INNERHEALTH P.C.
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ACUPUNCTURE ● CHINESE HERBAL MEDICINE

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(503) 364-3022

Welcome! *Acupuncture is an effective health care modality that can alleviate a variety of disorders and enhance your health. Michael Johnson and Katie Lundberg are licensed acupuncturists, who have been practicing since 2009. The professional services Michael and Katie provide include: acupuncture, cupping, Chinese herbal therapy, and allergy elimination (NAET). You may choose any one modality or any combination thereof. If you have questions about the treatments or about your individual prognosis and treatment plan, please feel free to ask. The following information will allow us to ascertain your treatment needs and assist us in establishing an accurate diagnosis.*

Name_____ Today's Date_____20_____

Street_____ City/State/Zip_____

Age_____ Height_____ Weight_____

Cell Phone_____ Email _____

Date of Birth_____ Last 4 of Social Security Number_____

Employer & Address_____

In Emergency notify (include phone) _____

Referred by_____ Family Physician_____

Main problem(s) you would like help with _____

How long have you experienced this problem?_____

Have you been given a diagnosis for the problem?_____

What kinds of treatment have you tried?_____

Have you tried Acupuncture/Oriental Medicine before? Yes / No

Do you have any other problems with your health?_____

Please list all prescriptions and OTC meds you are currently taking _____

_____

Please list all herbs, supplements, etc. you are taking _____

_____

Any digestive
problems?_____

Do you have a daily bowel movement? Yes / No If no, how often?_____

Do you have any food sensitivities, if so to what? Yes / No _____

Alcohol? Yes / No How often? _____ Do you use any recreational drugs? Yes / No

Coffee or Soda? Yes / No How much? _____ Do you smoke cigarettes? Yes / No

Do you exercise? If yes, how often, what kind? Yes / No _____

How are the stress levels in your life? High Med Low How do you feel emotionally? _____

_____

Have you suffered any significant trauma as an adult or child?_____

How is your level of energy? 1 2 3 4 5 6 7 8 9 10 Do you sleep well? Yes / No

Do you have any allergies?_____

Do you feel unusually hot or cold? Yes / No Hot Cold

Do you experience any unusual sweating? Yes / No

Do you have any uro-genital or sexual problems? Yes / No

Have you had any severe illness or surgeries in the past? Yes / No

Is there anything else you would like to discuss? _____

Have you had your blood pressure checked in the last 6 months, if so, what was it? Yes No _____

For Women:

Are your periods regular? Yes / No How many days between cycles? _____

How many days do you menstruate?_____ PMS? Yes / No

When was your last period? _____

Do you have any gynecological problems?_____

How many pregnancies? _____ What kind of birth control do you use?_____