Mulberry Healing Arts, LLC

Fumiko Mori LAc, MAcOM 2262 N Albina Ave, #128, Portland, OR 97227 503.680.0835

Patient Information Form

Name (Last, First, Middle):_____ Date:____/____/____

Home Address:_____

City:_____ State: _____ Zip:_____

Primary Ph #:_____ (Mobile / Home / Work) Text: Yes / No

Ph # we can leave a message:_____

E-mail: _____

Employer: _____ Occupation: _____

Date of Birth:____/____/____ Age: _____ Sex: Male / Female

Emergency Contact: _____ Ph#: _____ Relationship:_____

Have you been treated by acupuncture before? When?: _____

How did you find Mulberry Healing Arts?: _____

Insurance Information

Insurance Company: _____ Subscriber Name: _____

Relationship to Subscriber: Self / Spouse / Child / Other Subscriber DOB: ____/____/____

Subscriber Employer: _____ Policy/ID #: _____

Group #: _____ Ph #: _____

Accident Information

Is your current condition due to an accident?: Yes / No Date of Accident:___/___/____ State: _____

Type of Accident: Auto / Work / Other _____

To whom have you made a report of your accident?: Auto Ins / Workers Comp / Employer / Other

Insurance Company's Name: _____

Case Manager: _____ Ph#: _____ Physician: _____

Relationship to Subscriber: Self / Spouse / Child / Other Subscriber DOB: ____/____/____

Claim #: _____ Subscriber Employer: _____

Policy/ID #: _____ Group #: _____ Ph #: _____

Acknowledgement

I acknowledge that the information stated above is true. I understand that I am financially responsible for all the charges made by Mulberry Healing Arts for its health care services and/or goods.

Print:_____ Sig: _____ _____

Print Name of Patient/Guardian/Personal Representative | Signature of Patient/Guardian/Personal Representative | Relationship to Patient

Present Health Information (Name of Patient: Date:)

Primary Health Concern: _____

When did symptoms appear?: _____ Is this condition getting: Worse / Same / Better

Does this condition interfere with: Work / Daily Routine / Recreation / Sleep / Energy / Digestion / Emotional State

Are you currently receiving treatment for this condition?: Yes / No If yes: Medications / ND / Physical Therapy / Chiropractic /

Surgery / Other _____ Doctor/Practitioner:_____

Have you previously received treatment for this condition?: Yes / No If yes: Medications / ND / Physical Therapy / Chiropractic /

Surgery / Other _____ Doctor/Practitioner:_____

What type of treatment provided the most relief?: Medications / ND / Physical Therapy / Chiropractic / Surgery /

Other _____ Doctor/Practitioner:_____

Please circle the number that best rates the severity of your pain: 0 (No pain) 1 2 3 4 5 6 7 8 9 10 (Worst pain)

Activities or movements that are painful to perform: Sitting / Standing / Walking / Bending / Lying Down

How would you best describe your pain: Sharp / Dull / Throb / Numb / Shooting / Cramp / Ache / Burn / Tingle / Stiff / Swelling /

Other _____

What are your goals and expectations for treatment of this condition?

_____

Secondary Health Concern: _____

When did symptoms appear?: _____ Is this condition getting: Worse / Same / Better

Does this condition interfere with: Work / Daily Routine / Recreation / Sleep / Energy / Digestion / Emotional State

Are you currently receiving treatment for this condition?: Yes / No If yes: Medications / ND / Physical Therapy / Chiropractic /

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Other _____

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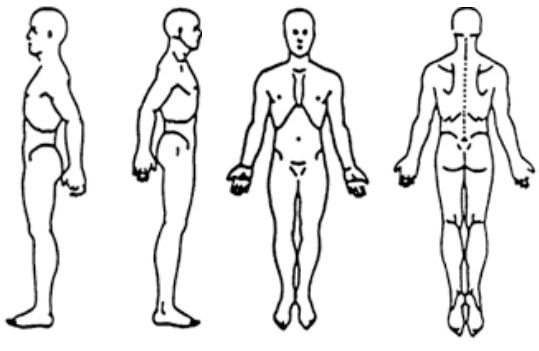
_____

Mark an X where you have symptoms: Please add additional info or comments that you would like me to know.



Fumi Mori, LAc. AC#160515 | 2262 N Alvina Ave, #128, Portland, OR 97227 | 503.680.0835

Health History (Name of Patient: Date:)

System Review (Please check all that apply)

Do you have or have had any of the following conditions?: AIDS/HIV / Bleeding Disorder / Blood Clots / Epilepsy / Herpes / Cancer / Alcohol or Chemical Dependency / Stroke / Heart Disease / Pacemaker / Hepatitis A/B/C / Diabetes / High Blood Pressure (Last BP Reading:_____/_____, Date Taken: _____/_____/_____) / Auto-Immune Disease (What?:)

Mental / Emotional

Anxiety (Clinical Diagnosis: Y / N, Date:_____/_____/_____) / Depression (Clinical Diagnosis: Y / N, Date:_____/_____/_____) / Mental Tension/Stress / Mood Swings / Nervousness / Poor Concentration / Poor Memory / Other _____

