Pearl Acupuncture & Healing Center
38530 Pleasant St., Suite B, Sandy, Oregon 97055
office 503-668-7631, fax 971-231-1503
www.pearlacupuncture.com

Today's Date ____/____/____ Name ______________________________________ Date of Birth ____/____/____
Street Address_____________________________ City ______________________ State ________ Zip ___________
Relationship Status: ☐ single ☐ married ☐ domestic partner ☐ divorced ☐ widowed
Spouse/Partners Name ______________ # Children _______ Ages of Children ____________________________
Height _________ Weight ________ Occupation ________________________ Phone # _____________________
How did you hear about Pearl Acupuncture? ____________________________ Cell # _______________________
Have you had acupuncture before? ________ E-mail address ____

Current Condition:
Major Complaint: 1) ____

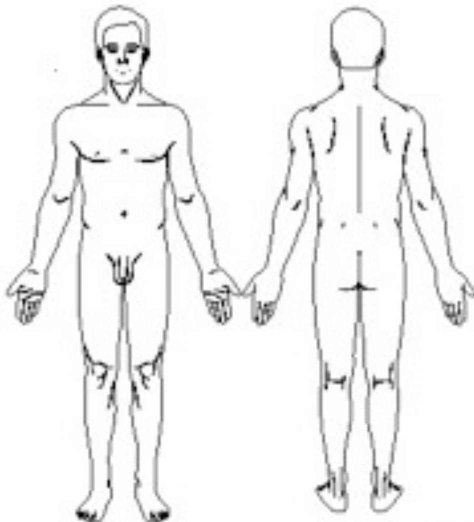
Secondary Conditions: 2) ____________________________________ 3) __________________________________

Date when you first noticed problem? _______________ Pain is: ☐ minimal ☐ slight ☐ moderate ☐ severe
How long have you had this condition? ________ Have you had this in the past? ☐ yes ☐ no When? __________
What kinds of treatments have you tried? ____
____

Lifestyle History: (please check all that apply and write in amount in the space provided)

☐ Smoke cigarettes __________________________
☐ Drink alcohol ____________________________
☐ Drink coffee _____________________________
☐ Drink tea _______________________________
☐ Drink sodas _____________________________
☐ Use laxatives ____________________________
☐ Take painkillers __________________________
☐ Recreational drugs ________________________
☐ Exercise ________________________________
☐ Meditate ________________________________

Work-related stresses (physical, chemical, emotional) ____
____
Please describe your sleep patterns ____
____
Please list the 1 or 2 emotions that seem predominant in your life ______________________________________
Do you: ☐ skip breakfast ☐ eat a hearty breakfast ☐ snack at work ☐ snack before bed
How many meals aday do you eat? _______________ When is your biggest meal? ________________________
Do you eat when you are worried or rushed? ☐ yes ☐ no How often? _________________________________
Do you have any known food allergies? ☐ yes ☐ no If yes, to what? __________________________________
Specific food cravings? ☐ yes ☐ no If yes, to what? ____
How many glasses of water do you drink a day? _________ ☐ Filtered ☐ Bottled ☐ Prefer cold ☐ Prefer Hot



Please mark your areas of pain on the diagrams.

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PLEASE CHECK ALL THAT CURRENTLY APPLY

GENERAL
- ☐ Heavy sleep
- ☐ Dream-disturbed sleep
- ☐ Difficulty getting to sleep
- ☐ Difficulty staying asleep
- ☐ Fatigue
- ☐ Fevers
- ☐ Chills
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Tremors
- ☐ Bleed/Bruise easily
- ☐ Weight-Loss
- ☐ Weight-Gain
- ☐ Peculiar tastes/smells
- ☐ Edema
- ☐ Dislike cold
- ☐ Dislike heat
- ☐ Reduced sexual energy
- ☐ Varicose veins
- ☐ Sudden energy drop
- ☐ Other _______________

MUSCULOSKELETAL
- ☐ Neck pain
- ☐ Muscle pains
- ☐ Knee pain
- ☐ Back pain
- ☐ Foot/ankle pains
- ☐ Hand/wrist pains
- ☐ Shoulder pains
- ☐ Hip pain
- ☐ Muscle weakness
- ☐ Swollen joints
- ☐ Numbness
- ☐ Other_______________

RESPIRATORY
- ☐ Oppression in the chest
- ☐ Chest pains
- ☐ Distention in chest
- ☐ Heat in the chest
- ☐ Shallow breathing
- ☐ Cough
- ☐ Phlegm
- ☐ Difficulty breathing
- ☐ Other _______________

URINATION
- ☐ Frequent urination
- ☐ Wake up to urinate
- ☐ Pain when urinating
- ☐ Decrease in urination
- ☐ Unable to hold urine
- ☐ Blood in urine
- ☐ Dark colored urine
- ☐ Clear urine
- ☐ Other _______________

