

**Red Peony Acupuncture, Inc. 1915 NW Kearney St. Portland, OR 97209**  
**NEW PATIENT INFORMATION**

*Important:* Please complete this document as thoroughly and legibly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

**All information is strictly confidential.**

Patient Name : \_\_\_\_\_ Today's Date: \_\_\_\_\_

Street address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Name of spouse/partner: \_\_\_\_\_ Phone number: \_\_\_\_\_

If patient is under 18, please list guardian and their relationship to patient:

\_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: \_\_\_\_' \_\_\_\_" Weight: \_\_\_\_\_# (currently) \_\_\_\_\_# (past max)

Emergency Contact: \_\_\_\_\_ Phone number: \_\_\_\_\_  
 same as spouse/partner

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Please indicate if this is a  Worker's Compensation or  Car Accident claim – Date of Injury: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Name of your primary care physician: \_\_\_\_\_

Phone# (\_\_\_\_) \_\_\_\_\_ Address: \_\_\_\_\_

Please list any other practitioners you have seen for your health concerns:

1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_
2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_
3. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever received Acupuncture?  No  Yes, From: \_\_\_\_\_

Please list any prescription or over the counter medication you are currently taking, including pain medications:

Medication	For?	Medication	For?	Medication	For?

List any supplements, vitamins, herbs or minerals you are currently taking: \_\_\_\_\_

\_\_\_\_\_

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What is your primary health concern? \_\_\_\_\_

When did this problem begin? \_\_\_\_\_

What makes it better or worse? \_\_\_\_\_

Has this condition been evaluated by your primary care physician? If so, please list any known western diagnosis.

What prior treatment have you had for this condition and what were the results? \_\_\_\_\_

Does this condition impair your daily activities?  No  Yes, please explain: \_\_\_\_\_

Please list any other health concerns that you wish to address:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
 3. \_\_\_\_\_ 4. \_\_\_\_\_

**Please provide complete information in the following pages related to your current and past health concerns:**

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Multiples Sclerosis (MS)
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure – High	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure – Low	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Virus	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	High Fever	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lyme’s Disease	Other: (please explain)		
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Measles			
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis			
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Migraines			

Recent medical tests:

Test:	Date:	Results:	Test:	Date:	Results:
Physical:			Pap Smear:		
Cholesterol:			HIV/STD:		
Prostate:			Blood Sugar:		
Mammography:			Thyroid:		
Other:					

List any known food allergies, sensitivities or intolerances and your reaction: \_\_\_\_\_

List any allergies related to medications or supplements and your reaction: \_\_\_\_\_

List any prior surgeries, what they were for and the date (or approximate date/year) performed:

1. Type: \_\_\_\_\_ Reason: \_\_\_\_\_ Date: \_\_\_\_\_  
 2. Type: \_\_\_\_\_ Reason: \_\_\_\_\_ Date: \_\_\_\_\_  
 3. Type: \_\_\_\_\_ Reason: \_\_\_\_\_ Date: \_\_\_\_\_

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Please indicate family history of:  Cancer  Heart Disease  Thyroid/Endocrine/Diabetes  Auto-immune Disease  
 Allergies  High Blood Pressure  High Cholesterol  Infertility  Other: \_\_\_\_\_

Please indicate any addictions to:  Nicotine  Prescription medication  Alcohol  Other: \_\_\_\_\_

**Energy, emotions and Immunity:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Slow Wound Healing         | <input type="checkbox"/> Easy to catch colds | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> Low Energy ____/10 (max) | <input type="checkbox"/> Stress Level ____/10 (max) | <input type="checkbox"/> Mood Swings         | <input type="checkbox"/> Anxious/Nervous          |
| <input type="checkbox"/> Mental Tension           | <input type="checkbox"/> Anger                      | <input type="checkbox"/> Grief               | <input type="checkbox"/> Depression               |
| <input type="checkbox"/> Irritable                | <input type="checkbox"/> Joy                        | <input type="checkbox"/> Worry               | <input type="checkbox"/> Fear                     |
| <input type="checkbox"/> Overwhelmed              | <input type="checkbox"/> Overworked                 | <input type="checkbox"/> Mental Fogginess    | <input type="checkbox"/> Cold Hands/Feet          |
| <input type="checkbox"/> Suicidal Thoughts        | <input type="checkbox"/> Panic Attacks              | <input type="checkbox"/>                     |   |

**Sleep:**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Restless                 | <input type="checkbox"/> Non-restful              | <input type="checkbox"/> Busy mind                                | <input type="checkbox"/> Night sweats   |
| <input type="checkbox"/> Difficult to fall asleep | <input type="checkbox"/> Difficult to stay asleep | <input type="checkbox"/> Nightmares                               | <input type="checkbox"/> Vivid dreaming |
| <input type="checkbox"/> Awaken to urinate        | <input type="checkbox"/> Awaken with pain         | <input type="checkbox"/> Number of hours of sleep per night: ____ |   |

**Head, Eye, Ear, Nose, and Throat:**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Impaired Vision        | <input type="checkbox"/> Eye Pain/Strain | <input type="checkbox"/> Glaucoma                        | <input type="checkbox"/> Tearing/Dryness |
| <input type="checkbox"/> Impaired Hearing       | <input type="checkbox"/> Ear Ringing     | <input type="checkbox"/> Earaches                        | <input type="checkbox"/> Swollen glands  |
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Migraines       | <input type="checkbox"/> Teeth Grinding/TMJ/Jaw Problems | <input type="checkbox"/> Allergies       |
| <input type="checkbox"/> Sinus Problems         | <input type="checkbox"/> Nasal Discharge | <input type="checkbox"/> Frequent Sore Throats           | <input type="checkbox"/> Nose Bleeds     |
| <input type="checkbox"/> Sores on tip of tongue | <input type="checkbox"/> Gum Disease     | <input type="checkbox"/> Teeth problems                  | <input type="checkbox"/> Dry Mouth       |