Energy / Immunity

Chronic Infection / Fatigue / Frequent Common Cold / Slow Wound Healing / Other _____

Sleep (Number of hour per night: _____)

Difficulty Falling Asleep / Disturbing Dreams / Insomnia / Not Rested Upon Waking / Restless Sleep (Wake _____ x / night) / Other _____

Musculoskeletal

Arthritis / Back Pain (Upper / Mid / Low) / Joint Pain / Limb Pain (Upper / Lower) / Shoulder Pain / Neck Pain / Muscle Weakness / Stiffness / Muscle Spasms/Cramps / Other _____

Skin

Acne / Bruise Easily / Dryness / Itching / Eczema / Hives / Rashes / Lumps / Other _____

Head

Headaches / Head Injury / Memory Loss / Migraines / Cluster Headaches / Tension Headaches / Other _____

Eyes

Blurry Vision / Dryness/Tearing / Eye Pain/Strain / Floaters/Spots / Impaired Vision / Twitching / Other _____

Ears

Dizziness/Vertigo / Earache/Pain / Ear Ringing/Tinnitus / Impaired Hearing / Other _____

Nose / Sinus

Hay Fever / Sinus Congestion/Infection / Nose Bleeds / Other _____

Mouth / Throat

Canker Sores / Dry Mouth / Halitosis (Bad Breath) / Sore Throat/Hoarseness / Teeth/Gum Disease / TMJ / Jaw Pain / Grinding / Other _____

Endocrine

Excessive Thirst/Hunger / Excessive Sweating / Feeling Hot or Cold / Hyper-/Hypothyroidism / Hypoglycemia / Addison's Disease (Hypoadrenalism) / Cushing's Syndrome (Hyperadrenalism) / Other _____

Respiratory

Asthma/Wheezing / Difficulty Breathing / Persistent Cough / Shortness of Breath / Sputum / Other _____

Cardiovascular

Chest Pain/Tightness / Heart Disease / High Blood Pressure / Low Blood Pressure / Palpitations / Swelling of Ankles / Varicose Veins / Angina / Other _____

Neurological

Loss of Balance / Numbness/Tingling / Paralysis / Seizure/Epilepsy / Tremor / Vertigo/Dizziness / Other _____

Health History (Cont.) (Name of Patient: Date:)

Gastrointestinal (Bowel movement how often? _____x / Every _____Days)

Abdominal Pain / Acid Reflux (GERD) / Blood/Mucus in Stool / Changes in Appetite / Constipation / Diarrhea / Gallbladder Diseases / Gall Stones / Gas/Bloating / Heartburn / Liver Diseases / Loose Stool / Nausea/Vomiting / Ulcers / Undigested Food In Stools / IBS / Ulcerative Colitis / Crohn's Disease / Diverticulitis / Other _____

Urinary

Blood in Urine / Cloudy Urine / Frequent Nighttime Urination (x / night) / Frequent Urination / Frequent UTI / Incontinence / Kidney Disease / Kidney Stones / Painful Urination / Other _____

Male Reproduction

Hemorrhoids / Hernia / ED / Penile Discharge/Sores / Prostate Disease / Testicular Pain/Swelling / Other _____

OBGYN (Length of menses: _____Days. Duration of a Cycle: _____Days. If Menopause, Last Menses: Age_____)

I am pregnant: Due_____/_____/_____ I am trying to get pregnant: Y / N # of Pregnancies: _____ # of Birth: _____

Abnormal Discharge / Breast Tenderness/Lumps / Clotting / Difficulty Conceiving / Dryness/Itching / Heavy Flow / Hemorrhoids / Hot Flashes / Irregular Menstruation / Night Sweats / Ovarian Cysts / Pain During Intercourse / Painful Menses / PMS / Spotting / Frequent Yeast Infection / Vaginitis / Candidiasis / STI (What: _____) / Other _____

Surgeries / Hospitalization (Please attach extra sheet if necessary)

Date: Procedure: Date: Procedure:

_____ _____

_____ _____

Medications / Supplements (Please list everything you are taking currently and your reason for taking them)

_____

_____

Allergies (Please list all food, drug, environmental or chemical allergies or hypersensitivities that you are aware of)

_____

Family Medical History (Please list diseases or illnesses that your immediate family members have / had)

_____

_____

_____

Exercise

None / Moderate (1~3 x / week) / Vigorous (4< x / week) Type of Activities: _____

Stress Level

Low / Medium / High Comments: _____

Habits

Alcohol: Y / N How many and what kind of drink(s) per week? _____

Caffeine: Y / N How many and what kind per week? _____

Cigarette: Y / N How many pack(s) per week? _____

Recreational Drugs: Y / N How often and what type of drug(s) per week? _____

Please note that the information provided on this form is confidential. It is important the information given is complete and accurate to properly assist you in your healing process. Please take a moment to review your form and make sure it is complete. Thank you.