

CARSON ACUPUNCTURE & HERBAL CLINIC, LLC

Acupuncture ~ Herbs ~ Massage  
Debbie Carson, L.Ac., Dipl. O.M.

130 SW 2<sup>nd</sup> Avenue, Suite 101 Canby, OR 97013

(503) 266-7999

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph #: \_\_\_\_\_ Work Ph #: \_\_\_\_\_ Cell Ph #: \_\_\_\_\_

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

E-Mail Address: \_\_\_\_\_ Marital Status: M, S, D, W

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

**Carson Acupuncture is contracted with ODS. For all other insurance carriers, we would be considered an out of network provider. Please check to see if you have out of network acupuncture benefits.**

Health Ins Co: \_\_\_\_\_ Subscribers Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Are you currently receiving health care?  Yes  No If yes, please list the following:

Physician Name: \_\_\_\_\_ Ph #: \_\_\_\_\_

If no, please indicate the last time that you received health care: \_\_\_\_\_

Please indicate your primary medical concerns and/or your reason for seeking treatment:

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

How does this condition affect you?

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

Please indicate current treatment for these concerns (this may include medical treatments as well as home treatment such as over-the-counter medications):

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Do you have any reason to believe that you are pregnant?  Yes  No

Do you have any chronic infectious diseases?  Yes  No

If yes, please explain: \_\_\_\_\_

Do you currently suffer from any chronic illnesses?  Yes  No

If yes, please explain: \_\_\_\_\_

Height: \_\_\_\_\_ Weight (current): \_\_\_\_\_ Weight (past maximum): \_\_\_\_\_

Blood Pressure: What is your most recent blood pressure reading? \_\_\_\_\_ / \_\_\_\_\_ When: \_\_\_\_\_

Please circle any of the following if you are currently experiencing or have experienced them in the past:

**Circulatory:**

Hypertension	Heart Attack	Diagnosed Heart Disease	Irregular Heart Beat
Heart Murmur	Chest Heaviness	Palpitations/Fluttering	Pace Maker
Stroke	Anemia	Rheumatic Fever	
Cold Hands & Feet	Varicose Veins	Swelling of the Ankles	

**Respiratory:**

Asthma	Chronic Bronchitis	Pneumonia	Frequent Colds	Seasonal Allergies
Sinusitis	Nosebleeds	Shortness of Breath		

**Gastrointestinal:**

Loss of Appetite	Diarrhea	Constipation	Acid Reflux	Ulcers
Abdominal Pain	Hemorrhoids	Ulcerative Colitis	Irritable Bowel Disease	
Crohns' Disease	Diverticulitis	Hepatitis	Gallstones	Gall Bladder Removal

**Urogenital:**

Bladder Infections	Frequent Urination	Urinary and/or Bowel Incontinence
Kidney Stones	Low Libido	Sexual Dysfunction

**Endocrine:**

Hypothyroidism	Hyperthyroidism	Diabetes	Hypoglycemia
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**Gynecological:**

Irregular Menses	Painful Menses	Endometriosis	PMS	Ovarian Cysts	Infertility
Chronic Pelvic Pain	Pregnancy Related Issues	Menopause Related Issues			Hysterectomy

**Musculoskeletal:**

Injuries	Back Pain	Muscle Pain	Tendonitis	Bursitis	Post-Operative Pain
Arthritis	Neck Pain	TMD (TMJ)	Jaw Tension/Teeth Grinding		
Carpal Tunnel Syndrome	Tennis Elbow	Knee Pain	Plantar Fascitis		

**Eyes:**

Pain                      Blurry Vision                      Redness and/or Itching                      Tired Eyes                      Floaters  
Diagnosed Eye Disease (such as Glaucoma or Macular Degeneration)

**Ears:**

Pain                      Deafness                      Tinnitus                      Plugged Ears

**Neurological:**

Sciatica Pain                      Headaches                      Migraines                      Dizziness                      Numbness                      Seizures

**Dermatological:**

Skin Rashes                      Eczema                      Acne                      Scars                      Rosacea

**Sleep:**

Difficulty Falling Asleep                      Difficulty Staying Asleep                      Disturbed Dreams                      Vivid Dreams  
Nighttime Urination That Disturbs Sleep

**Emotional:**

Anxiety Disorder                      Clinical Depression                      Non-Clinical Depression                      Mood Swings

**If you have any other medical diagnoses that are not listed that may be important, please list:**

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**Current Medications:** Please list current medications that you are taking (including over-the-counter meds)

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**Family Medical History:**

Please list any medical concerns your parents, grandparents, and siblings may have or have had. Please list current age or age of death. Health concerns may include: diabetes, hypertension, high cholesterol, cancer.

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**Lifestyle:**

Fluid Intake (please indicate what kinds of fluids – water, coffee, tea, soda – and how much per day):

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Typical Diet (please include some of the main foods that you eat):

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