**Respiratory:**

- |                                 |  |                                    |                                   |
|---------------------------------|--|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Cough  | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Asthma |  |                                    |                                   |

**Skin:**

- |                                   |                                 |                                    |                                     |
|-----------------------------------|---------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Rash     | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itchy skin |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Hives  | <input type="checkbox"/> Acne      | <input type="checkbox"/> Dandruff   |

**Cardiovascular:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Chest Pain              | <input type="checkbox"/> Swelling of Ankles | <input type="checkbox"/> Heart Murmurs  |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Palpitations/Fluttering | <input type="checkbox"/> Poor Circulation   | <input type="checkbox"/> Varicose Veins |

**Gastrointestinal:**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Nausea/Vomiting          | <input type="checkbox"/> Heartburn           | <input type="checkbox"/> Belching/gas         | <input type="checkbox"/> Abdominal Pain  |
| <input type="checkbox"/> Undigested food in stool | <input type="checkbox"/> Gurgling in Stomach | <input type="checkbox"/> Fatigue after eating | <input type="checkbox"/> Mucous in stool |
| <input type="checkbox"/> Ulcers                   | <input type="checkbox"/> Incomplete stools   | <input type="checkbox"/> Bloating             | <input type="checkbox"/> Epigastric Pain |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Constipation        | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Liver Disease   |
| <input type="checkbox"/> Hemorrhoids              | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Food Cravings: _____ |  |

**Genito-Urinary Tract:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Frequent Urination          | <input type="checkbox"/> Blood in Urine   | <input type="checkbox"/> Impaired Urination     |
| <input type="checkbox"/> Frequent UTI      | <input type="checkbox"/> Frequent Urination at Night | <input type="checkbox"/> Kidney Stones    | <input type="checkbox"/> Kidney Disease         |
| <input type="checkbox"/> Incontinence      | <input type="checkbox"/> Pain during intercourse     | <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Veneral Disease: _____ |

**Endocrine:**

- |                                      |                                       |                                       |  |
|--------------------------------------|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Diabetes Mellitus |
| <input type="checkbox"/> Feel Hot    | <input type="checkbox"/> Feel Cold    | <input type="checkbox"/> Low libido   | <input type="checkbox"/> Hair loss         |

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**Neurologic:**

- Vertigo/Dizziness                       Numbness/Tingling                       Loss of Balance                       Paralysis

**Pain:**

- Neck/Shoulder Pain                       Low Back Pain                       Upper Back Pain                       Mid Back Pain  
 Muscle Spasms/Cramps                       Arm Pain                       Leg Pain                       Arthritis  
 Tendonitis                       Bone Pain                       Swollen Joints                       Repetitive Strain  
 Sharp Pain                       Fixed Pain                       Moving Pain                       Dull Pain  
 Achy Pain                       Burning                       Numbness/tingling                       Radiating Pain

**What makes pain better:**

- Soft pressure                       Hard Pressure                       Heat                       Cold  
 Rest                       Activity                       Other: \_\_\_\_\_

**What makes pain worse:**

- Pressure                       Heat                       Cold                       Activity  
 Rest                       Standing or sitting too long                       Other: \_\_\_\_\_

**Please rate your pain:**

Current:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild			Moderate		Severe		Very Severe	

**Male Reproductive\*:**

- Sexual Difficulties                       Prostrate Problems                       Testicular Pain/Swelling                       Penile Discharge

**Female Reproductive\*:**

- Irregular Cycles                       Amenorrhea (no periods)                       Painful Periods                       PMS  
 Bleeding Between Cycles                       Light Flow                       Heavy Flow                       Clotting  
 Vaginal Discharge                       Vaginal itching/burning                       Sores on genitalia                       Vulvodynia  
 Menopausal Symptoms                       Breast Lumps/Tenderness                       Nipple Discharge

Are you currently pregnant?  No  Yes, please list due date: \_\_\_\_\_  
 Are you currently taking BCP?  No  Yes – please list medication: \_\_\_\_\_

\*If you are seeing us for fertility enhancement or infertility concerns, please make sure you fill out our separate questionnaire.

**Habits/Lifestyle:**

Exercise: \_\_\_\_\_ times/week  mild  moderate  intense  
 Occupation: \_\_\_\_\_ #hrs/wk \_\_\_\_\_  
 Work Activity:  Sitting  Standing  Computer  
     Light Labor  Heavy Labor  
 Do you enjoy your work?  No  Yes  
 Reading:  No  Yes - How many hrs per day? \_\_\_\_\_  
 Stress level?  None  Small  Medium  High  
 Spiritual Practice?  No  Yes  
 Have you experienced any major traumas?  No  Yes,  
 please explain: \_\_\_\_\_  
 \_\_\_\_\_

Hobbies: \_\_\_\_\_  
 Alcohol:  No  Yes – How much per day? \_\_\_\_\_ week? \_\_\_\_\_  
 Caffeine:  No  Yes – How many cups per day? \_\_\_\_\_  
 Tobacco:  No  Yes – How many per day? \_\_\_\_\_  
 Television:  No  Yes – How many hrs per day? \_\_\_\_\_

Breakfast:	Lunch:
Dinner:	Snacks:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Lisa Pool, LAc  Jelena Stefanovic, LAc Signature: \_\_\_\_\_ Date: \_\_\_\_\_