



CASCADe
ACUPUNCTURE &
HERBAL MEDICINE

Carolyn Grissom, M. Ac., L. Ac. John Hostetler, M. Ac., L. Ac.

10212 5th Ave N.E., Suite 116, Seattle, Washington 98125

Phone: 206-633-0908

Fax: 206-525-3775

Patient Information

Name:			Date:		
Address:		City:		State:	Zip:
Home Phone: ()		Work Phone: ()		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Age:		Date of Birth:	City of Birth:	State of Birth:	Height:
Weight:		Employer Name:	Occupation:	Family Physician:	Referred by:
Emergency Contact (Name):		Emergency Contact Phone: ()		Have you been treated by acupuncture or oriental medicine before? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Insurance Information

Insurance Company:			Name of Subscriber:		
Relation of Subscriber to Patient:		Subscriber's Birth Date:		Social Security Number:	
Address: (if different from Patient's address)			City:		State: Zip:
Insurance Company Telephone Number: ()		Subscriber Number:		Group Number:	
Is this a Personal Injury Auto Insurance Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No				If YES, what is the date of the injury?	
Claim Number:		Claim Adjuster's Name:		Claim Adjuster's Phone Number: ()	

Health Information

What is/are the main problem(s) you would like us to help you with? _____ _____
How long ago did this problem begin (be specific)? _____ _____
To what extent does this problem interfere with your daily activities (work, sleep, sex)? _____ _____
What kinds of treatment have you tried? _____ _____
What kinds of treatment have you tried? _____ _____

Past Medical Information

Please check all that apply, and include the date.

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Thyroid Disease _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Seizures _____
<input type="checkbox"/> Hepatitis _____	<input type="checkbox"/> Rheumatic Fever _____	<input type="checkbox"/> Venereal disease _____

Surgeries (Type and Date)? _____

Significant Trauma (Auto Accidents, Falls, etc.)? _____

Significant Dental Work (Type and Date)? _____

Birth History (Prolonged Labor, Forceps Delivery, etc.)? _____

Allergies (Drugs, Chemicals, Foods/Result)? _____

Family Medical History – Please check all that apply.

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Allergies
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____

Medicines taken within the last two months (Vitamins, Drugs, Herbs, etc.): _____

Occupational Stress (Chemical, Physical, Psychological, etc.): _____

Do you have a regular exercise program? Yes No Please Describe: _____

Have you ever been on a restricted diet? Yes No What Kind? _____

Please Describe Your Average Daily Diet:

Morning _____

Afternoon: _____

Evening: _____

How many packs of cigarettes do you smoke per day? _____

How much alcohol to you drink per week? _____

How much coffee, tea or cola do you drink per week? _____

Please describe any use of drugs for non-medical purposes: _____

Please Check Any Symptoms You Have Had in the Last Three Months

General

- Chills
- Fevers
- Sweat Easily
- Night Sweats
- Localized Weakness
- Bleed or Bruise Easily
- Peculiar tastes or smells
- Strong thirst
- Thirst, no desire to drink
- Fatigue
- Sudden Energy Drop
Time of day _____
- Edema
Where _____
- Poor Sleeping
- Tremors
- Poor Balance
- Cravings
- Change in Appetite
- Weight Gain
- Weight loss

Skin and Hair

- Rashes
- Itching
- Change in Hair or Skin
- Ulcerations
- Eczema
- Oozing on skin/ lesion
- Hives
- Pimples
- Recent Moles
- Loss of Hair
- Dandruff

Other hair or skin problems

Head, Eyes, Ears, Nose And Throat

- Dizziness
- Migraines
- Headaches
When: _____
Where: _____
- Facial Pain
- Glasses
- Poor Vision
- Night Blindness
- Blurry Vision
- Color Blindness
- Blind field
- Spots in front of eyes
- Eye Pain
- Eye strain
- Cataracts
- Eye Dryness

- Excessive tear
 - Discharge from eyes
 - Poor Hearing
 - Ringing in ears
 - Earaches
 - Discharge from ear
 - Nose Bleeds
 - Sinus Congestion
 - Nasal Drainage
 - Grinding Teeth
 - Teeth Problems
 - Jaw Clicks
 - Concussions
 - Recurrent sore throats
 - Hoarseness
 - Sores on lips or tongue
- Other head or neck problems:*

Cardiovascular

- High blood pressure
 - Low blood pressure
 - Chest discomfort or pain
 - Heart palpitations
 - Cold hands or feet
 - Swelling of hands
 - Swelling of feet
 - Blood clots
 - Fainting
 - Difficulty in breathing
- Other heart or blood vessel problems:*

Respiratory

- Cough
 - Asthma/ wheezing
 - Pain with a deep breath
 - Difficulty in breathing when lying down
 - Production of phlegm.
What color: _____
 - Coughing blood
 - Pneumonia
 - Bronchitis
- Other lung problems:*

Gastrointestinal

- Bad Breath
- Nausea
- Vomiting
- Heartburn
- Belching
- Indigestion

- Diarrhea
 - Constipation
 - Chronic Laxative use
 - Blood in Stools
 - Black Stools
 - Abdominal pain or cramps
 - Gas
 - Rectal Pain
 - Hemorrhoids
- Other Stomach or intestinal problems:*

Genito-Urinary

- Pain on urination
 - Urgency to urinate
 - Frequent urination
 - Blood in Urine
 - Dribbling
 - Kidney Stones
 - Impotency
 - Change of sexual drive
 - Sores on genitals
- Do you wake up to urinate?*
Yes No
How often?

