Wellness At The Center: 8931 SE Foster Road, Ste 102, Portland, OR 97266; P:503-255-7000 F: 503-255-7001

Name_____**DOB**_____**Age**_____Height: _____ Weight: _____ Gender _____

Address:_____City_____State_____Zip_____

Phone # Home_____ Cell/Work _____ E Mail _____

Occupation_____Hrs/wk_____Employer_____

Health Insurance Company _____ Insurance phone #_____

Policy ID# or Claim #_____Group#_____

Is this an Motor Vehicle Collisoin or Worker's Compensation Claim?____ If yes, Date of incident: _____

Policyholder's name_____Employer of Policy Holder_____

How did you hear about our clinic_____

Next of Kin / emergency_____Relationship_____ Phone_____ Address_____

If you are currently receiving healthcare, please list from whom & where: _____

When did you last receive health care & why?_____

History of Hospitalization, Surgery / Serious Injury: Occurrence & Date _____

_____

Chief Complaint(s) 1-4 :

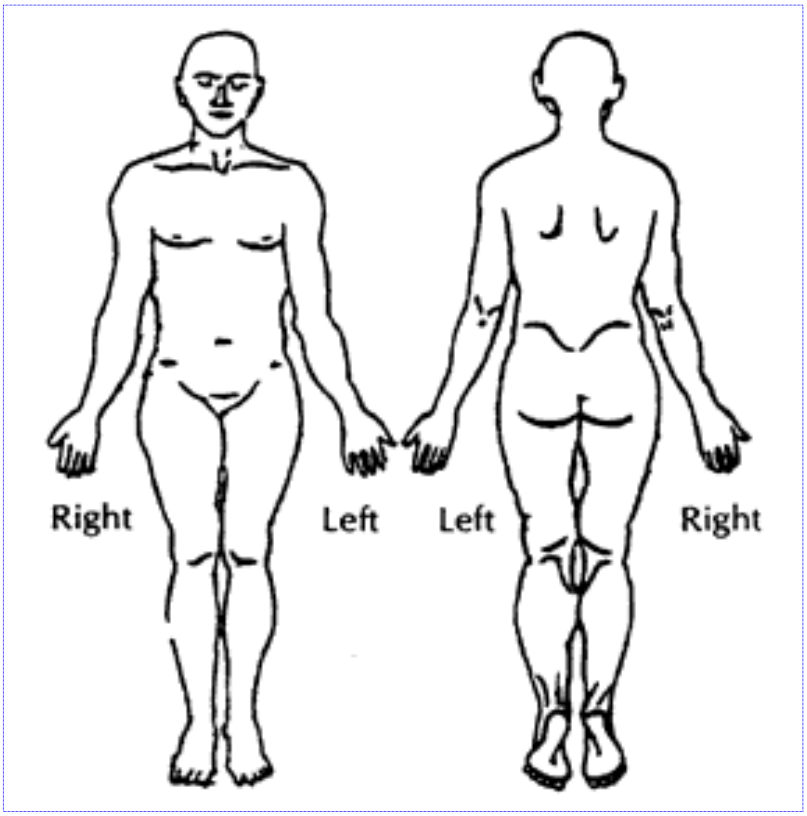
1. _____

_____

Start Date: _____ What makes the issue Better _____

What makes it worse? _____

Please mark areas of pain / discomfort:



2.: _____

_____

_____ Start Date: _____

3._____

_____

_____ Start Date: _____

4. _____

_____Start Date: _____

On a 1 to 10 scale please mark your pain level today, on the diagram next to each area of pain:

1 = barely noticing any pain & 10 = worst pain imaginable.

What is the worst #1 has been in the last week:

0 1 2 3 4 5 6 7 8 9 10

Initials: _____Date_____

Personal Health History: Please circle if experienced issue, add dates & add a "C" if currently experincing.

Anemia	Headache: _migraine_tension _cluster	Liver Disease	Depression/Anxiety
Diabetes	Positional Dizziness or Vertigo	Hepatitis	Eye, Ear, Nose, Throat:
Thyroid Disorder:	Blood Transfusion	Respiratory Disorder	Dental Problems:
Arthritis:	Seasonal Allergies	Asthma	Tinnitus (Ears Ringing)
Kidney Disease	Skin Disorders:	Pneumonia	Night Sweats
Low Libido	Sexual Dysfunction	Sexual Transmitted Infection:	Other:
Bladder Infections / UTI	Gastrointestinal Disease	Eating Disorder:	
High Blood Pressure	Stomach Ulcers	Chronic Fatigue Syndrome	
High Cholesterol	Gallbladder Disease	Cancer:	
Stroke/TIA	Poor Circulation / Cold Hands / Feet	Poor Appetitie	

Family History: *List Disease & Familial Relationship to you:*

Diabetes		
Alcoholism	Cancer (type)	Birth Defects
Heart Disease	Bleeding Disorder	Osteoporosis
Thyroid Disorder	Arthritis (type)	Mental Illness
Hypertension	Stroke	Other:_____
High Cholesterol	Seizures	_____

