Canyon Medical Center

2100 SW Camelot Ct
Portland, OR 97225
P: (503) 252-8125
F: (503) 256-8422
info@canyonmedcenter.com
www.canyonmedcenter.com

Chinese Medicine Adult Intake Form

Name (Last, First): _____

Date of Birth: _____

Occupation: _____ Hours per week: _____

Home address: _____

Phone: _____ Email: _____

Preferred contact method (circle one): Phone / Email

Emergency contact name & phone number: _____

Relationship Status: _____

Children: _____ Pets: _____

What major concern(s), symptom(s), or problem(s) brings you in today?
(List in order of importance)

When and how did these begin?

What have you done for these in the past?

What are your goals for this and future treatments?

Please list any other medical diagnoses or current treatments you receive:

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PT DOB: _____

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Please list all medications, supplements, and/or herbs you are currently taking, or have taken recently. Indicate the dose and frequency for each.

Does anyone in your immediate family (mother, father, grandparents, siblings) have any chronic medical conditions? Please list them here:

What significant illnesses, injuries, or hospitalizations have you had throughout your life?

What are your major causes of stress? On a scale from 1-10 (low to high), what is your current stress level?

What do you do to manage stress?

What do you do for fun?

What do you do for self-care?

Who do you live with?

What makes you remarkable?

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How have you changed in the past few years?

In what direction would you like to grow in the next 12 months?

Do you tend to run hot or cold in general? How about your hands and feet?

Do you crave hot, room temperature, or cold beverages?

Do you sweat easily? Do you experience sweating at night?

Do you experience headaches?
If so, what is their quality and location? When did they begin? How long do they last? How often do you have them? Have you identified any triggers?

Do you ever experience dizziness, fainting, blurred vision, floaters or foggy-brained feelings? (List all that apply)

How thirsty are you?

How often do you urinate? What color is the urine? Any discomfort with urination?

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How often do you have a bowel movement? Do you tend toward loose stools or constipation?

How's your appetite?

What do you eat on a typical day?
(If this is too abstract, list what you had in the last 24 hours)

Do you experience gas, belching, heartburn, and/or bloating? Have you observed any triggers?

Any abdominal or chest pain, pressure, or discomfort? Where exactly? What is the quality (dull, sharp, achey, stabbing, comes and goes, constant, etc.)?

Do you frequently have a cough, sore throat, phlegm, or shortness of breath?

Do you get sick easily?

Do you have any food sensitivities or allergies?

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Any skin conditions?

Do you experience any tastes in your mouth?

Do you crave specific flavors?

What is your sleep schedule?

Do you fall asleep easily? Do you stay asleep? How do you feel in the morning when you wake up?

Do you dream? Are there reoccurring themes to your dreams? If so, what are they?

When is your energy highest? When is it lowest?

How often do you exercise? What kind of exercise do you prefer?

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How do you feel after you exercise?

Do you drink alcohol? If so, how many drinks per week?

Do you smoke? If so, how much?

If you have time, please attach a full timeline of your life with all major life events from infancy to the present day, including illnesses, births, deaths, marriage, divorce, moves, friendships, traumas, accidents, injuries, accomplishments, jobs, travel, etc.

Also, if you have time, what is your family like?

Female patients:

At what age did you first have your menstrual period?

Please list your birth control history:

How long is your typical cycle?
(From the first day of bleeding one month to the first day of bleeding the next)

How many days do you bleed?

What color is the blood from beginning to end? Any clots?

Do you experience spotting? Before, after, or between menstruation?

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Do you experience sharp or dull pain? Before, during, or after your period? Where is the pain located?

Please list any PMS symptoms:

Do you experience vaginal discharge?

If applicable, please describe your pregnancy history:

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Chinese Medicine Consent Form

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture and Chinese medicine on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that the methods of treatment may include, but are not limited to, acupuncture, direct and indirect moxabustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese and/or other herbal medicine, and drop blood letting, guided visualizations, yoga & qigong sequencing, aromatherapy, nutritional counseling, lifestyle advice, and other modalities. These techniques are practiced at the discretion of the provider and with my consent. I understand that the herbs may need to be prepared and the teas consumed according to instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that treatment of any type may have side effects, including (but not limited to) bruising, mild burns, fatigue, soreness, temporary exacerbation of symptoms, etc. I also understand that I have the right to stop treatment at any point and that it is my responsibility to inform my practitioner of my discomfort or preference to stop treatment. I understand that it is my responsibility to check in with my primary health care provider about any and all complementary treatments, including labor induction if applicable. I understand that my practitioner is skillfully trained and is practicing with the intention of helping me in my healing process.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Acupuncturist Name: _____

Patient Name: _____

Patient Signature _____Date _____

(Parent or guardian signature) _____

Relationship to Patient _____