CARDIOVASCULAR
- ☐ Heart palpitations
- ☐ High blood pressure

  last reading ___________
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Fainting
- ☐ Cold hands/feet
- ☐ Selling of hands
- ☐ Swelling of feet
- ☐ Sweaty hands and feet
- ☐ Other _______________

NEUROPSYCHOLOGICAL
- ☐ Seizures
- ☐ Dizziness
- ☐ Vertigo
- ☐ Loss of balance
- ☐ Areas of numbness
- ☐ Lack of co-ordination
- ☐ Poor memory
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Irritable
- ☐ Have anger
- ☐ Lose temper easily
- ☐ Indecisive
- ☐ Fearful
- ☐ Easily stressed
- ☐ Thought of suicide
- ☐ Other _______________

____
____

HEAD AND EYES
- ☐ Wear glasses
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Spots in front of eyes
- ☐ Blurry vision
- ☐ Eye strain
- ☐ Eye pain
- ☐ Dry eyes
- ☐ Migraines
- ☐ Headaches:

  Where? _______________

  ____

  How often? ___________

  ____

EARS, NOSE, THROAT
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Sinus problem
- ☐ Nose bleeds
- ☐ Recurrent sore throats
- ☐ Grinding teeth
- ☐ Facial pain
- ☐ Sores on lips/tongue
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Dry mouth
- ☐ Excessive saliva
- ☐ Other _______________

____

SKIN AND HAIR
- ☐ Dry skin/hair
- ☐ Dandruff
- ☐ Loss of hair
- ☐ Oily skin
- ☐ Oily hair
- ☐ Acne/pimples
- ☐ Open sores on skin
- ☐ Skin rash
- ☐ Itching
- ☐ Eczema
- ☐ Hives
- ☐ Recent moles
- ☐ Other _______________

____

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Loose stools
- ☐ Diarrhea (watery)
- ☐ Constipation
- ☐ Black stools
- ☐ Blood in stools
- ☐ Gas
- ☐ Belching
- ☐ Indigestion
- ☐ Bad breath
- ☐ Hemorrhoids
- ☐ Stomach acid
- ☐ Low body weight
- ☐ Frequent desire to eat
- ☐ Disinterest in eating
- ☐ Stomach pain or cramps
- ☐ Abdominal bloating
- ☐ Other _______________

____

FEMALE PATIENTS ONLY
Date of last PAP _________
- ☐ Heavy menses-_____days
- ☐ Light menses-______days
- ☐ Irregular menses
- ☐ Painful menses
- ☐ Blood clots
- ☐ PMS
- ☐ Ovarian cyst
- ☐ Breast lumps
- ☐ Endometriosis
- ☐ Infertility
- ☐ Menopause
- ☐ Hysterectomy at age ____
- ☐ Pregnancies ___________
- ☐ Miscarriages ___________
- ☐ Abortions _____________
- ☐ Currently pregnant

MALE PATIENTS ONLY
- ☐ Burning urination
- ☐ Urinary incontinence
- ☐ Impotence
- ☐ Prostatitis
- ☐ Premature ejaculation
- ☐ Nocturnal emissions
- ☐ Painful/swollen testicles
- ☐ Other _______________

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MEDICAL HISTORY

	You	Mother	Father	Brother	Sister	(please check all that apply & give dates)
Cancer.........................	☐	☐	☐	☐	☐	___________
Heart Disease.............	☐	☐	☐	☐	☐	___________
High Blood Pressure....	☐	☐	☐	☐	☐	___________
Diabetes......................	☐	☐	☐	☐	☐	___________
Asthma........................	☐	☐	☐	☐	☐	___________
Hepatitis......................	☐	☐	☐	☐	☐	___________
Thyroid Disease...........	☐	☐	☐	☐	☐	___________
Pneumonia..................	☐	☐	☐	☐	☐	___________
AIDS/HIV....................	☐	☐	☐	☐	☐	___________
Drug/Alcohol Addiction	☐	☐	☐	☐	☐	___________
Seizures......................	☐	☐	☐	☐	☐	___________
Venereal Disease.........	☐	☐	☐	☐	☐	___________
Frequent Colds/Flu......	☐	☐	☐	☐	☐	___________
Bronchitis....................	☐	☐	☐	☐	☐	___________
Allergies......................	☐	☐	☐	☐	☐	___________

Please list surgeries and dates ________________________________

____

____

____

____

____

Significant physical trauma (auto accidents, work-related accidents, physical abuse, etc.)

____

____

____

____

____

____

Significant emotional trauma (divorce, death-family/friend, abuse, change of residence/employment, etc.)

____

____

____

Medications/Drugs/Herbs/Vitamins you are currently taking:

____

____

____

____

____

____