Cayly Christensen, L.Ac.
3735 SE Division Street
Portland, OR 97202
Ph: 503.302.4303

PATIENT INFORMATION AND HEALTH HISTORY

Patient Name ________________________________ Date of Birth _______________

Address ____

City ________________________ State ______________ Zip code _________________

Home phone_______________________ Cell phone ___________________________

Work phone _______________________ Email ________________________________

Would you like to be added to my email list to receive updates
and special offers? Yes No

How did you hear about me? ____

What is your preferred name? (Nickname, chosen name, etc.)

____

What is your birth sex? _____________________

What gender do you identify as? ________________________

What is your preferred pronoun? He She Other (please specify) ___________

Occupation ______________________________ Hours worked per week ______________

Marital Status: ☐ Single ☐ Married ☐ Partnership ☐ Divorced/Separated ☐ Widowed

With whom do you live? ☐ Spouse ☐ Partner ☐ Parents ☐ Roommates

☐ Children ☐ Alone

Emergency Contact ____

Relationship _______________________________ Phone ____________________________

Basic Medical History and Personal Information

When did you last visit a doctor's office, medical clinic, or hospital? Please explain.

____

____

What is the main reason for your visit today? ___________________________________

____

Please list your top 3 health concerns.

1. ____

2. ____

3. ____

Are you aware of any allergies to food, drugs, or environmental allergens (cats, mold, dust, etc.)? If yes, please list and explain. ____________________________________

____

____

____

Please list all hospitalizations and surgeries, including dates and outcomes: ___________

____

____

____

What diagnostic imaging studies have you had?

☐ Bone density scan ☐ Mammogram ☐ Electrocardiogram ☐ Electroencephalogram

☐ X-rays ☐ CT scan ☐ MRI

Do you take or use any of the following:

☐ Pain relievers (aspirin, ibuprofen)
☐ Cortisone (cream or pills)
☐ Antacids
☐ Tranquilizers
☐ Sleeping pills
☐ Diet pills, appetite suppressants
☐ Thyroid medication
☐ Laxatives
☐ Antibiotics

Please least any prescription medications, over-the-counter medications, vitamins, or other supplements you are taking: ____

____

____

____

Height: __________ Weight: __________ Weight one year ago: __________

Maximum weight: __________ When? __________

Family Medical History

Is your mother still living? ____ If yes, her age: ____ If no, her age at time of death: ____

Cause of death: ____

Is your father still living? _____ If yes, his age: ____ If no, his age at time of death: ____

Cause of death: ____

Do you have a family history of any of the following:

❒Anemia
❒Arthritis
❒Asthma
❒Cancer
❒Cataracts
❒Diabetes
❒Epilepsy
❒Gall bladder disease
❒Glaucoma
❒Goiter
❒Hayfever/hives
❒Heart disease
❒Heart murmur
❒High blood pressure
❒Kidney disease
❒Liver disease
❒Mental illness
❒Stroke
❒Tuberculosis

Please circle one: **Y** for a condition you have now; **P** for a condition you have had in the past; **N** for never had:

Skin

Rashes	Y	P	N
Eczema, hives	Y	P	N
Acne, boils	Y	P	N
Itching	Y	P	N
Color change	Y	P	N
Lumps	Y	P	N
Night sweats	Y	P	N

Head

Headache	Y	P	N
Head injury	Y	P	N
Migraines	Y	P	N

Eyes

Impaired vision	Y	P	N
Glasses/contacts	Y	P	N
Eye pain	Y	P	N
Tearing, dryness	Y	P	N
Double vision	Y	P	N
Glaucoma	Y	P	N
Cataracts	Y	P	N

Ears

Impaired hearing	Y	P	N
Ringing	Y	P	N
Earache	Y	P	N
Dizziness	Y	P	N

Nose and Sinuses

Frequent colds	Y	P	N
Nose bleeds	Y	P	N
Stuffiness	Y	P	N
Allergies	Y	P	N
Sinus problems	Y	P	N

