Lisa C. Francolini, L.Ac., PC
State License # 0283

RiverWest Acupuncture

Sheridan Horning, L.Ac.
State License # 1195

WELCOME TO OUR OFFICE!

Thank you for choosing our office. The purpose of RiverWest Acupuncture is to assist each individual in achieving their optimum health. We look forward to providing the best care for your health and wellbeing. Traditional Chinese Medicine, which primarily includes Acupuncture and Chinese Herbs, offers an approach that may differ from other methods but is very complimentary to other medical approaches. We refer to and work closely with physicians, medical specialists, other complimentary practitioners as well as our patients in order to accomplish our stated purpose.

In order to serve you properly we will need the following information. Please print and answer all questions completely. All information will be strictly confidential according to HIPAA standard.

Name:____Date:_______________

Address:____________________________________City/State/Zip:_________________________

Age:____ Date of Birth:_____________ E-Mail:_____________________________________

Mobile Phone: _________________________Other Phone:_________________________ ❑ work ❑ home

Emergency Contact: ______________________Relation: ___________Phone Number:_________________

How did you find out about us?____

Have you had acupuncture before?____

I voluntarily consent to be treated with acupuncture by Lisa C. Francolini or Sheridan Horning, Licensed Acupuncturists, at RiverWest Acupuncture and/or my residence.

I understand that acupuncture is performed by the insertion of needles. This occurs through the skin, and/or by the application of heat to the skin, at certain points on or near the surface of the body. The effect of acupuncture is to treat bodily dysfunctions or diseases, to modify or prevent the perception of pain, and to make normal the body's physiological functions. I have been informed that only single-use disposable needles will be used during each treatment.

I have been made aware that certain adverse side effects may result. These could include, but are not limited to, some local bruising, minor bleeding, fainting, temporary pain or discomfort, and the possible temporary aggravation of symptoms existing prior to acupuncture treatment.

I am also aware that acupuncture is licensed in Oregon and many other states and has been safely practiced for centuries and the FDA classifies the procedure as a medical procedure. I understand that no guarantees concerning its use and effects are given to me, and that I am free to stop acupuncture treatments at any time.

I have carefully read and understand all of the information and I am fully aware of what I am signing.

____

Signature (Patient/Parent/Guardian) Date

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OFFICE PROCEDURES

Please read carefully and then acknowledge your understanding by signing where indicated. If you need clarification or have any questions please ask.

PAYMENT OF SERVICES:

Payment is due at the time of service unless arrangements are made in advance. The initial office visit and treatment are due at the time of service. Payment can be made with cash, personal check, or credit card.

We have found this policy to be most effective for both patients and providers. Outstanding balances can cause embarrassment and communication breakdowns, and potentially decrease adherence to the prescribed treatment program. If you foresee any financial challenges, be sure to address them with us prior to your appointment.

APPOINTMENT SCHEDULING:

Our commitment is to remove the cause of illness rather than to treat the symptoms. In order to identify the cause(s) of your condition, the practitioner will conduct a consultation, examination, and any other indicated assessment (e.g. lab, nutritional, stress, etc.). If at the end of your evaluation the practitioner feels you will respond favorably to treatment, they will prescribe a course of care that can include a combination of educational materials, specific therapies, consultations, and then subsequent re-evaluation and re-examination.

These re-assessments and re-examinations are crucial to the practitioner's ongoing evaluation of your response to the prescribed program. They are necessary to help distinguish whether changes in your treatment plan are needed. *Remember that symptoms may resolve long before the underlying causes of disease have been eliminated completely.* Our aim is to support you in eliminating the cause of any condition.

APPOINTMENT CHANGES:

We request at least 24 hour's notice to cancel an appointment. We do realize emergencies occur, and ask you contact our office as soon as possible so we may document the emergency. Missed appointments are appointments not kept or not cancelled 24 hours prior to the appointment time by the patient or guardian. We do notify patients of missed appointments through letters and charge a fee of $50.00.

I have read, understand, and agree to the above statement regarding responsibility for my health care and payment policy.

____
Signature (Patient/Parent/Guardian) Date

RELEASE OF INFORMATION:

I consent for my practitioner to consult with other practitioners as necessary in the RiverWest Acupuncture Clinic regarding my diagnosis and treatment program.

