503.505.9677
2915 SE Belmont St., # 1
Portland, OR 97214
elementalmedicinepdx.com

Confidential Patient Health Questionnaire

Name________________________________Date of Birth ___________ Today's Date_______
Address____
Phone (home)_____________(cell)_______________Email_____________________________
Is it all right to leave a message about your care at these numbers? Yes / No

Emergency Contact ____
Relationship & Phone # ____
Physician ____ Phone # ___________________
How did you hear about Elemental Medicine? ____

Please list the health concerns you would like to address in order of importance:
1. ____Date of onset:________________________
2. ____Date of onset:________________________
3. ____Date of onset:________________________

LIFESTYLE

	None	A little	Some	A lot		None	A little	Some	A lot
Fruits & veggies					Soda				
Meat					Caffeine				
Dairy					Sweets				
Fast Food					Alcohol				
Water					Tobacco				

What is your current level of stress? ☐ Little to none ☐ Minimal ☐ Moderate ☐ Severe
What is your current level of exercise? ☐ None ☐ Light ☐ Moderate ☐ Strenuous
Please describe your exercise____

What is your current occupation?________________________How many hours/week:________
Do you enjoy your work? Y / N Why? ____

Please list all medications/supplements/vitamins you are currently taking:
Name / Dosage Reason For How Long
____
____
____
____
____

Please list all surgeries, hospitalizations, illnesses and major accidents and when they occurred:
____
____
____
____

Please list all Diseases or Conditions that you are currently diagnosed with or believe you may have:____

Please list any allergies you have and your response to them (medications, foods, animals, environmental substances, etc.): ____

Family health history: ☐ Diabetes ☐ High blood pressure ☐ High cholesterol ☐ Stroke ☐ Mental Health Issues ☐ Cancer (type)____

Are you or might you currently be pregnant? Y / N
Do you have a pacemaker? Y / N Heart Murmur? Y / N
Do you have a history of seizures? Y / N Fainting? Y/ N

Chronic Infections, Please check all that apply:
☐ Tuberculosis ☐ Hepatitis A/B/C ☐ STD ________________
☐ HIV ☐ AIDS ☐ Other ______________________

HEALTH HISTORY AND REVIEW OF SYSTEMS

Please use the following scale to indicate the frequency of symptoms that you experience:

1 = rarely 2 = occasionally 3 = frequently 4 = always

If you do not experience the symptom at all, you can leave it unmarked.

Energy & Stress
1 2 3 4 fatigue / low energy
1 2 3 4 symptoms are worse with exercise
1 2 3 4 symptoms are better with exercise
1 2 3 4 symptoms are worse with stress
1 2 3 4 heavy sensation of the body
1 2 3 4 unclear or foggy thinking
1 2 3 4 hands & feet feel cold

Endocrine & Immune Function
1 2 3 4 body tends to feel warm / hot
1 2 3 4 body tends to feel cool / cold
1 2 3 4 spontaneous daytime sweating
1 2 3 4 night sweats
1 2 3 4 skin (itch, rash, dry, acne)
1 2 3 4 excess thirst
1 2 3 4 hair loss or thinning
1 2 3 4 unusual hair growth
1 2 3 4 slow wound healing
1 2 3 4 easy bruising

Neurological Function
1 2 3 4 muscle weakness
1 2 3 4 numbness / tingling
1 2 3 4 loss of sensation / function
1 2 3 4 paralysis
1 2 3 4 balance problems

Mental & Emotional Tendencies
1 2 3 4 anxiety / excess worry
1 2 3 4 panic attacks
1 2 3 4 obsessive / compulsive behaviors
1 2 3 4 easy to anger / irritability
1 2 3 4 indecisiveness
1 2 3 4 feelings of grief / sadness
1 2 3 4 feelings of worthlessness
1 2 3 4 frequent crying
1 2 3 4 difficulty concentrating / focusing
1 2 3 4 excess fear
1 2 3 4 feel generally positive and capable

Genito-Urinary
1 2 3 4 excess or frequent urination
1 2 3 4 waking to urinate at night # times _____
1 2 3 4 pain or burning with urination
1 2 3 4 urinary tract infections
1 2 3 4 difficulty passing urine
1 2 3 4 blood in the urine
1 2 3 4 cloudy urine
1 2 3 4 dribbling or incontinence
1 2 3 4 kidney stones

Musculo-Skeletal
1 2 3 4 muscle tightness / achiness
1 2 3 4 muscle spasms / cramping
1 2 3 4 frequent sprains or strains
1 2 3 4 joint pain / stiffness

1 = rarely 2 = occasionally 3 = frequently 4 = always

Cardiovascular

1 2 3 4 palpitations
1 2 3 4 chest tightness or pain
1 2 3 4 ankle / lower body swelling
1 2 3 4 varicose veins
1 2 3 4 high blood pressure
last reading ____/____ Date_____
1 2 3 4 low blood pressure
1 2 3 4 fainting or dizziness
1 2 3 4 poor memory
1 2 3 4 pale face, nails or inside eyelids
1 2 3 4 blackouts / loss of consciousness
1 2 3 4 high cholesterol
last reading _________ Date_____