Mouth and Throat

Sore throat	Y	P	N
Sore tongue	Y	P	N
Gum problems	Y	P	N
Hoarseness	Y	P	N
Dental cavities	Y	P	N

Neck

Swollen glands	Y	P	N
Lumps/Goiter	Y	P	N
Pain or stiffness	Y	P	N

Chest

Asthma	Y	P	N
Bronchitis	Y	P	N
Pneumonia	Y	P	N
Emphysema	Y	P	N
Difficulty breathing	Y	P	N
Pain on breathing	Y	P	N
Tuberculosis	Y	P	N

Cardiovascular

Heart disease	Y	P	N
High blood pressure	Y	P	N
Murmurs	Y	P	N
Rheumatic fever	Y	P	N
Chest pain	Y	P	N
Swollen ankles	Y	P	N
Palpitations	Y	P	N

Respiratory

Cough	Y	P	N
Sputum	Y	P	N
Spitting up blood	Y	P	N
Wheezing	Y	P	N

Urinary

Pain on urination	Y	P	N
Increased frequency	Y	P	N
Frequency at night	Y	P	N
Kidney stones	Y	P	N
Inability to urinate	Y	P	N
Weak urine stream	Y	P	N

Gastrointestinal

How often do you have a bowel movement? ____________________

Is this a change?	Y	P	N
Trouble swallowing	Y	P	N
Heartburn	Y	P	N
Change in thirst	Y	P	N
Change in appetite	Y	P	N
Nausea /vomiting	Y	P	N
Vomiting blood	Y	P	N
Gas/bloating/belching	Y	P	N
Liver disease	Y	P	N
Gall bladder disease	Y	P	N
Ulcer	Y	P	N
Hemorrhoids	Y	P	N

Peripheral vascular

Deep leg pain	Y	P	N
Cold hands/feet	Y	P	N
Varicose veins	Y	P	N

Blood

Anemia	Y	P	N
Easy bleeding/bruises	Y	P	N

Neurological

Fainting	Y	P	N
Seizures	Y	P	N
Muscle weakness	Y	P	N
Numbness/Tingling	Y	P	N
Loss of memory	Y	P	N

Emotional

Depression	Y	P	N
Mood swings	Y	P	N
Anxiety	Y	P	N
Tension	Y	P	N

Social

Use rec. drugs	Y	P	N
Use alcohol	Y	P	N

Drinks per week: ______________

Use tobacco	Y	P	N

In what quantity: ______________

Musculoskeletal

Joint pain/stiffness	Y	P	N
Arthritis	Y	P	N
Broken bones	Y	P	N
Muscle spasms	Y	P	N

Endocrine

Diabetes	Y	P	N
Hypothyroid	Y	P	N
Heat/cold intolerance	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N

Breast

Self exams	Y	P	N
Lumps	Y	P	N
Tenderness/Pain	Y	P	N
Nipple discharge	Y	P	N

Male reproductive

Hernias	Y	P	N
Testicular masses	Y	P	N
Sexually active	Y	P	N
Sexual difficulties	Y	P	N
Prostate disease	Y	P	N
Venereal disease	Y	P	N
Discharge	Y	P	N
Sores	Y	P	N

Sexual preference:

Heterosexual ________

Bisexual ________

Homosexual _______

Female reproductive

Days of bleeding __________
Length of cycles __________
Bleed between periods Y P N
Irregular cycles Y P N
Painful menses Y P N
Excessive flow Y P N
Pain with intercourse Y P N
Birth control Y P N
What type? ____________________
# of Pregnancies __________
# of miscarriages __________
# of abortions __________
Difficulty conceiving Y P N
Menopause symptoms Y P N
Sexually active Y P N
Sexual difficulties Y P N
Venereal diseases Y P N
Sexual preference:
Heterosexual _________
Bisexual _________
Homosexual _________

Is there anything else you would like me to know to help serve you better?

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