____
Signature (Patient/Parent/Guardian) Date

3314 SW Kelly Avenue | Portland, OR 97239 | 503.246.0103

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SYMPTOM SURVEY

What are the top three health conditions for which you are seeking treatment? Please include approximately how long you've had the condition and the severity/pain on a scale of 0-10. (0=no pain, 10= extremely severe). **If relevant, please note which side the pain is occurring (i.e., right shoulder pain).*

1)________________________________ How Long? ___________Severity/Pain Level___________

2)________________________________ How Long? ___________Severity/Pain Level___________

3)________________________________ How Long? ___________Severity/Pain Level___________

Have you sought treatment for any of these conditions? If YES, please briefly describe:

____

____

Acupuncture and Traditional Chinese Medicine work by treating the whole body. This survey will help us to evaluate you more completely and ensure you are receiving the best treatment protocol to suit your individual needs. Please place a check mark next to those symptoms which you NOW experience or have experienced in the PAST. Include all the complaints which are familiar to you. **If there are one or more words in a line which describe your specific problem you may want to circle those words.*

GENERAL SYMPTOMS

NOW	PAST	
❑	❑	Tired, Weak, Lack of energy
❑	❑	Depression, Melancholy, Moodiness
❑	❑	Worry, Anxiety, Nervousness, Irritability
❑	❑	Panic Attacks
❑	❑	Sleeplessness, Sleep too much
❑	❑	Frequent colds or other illness
❑	❑	Headaches and/or migraines
❑	❑	Don’t sweat
❑	❑	Sweat too much
❑	❑	Night sweats
❑	❑	Dizziness, Fainting, Convulsions
❑	❑	Loss or gain of weight

EYES

NOW	PAST	
❑	❑	Nearsightedness, Farsightedness
❑	❑	Blurred, failing vision
❑	❑	Dryness, burning, itching
❑	❑	Eyes water excessively
❑	❑	Sensitivity to light
❑	❑	Night Blindness
❑	❑	Bloodshot, puffy
❑	❑	Other:_________________________

EARS

NOW	PAST	
❑	❑	Earaches
❑	❑	Noises or ringing in ears
❑	❑	Ear discharges
❑	❑	Loss of hearing
❑	❑	Other:_________________________

NOSE, MOUTH AND THROAT

NOW	PAST	
❑	❑	Hay fever, Sinusitis, runny nose
❑	❑	Dry mouth or nose
❑	❑	Frequent nosebleeds
❑	❑	Cracks in corners of mouth
❑	❑	Dry or chapped lips
❑	❑	Sore throats, Tonsillitis
❑	❑	Clears throat frequently
❑	❑	Sore, red, or cracked tongue
❑	❑	Cold Sores
❑	❑	Inability to smell or taste
❑	❑	Gingivitis
❑	❑	Hoarseness
❑	❑	Other:______________________

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GASTROINTESTINAL

NOW	PAST	
❑	❑	Irritable Bowel Syndrome
❑	❑	Crohn's Disease
❑	❑	Loss of appetite
❑	❑	Gagging
❑	❑	Difficulty swallowing
❑	❑	Nausea, Vomiting
❑	❑	Bad breath
❑	❑	Metallic or bitter taste in mouth
❑	❑	Food cravings or strong desires
❑	❑	Can't eat fats
❑	❑	Heartburn
❑	❑	Indigestion or distress
❑	❑	Heaviness after eating
❑	❑	Gas, Belching
❑	❑	Bloating
❑	❑	Stomach or abdomen tender or painful
❑	❑	Symptoms relieved by eating
❑	❑	Symptoms worse after eating
❑	❑	Avoid certain foods
❑	❑	Headache, Dizziness, Irritability if skip meals
❑	❑	Diarrhea or loose stools
❑	❑	Constipation
❑	❑	Change in bowel movements
❑	❑	Light colored or greasy stools
❑	❑	Dark stools
❑	❑	Blood in stools
❑	❑	Feeling of incomplete evacuation
❑	❑	Undigested food in stool
❑	❑	Foul odor of stool or gas
❑	❑	Hemorrhoids
❑	❑	Other: ___________________________

CARDIOVASCULAR

NOW	PAST	
❑	❑	Heart beats fast or irregular
❑	❑	Tightness in chest
❑	❑	Dizzy or weak upon standing
❑	❑	Swollen feet, ankles, or legs
❑	❑	Cold hands or feet
❑	❑	Hands or feet turn blue
❑	❑	Blue fingernails
❑	❑	Leg pains when walking
❑	❑	Varicose veins
❑	❑	Tendency to anemia
❑	❑	High blood pressure
❑	❑	Low blood pressure
❑	❑	Other: ________________________

RESPIRATORY

NOW	PAST	
❑	❑	Asthma
❑	❑	Cough frequently
❑	❑	Spitting up mucus or blood
❑	❑	Difficulty Breathing
❑	❑	Shortness of breath on exertion
❑	❑	Chest pain
❑	❑	Other:___________________________

MUSCULO-SKELETAL

NOW	PAST	
❑	❑	Muscle pain or stiffness Where? ___________________________
❑	❑	Swollen, Painful, Stiff joints
❑	❑	Bone pain
❑	❑	Fibromyalgia
❑	❑	Feet, Ankle, Calve pain
❑	❑	Tremors, Twitches
❑	❑	Loss of strength
❑	❑	Hernia
❑	❑	Muscle wasting
❑	❑	Other: ___________________________