Head, Eyes, Ears, Nose & Throat

1 2 3 4 headaches
1 2 3 4 sinus congestion / pressure
1 2 3 4 blurry vision / poor night vision
1 2 3 4 ear ringing
1 2 3 4 hearing loss
1 2 3 4 nasal discharge
1 2 3 4 nose bleeds
1 2 3 4 dry nose / mouth / throat / eyes
1 2 3 4 sore throat
1 2 3 4 bleeding or swollen gums
1 2 3 4 jaw pain or tightness

Gastro-Intestinal

1 2 3 4 low appetite (<3 meals/day)
1 2 3 4 big appetite (3+ meals/day)
1 2 3 4 fatigue after meals
1 2 3 4 gas or bloating after meals
1 2 3 4 acid reflux / heartburn
1 2 3 4 belching
1 2 3 4 nausea or vomiting
1 2 3 4 stomach pain
1 2 3 4 side or rib pain
1 2 3 4 gallbladder stones
1 2 3 4 intolerance of fatty foods
1 2 3 4 constipation
1 2 3 4 loose stools or diarrhea
1 2 3 4 blood in stools
1 2 3 4 mucous in stools
1 2 3 4 undigested food in stools
1 2 3 4 hemorrhoids
Have you traveled outside of the U.S.? Y / N
Have you ever had a parasite? Y / N

Respiratory

1 2 3 4 catch cold easily (>3x/year)
1 2 3 4 cough
1 2 3 4 cough up of phlegm or blood
1 2 3 4 asthma / difficulty breathing
1 2 3 4 chest tightness or pain

Women's Health

1 2 3 4 vaginal / labial pain or swelling
1 2 3 4 difficulty conceiving
1 2 3 4 excess vaginal discharge
1 2 3 4 yeast infections
1 2 3 4 nipple discharge
1 2 3 4 breast lumps
self breast exam monthly? Y / N
1 2 3 4 low libido

Menstrual History & Patterns

Date of last annual exam __________________
Date of last Pap smear________ Normal? Y / N
Age at first period ________________________
Age at Menopause ________________________
Is your cycle regular? Y / N
# of bleeding days ________________________
Do you bleed between periods? Y / N
Total length of cycle (# of days) ____________
Is your bleeding heavy / moderate / light?
Do you have clots? Y / N
Do you have cramping? Y / N
Cramping before / during / after menses?
Do you have PMS symptoms? Y / N
• Breast tenderness Y / N
• Emotional instability / mood swings Y/ N
• Cravings Y / N ________________________
• Other? ______________________________

Pregnancy

# of pregnancies ________________________
# of live births __________________________
# of miscarriages ________________________
# of abortions ___________________________
Types of protection/birth control used?
____

Men's Health

1 2 3 4 testicular pain / swelling
1 2 3 4 penile discharge
1 2 3 4 low libido
1 2 3 4 sexual difficulties
Have you had your prostate checked? Y / N

Patient Signature:____ Date:________________

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Privacy Policy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patient's privacy and strive to protect the confidentiality of your medical information. Federal legislation requires that we issue this notice of our privacy practices. You have the right to confidentiality of your medical information, and we are required by law to maintain the privacy of that information.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. We may also share medical information about you to your other health care providers to assist them in treating you.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations

We may use and disclose your information for our health care operations. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting the accreditation, certificates, licenses and credentials needed to serve you. We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law: public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, workers compensation, and law enforcement. You may revoke this authorization at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization

Your Rights

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in anticipation of, or use in, a civil, criminal, or administrative action or proceeding. A copy of your records must be requested in writing. *You have the right to request a restriction of your protected health information.* The physician is not required to agree to a restriction that you request. *You have the right to request that we communicate with you about your medical information by different means or to a different location.* This request must be made in writing. *You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.* We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. *You may request a copy of this notice.*

Questions or Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. *We will not retaliate against you for filing a complaint.*

By signing below, I acknowledge that I have read, understand and accept the terms of this document.

Signature: ____ Date: _________________________

Printed Name: ____ Date of Birth: _________________

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Consent to Treat

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at Elemental Medicine. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion/Cupping: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that acupuncture is a generally safe treatment; however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. Unusual risks include spontaneous miscarriage, nerve damage and organ puncture, including that of the lung (pneumothorax). Bruising is a common side effect of cupping. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call my practitioner as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I do not expect clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician and I have carefully read or have had read to me and understand all of the above information, have had an opportunity to ask questions, and am fully aware of what I am signing. I intend this consent form to cover my entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment.

Signature: ____ Date: _________________________

Printed Name: ____ Date of Birth: _________________