- ☐ Arteriosclerosis
- ☐ Seizures
- ☐ Asthma
- ☐ Diabetes
- ☐ Hypertension
- ☐ Others _____
- ☐ Cancer
- ☐ Stroke
- ☐ Alcoholism
- ☐ Heart Disease
- ☐ None

If cancer, what type?

Daily Habits/Diet

Appetite
- ☐ Low
- ☐ High
- ☐ Normal

Thirst
- ☐ Low
- ☐ High
- ☐ Normal

Cravings
- ☐ Salty Food
- ☐ Greasy Food
- ☐ Others _____
- ☐ Sweet Food

Number of alcoholic drinks per week.

Drug use? ☐ Yes ☐ No

Type of drug

Number of cups of coffee/caffeinated drinks per day

Number of cups of water per day

Number of cups of soda per day _____

_____

_____

_____

Average Daily Menu

Breakfast _____

_____

_____

_____

Lunch _____

_____

_____

_____

Dinner _____

_____

_____

_____

What do you do for exercise? _____

_____

_____

_____

How many times a week do you exercise? _____

PATIENT SIGNATURE : _____

Date _____