URINARY

NOW	PAST	
❑	❑	Difficulty urinating
❑	❑	Urinate frequently at night
❑	❑	Bed-wetting
❑	❑	Incomplete urination or dribbling
❑	❑	Pain when urinating
❑	❑	Urinary Tract Infections
❑	❑	Bladder infections
❑	❑	Kidney infections
❑	❑	Kidney stones
❑	❑	Low back pain
❑	❑	Other: _________________________

NEUROLOGICAL/NERVE

NOW	PAST	
❑	❑	Seizures
❑	❑	Neuropathy
❑	❑	Nerve damage
❑	❑	Trigeminal Neuralgia
❑	❑	Bell's Palsy
❑	Other:___________________________________	

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ALLERGIES

❑Food: ____________________________________
❑Medications: ________________________________
❑Plants: _____________________________________
❑Pollens: ____________________________________
❑Insects: _____________________________________
❑MSG: _______________________________________
❑Chemicals: __________________________________
❑Other: ______________________________________

REPRODUCTIVE

❑ Male ❑ Female ❑ Transgender

NOW	PAST	
❑	❑	Prostate Problems. PSA levels________
❑	❑	Discomfort or pain in genital area
❑	❑	Diminished or excessive sexual desires
❑	❑	Erectile Dysfunction
❑	❑	Difficulty having orgasm
❑	❑	**Other**: __________________________

Gynecological

NOW	PAST	
❑	❑	Irregular menstruation
❑	❑	Pain prior to or with periods
❑	❑	Depressed, tense, irritable with periods
❑	❑	Painful or swollen breasts
❑	❑	Discharge from breasts
❑	❑	Lumps in breasts
❑	❑	Symptoms occur in monthly pattern
❑	❑	Diminished or excessive sexual desire
❑	❑	Difficulty having orgasm
❑	❑	Inability to conceive
❑	❑	Miscarriage(s)
❑	❑	Abortion(s)
❑	❑	Vaginal discharge
❑	❑	Pain, Discomfort, Itching in genital area
❑	❑	Hot flashes
❑	❑	**Other**: __________________________

Date of last period? ______________________________
# of days? ______ Length of cycle? _________________
Date of last PAP smear? __________________________
Was it normal? _________________________________
Type of birth control? ____________________________
Have you ever used birth control pills or an IUD? _______
What type and how long? ___________________________

SKIN AND HAIR

NOW	PAST	SKIN AND HAIR
❑	❑	Eczema
❑	❑	Psoriasis
❑	❑	Acne, Pimples
❑	❑	Skin Rashes
❑	❑	Hives
❑	❑	Skin ulcers or sores
❑	❑	Dryness, Roughness, Scaling skin, Scalp Elbows, Knees Feet, around the Nose, Ears, Eyebrows
❑	❑	Hair loss, Thinning
❑	❑	Dry, Coarse hair, Split ends
❑	❑	Bruise easily
❑	❑	Cuts heal slowly, Scar badly
❑	❑	Flush easily
❑	❑	Hands/Feet numb or tingling
❑	❑	Feet burn
❑	❑	Athletes foot
❑	❑	Other: ___________________________

HABITS – ESTIMATE FREQUENCY OR QUANTITY

❑Tobacco usage per day____________
❑Coffee or caffeinated tea _______ cups a day
❑Alcohol _______drinks per week
❑Cannabis _______times per week
❑ Opioid use: ❑now ❑past Frequency ________

❑Vitamins & Supplements (Please list)
____
____
____

❑Prescription medications (Please list)
____
____

❑Do you get regular exercise? What and how often?
____
____

OTHER MEDICAL CONDITIONS

NOW	PAST	
❑	❑	Diabetes. Type: _____________________
❑	❑	Thyroid Issues
❑	❑	PTSD
❑	❑	Autoimmune:_______________________

❑Other: ____

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FAMILY HISTORY:
Have any of your family members had any of the issues/medical diagnoses listed in this chart? Please indicate by checking the appropriate space.

**Please note if you were adopted* ____________

	YOUR FATHER	YOUR MOTHER	YOUR SIBLINGS			YOUR CHILDREN		
			1	2	3	1	2	3
Age (if living)								
Age at death								
Cause of Death								
Overall Health: **A**=good **B**=bad								
Cancer								
Heart Issues								
Digestive Problems								
Respiratory Problems								
Urinary Tract Problems								
Diabetes								
Hypoglycemia								
Thyroid Problems								
Gallbladder Problems								
High Blood Pressure								
Anemia								
Migraines								
Stroke								
Epilepsy								
Tuberculosis								
Allergies								
Asthma								
Diagnosed Mental Illness								
Birth Defects								
Other:								

Thank you for taking the time to fill out this questionnaire. For additional comments use the space on back.