- Any particular color to your urine?*

- Other genital or urinary system problems:*

Pregnancy & Gynecology

- Number of pregnancies: _____
- Number of births: _____
- Number of premature births: _____
- Number of miscarriages: _____
- Number of abortions: _____
- Age at first menses: _____
- Period between menses (days) _____
- Duration of menses: (days): _____
- First of date of last menses: _____
- Heavy periods
- Light periods

- Painful periods
 - Irregular periods
 - Changes in body/psyche prior to menstruation
 - Clots
 - Menopause:
Age: _____
Year: _____
 - Vaginal Discharge
 - Post-coital bleeding
 - Vaginal sores
- Date of Last Pap:* _____
- Breast lumps
 - Nipple discharge
- Do you practice birth control?*
 Yes No
- What type and for how long?* _____

Musculoskeletal

- Neck pain
- Shoulder pain
- Back pain
- Elbow pain
- Hand/wrist pain
- Hip pain
- Knee pain
- Foot/ankle pain
- Muscle pain
- Muscle weakness

Neuropsychological

- Seizures
 - Ares of numbness
 - Weakness
 - Sleep disorder
 - Concussion
 - Bad temper
 - Loss of control/violence potential
 - Vertigo
 - Lack of coordination
 - Depression
 - Easily susceptible to stress
 - Loss of balance
 - Poor memory
 - Anxiety
 - Substance abuse
- Other neurological or psychological problems:*

I, _____ authorize that all of the above information is accurate and correct on this day _____ of _____, 20____.

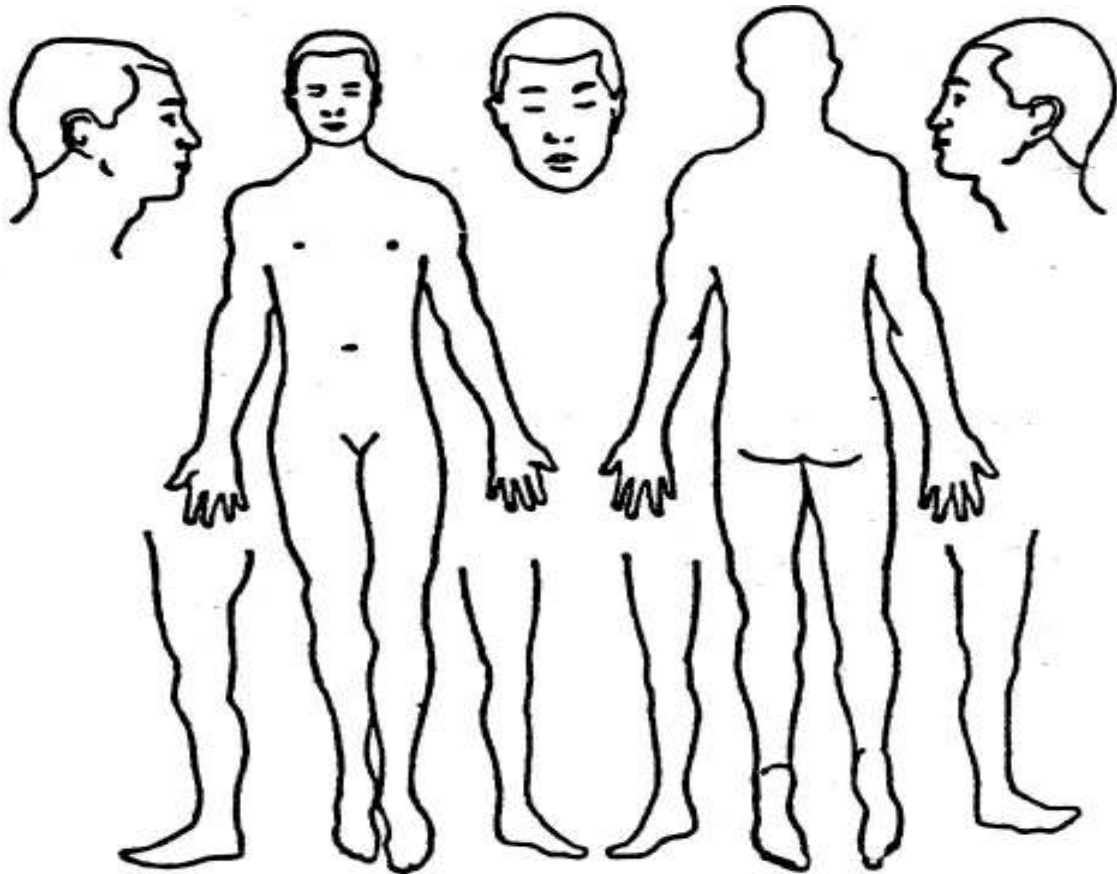
Please rate the degree of severity of your problem now:

No Problem |-----| Worst Imaginable

Please note the greatest degree of severity of your problem within the last week:

No Problem |-----| Worst Imaginable

Indicate painful or distressed areas:



Comments: (please tell us any other problems you would like to discuss):
