

Medical History Questionnaire

This is an outline for recording your medical history. **This information as well as the results of any Physical examinations, conversations, special procedures and laboratory test is confidential. Reports will be furnished only with your request and permission.**

You are asked to fill out this record and bring it with you to your first appointment. Please complete each page. Remember to take your time. It will help us help you.

Many of our patients are chemically sensitive. Please avoid the use of fragrances or perfumes when visiting our office. Thank you.

East-West Acupuncture Clinic
Steve Snyder, L.Ac.
(503)-231-4101
3703 SE 39th Ave.
Portland, OR 97202

www.east-westacupuncture.com

Your appointment will be

Date _____

Time _____

There is a large demand for appointments and specific appointment times and limited number of spaces available. We do our best to try and accommodate patient's needs. We are also very careful about our schedule so patients do not have to wait.

Please read and sign below:

“I understand that appointment times are reserved especially for me. 24 hours notice of any changes is appreciated. Full fee will be charged for missed appointments and half fee for same day cancellations. Unless other arrangements have been made, I understand the payment is due at the end of each visit.”

Signed _____

Date _____

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Date _____

Patient Record

Name _____

Address _____

Home Phone _____ Email _____

Employer _____

How did you hear about this Clinic? _____

Do you have a current/pending Worker's Comp Claim? _____

Describe the disorder which is bothering you most _____

Duration of Disorder _____

Other Health Problems? _____

Previous Treatment _____

Disorders & Surgeries (give dates if possible) _____

Current & Recent Medications _____

Usual Intake of

Tobacco	Y	N	Coffee	Y	N
Alcohol	Y	N	Sweets	Y	N
Marijuana	Y	N	Other	Y	N

If Yes, Please List _____

Current or previous problems in the following areas

Muscles, Bones & Joints	Y	N	Nervous System	Y	N
Heart	Y	N	Psychological	Y	N
Circulation	Y	N	Hormonal	Y	N
Digestion	Y	N	Blood/Lymph Nodes	Y	N
Lungs, Nose & Throat	Y	N	Skin	Y	N
Kidney & Bladder	Y	N	Other	Y	N
Reproductive & Genital	Y	N			

If Yes, Please List _____

Do you have or had you had

Diabetes, Immunity problems, Nosebleeds, Excessive Bleeding from Cuts/Wounds Y N

Are you or could you be Pregnant Y N

Other Issues Y N

If Yes, Please List _____