Surgical trauma: _____Date? _____

Surgical trauma: _____Date? _____

Other physical trauma/ injury: _____Date? _____

Other physical trauma/ injury: _____Date? _____

Additional Space: _____

Do you follow any special diet? If yes, what kind? _____

_____

Have you had any significant weight fluctatauations in the last 5 years? _____

If yes, last highest weight and date: _____ Lowest weight and date: _____

How much: Water do you drink /day? _____ Coffee, Tea, Soft drinks, chocolate, caffeine sources: _____

_____

Cigarettes/Tobacco_____Chew_____How much/day ?_____Year started_____Year quit_____ Want to quit? _____

Alcohol drinks/day? (1 drink=12oz beer/6oz wine/1 oz liquor) _____ Other Substances:_____

Regular Exercise: How many hours per week?_____What type?_____

Other actvities?_____

Sleep Habits _____Fall asleep easily _____Difficult_____Wakes Frequently_____Hours/Day_____

Bowel Movements/Day_____ Easy/Difficult____ Formed ___ Loose_____ Other_____

What is your energy level? On a scale of 1 to 10, with 1 = can get out of bed & 10 = super energized: go!go!go

0 1 2 3 4 5 6 7 8 9 10

Any recent or past history of hair loss? Y / N If Yes, Explain: _____

Do you have any unwanetd Hair Growth? _____ What was the onset, area, and for how long? _____

_____

Are yu wanting to conceive a child in the next year? Y / N _____

Women:

Date last menstrual period _____/_____/_____ Period length (Day one to end of bleeding) _____ Any Pain? _____

Cycle duration (# days btwn start of each period) _____PMS / breast tenderness / cravings / emotional _____

Flow quality (clots, bright, heavy, light)_____

Pregnancies_____ year(s)_____ Live births_____ year(s) _____ Miscarriages_____ Other_____

Birth Control History_____

Current Birth Control or Pre-concpetion Care: _____

What are your primary goals with treatment:

1.

2.

3.

Additional Information:

Medication / Supplement Name	Start date	Dosage	Modification + Date	Purpose	Side Effect	Comments	End Date

Allergies	Side Effect	Avoidance Start date	Comments
Other Topics:			

Acupuncture Scope of Practice

I, _____, understand that techniques within the Licensed Acupuncturist's scope of practice include acupuncture, moxibustion, cupping and bleeding, electrical stimulation, Tuina (Chinese massage), Shiatsu/Sotai (Japanese massage), reflexology, dermal friction (gua sha), infrared heating lamps, Chinese herbal medicine, the use of vitamins, minerals, supplements and nutritional counseling. Any herbs prescribed may need to be prepared and that once prepared, should be consumed according to the instructions provided to the patient orally and in writing. Your acupuncture provider should be notified immediately of any unanticipated or unpleasant effects associated with the consumption of herbs or other supplemental products.

Potential Side Effects

Acupuncture is a considered a safe method of treatment, but it may have some side effects, including bruising, scarring, swelling, and numbness or tingling near the needling sites that may last a few days. Unusual risks of acupuncture include: dizziness, fainting, nerve damage, organ puncture such as lung puncture or pneumothorax, and burning due to moxa or infrared heat therapy. Because of any possible side effects of acupuncture related to pregnancy, the acupuncturist(s) associated with Young East Asian Medicine, LLC must be informed prior to treatment if there is a possibility of pregnancy. Infection is another possible risk, although the acupuncturists at Wellness At The Center use sterile, disposable needles and maintain a clean and safe environment. While this document describes the major risks of treatment, other side effects and risks may occur. Results of treatment are not guaranteed.

By voluntarily signing below I agree that I have read or have had read to me the above consent to treatment, agree to accept the statements above and I am aware of 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.

Patient Signature X _____Date_____

Patient Name (printed)_____

Practitioner Name (printed)_____

Authorization to Release Medical Records

(always required for insurance billing or referral purposes):

This serves as authorization by:

(Full legal Name) _____ Date Of Birth:_____

hereafter referred to as the Patient, to allow all providers and staff at Wellness At The Center to release the following as indicated by Patient's initials:

Billing Claim Forms initial: _____ **Medical Records** initial: _____

to the appropriate insurance company, _____
for the purposes of reimbursement for services rendered, from (effective dates, if applicable)
_____ through _____.

Signature: _____ Date: _____

IF APPLICABLE, when legal representaion is required, this serves as authorization by the Patient to allow all providers and staff at Wellness At The Center to release **Medical and Billing Records** pertaining to treatment received by the Patient to their designated **legal representative**:

_____

for the purpose of collaborative care and reimbursement for services rendered.

Signature: _____ Date: _____

Authorized Representative Signature (if under 18YO): _____ Date _____

Cancellation Policy

Wellness At The Center has a 24 hour cancellation policy. By booking this appointment, you authorize Wellness At The Center to charge a **no-show fee of $40** to your credit card on file should you miss the appointment without giving 24-hour notice. You can reschedule by phone or online. Exceptions are made for emergencies. Insurance will not cover this fee. By signing below, I acknowledge that I understand and agree to the above policy.

Signature: _____ Date: _____