Becca Seitz, MAcOM, LAc
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(971) 285-4825
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Name: _____Date:_____
(First) (Middle) (Last)

Address: _____

City, State, Zip: _____Phone: _____

Date of Birth: _____ Gender: _____ Marital Status: _____ Preferred Name:_____

Email Address: _____

Emergency Contact: _____ Phone: _____

How did you hear about me? _____

Are you interested in receiving our E-newsletter? Y N

Are you currently receiving healthcare? Y N
If yes, where and from whom? _____

For what reason? _____

What health concerns have brought you here today (in order of importance to you)?

	Condition	Past Treatment
1.	_____	
2.	_____	

Do you have any reason to believe you're pregnant? Y N

Do you have any chronic infectious diseases? Y N If yes, please explain: _____

Do you currently suffer from any chronic illnesses? Y N If yes, please explain: _____

Please list any allergies or hypersensitivities (environmental, foods, medications): _____

_____

Please list all prescribed medications, over-the-counter medications, vitamin supplements, mineral supplements or herbal supplements that you are currently taking: _____

_____

Height: _____ Weight (current): _____ Weight (past maximum): _____ When? _____

What was your most recent blood pressure reading? _____ When was this reading taken? _____

Hospitalizations and Surgeries:

Reason: _____ Date: _____

Reason: _____ Date: _____

X-Rays/CT Scans/MRIs/Special Studies:

Reason: _____ Date: _____

Reason: _____ Date: _____

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Name: _____ Sex: _____ DOB: _____ Date: _____

Family History:	Mother	Father	Brothers	Sisters	Spouse	Children
Age: (if living, or at death)						
Health: (G=Good, P=Poor)						
Cause of death: (if deceased)						
Check any conditions below that the above family members have had:						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						

Please check the box for symptoms below that you have experienced in the past year:

Head, Eyes, Ears, Nose and Throat:
- ☐ Headaches
- ☐ Impaired Vision
- ☐ Eye Pain/Strain
- ☐ Glaucoma
- ☐ Tearing/Dryness
- ☐ Hay Fever
- ☐ Impaired Hearing
- ☐ Ear Ringing
- ☐ Earaches
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Frequent Sore Throat
- ☐ Teeth Grinding
- ☐ TMJ/Jaw Problems
- ☐ Other? _____

Gastrointestinal:
- ☐ Ulcers
- ☐ Changes in Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach Pain
- ☐ Passing Gas
- ☐ Heartburn
- ☐ Belching
- ☐ Gall Bladder Disease
- ☐ Liver Disease
- ☐ Hepatitis B or C
- ☐ Abdominal Pain
- ☐ Hemorrhoids
- ☐ Other?_____

Cardiovascular:
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Palpitations/Fluttering
- ☐ Swelling of Ankles
- ☐ Varicose Veins
- ☐ Other?_____

Respiratory:
- ☐ Pneumonia
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Persistent Cough
- ☐ Difficulty Breathing
- ☐ Frequent Common Colds
- ☐ Shortness of Breath
- ☐ Other?_____

Stools:
- ☐ Blood in Stool
- ☐ Undigested Food
- ☐ Diarrhea
- ☐ Constipation
- ☐ Mucous
- ☐ Other?_____

Urinary:
- ☐ Kidney Disease
- ☐ Painful Urination
- ☐ Impaired Urination
- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Blood in Urine
- ☐ Frequent Urinary Tract Infections
- ☐ Cloudy Urine
- ☐ Other?_____

Musculoskeletal:
- ☐ Muscle Spasms/Cramps
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Lower Back Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Other?_____

Neurological:
- ☐ Dizziness/Vertigo
- ☐ Paralysis
- ☐ Numbness/Tingling
- ☐ Loss of Balance
- ☐ Seizures/Epilepsy
- ☐ Other?_____

Endocrine:
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Hypoglycemia
- ☐ Diabetes
- ☐ Night Sweats
- ☐ Feeling Hot or Cold
- ☐ Other?_____

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Name: _____ Sex: _____ DOB: _____ Date: _____

Miscellaneous:	**Male Reproductive:**	**Female Reproductive:**
☐ Fatigue	☐ Sexual Difficulties	☐ Irregular Cycles
☐ Slow Wound Healing	☐ Prostate Problems	☐ Breast Lumps
☐ Chronic Infections	☐ Testicular Pain/Swelling	☐ Breast Tenderness/Swelling
☐ Mood Swings	☐ Penile Discharge	☐ Nipple Discharge
☐ Nervousness	☐ Sexually Transmitted Infections	☐ Vaginal Discharge
☐ Mental Tension	☐ Other?_____	☐ Heavy Flow
☐ Anemia		☐ Clotting
☐ Cancer		☐ Premenstrual Symptoms
☐ Rashes/Eczema/Hives		☐ Menopausal Symptoms
☐ Cold Hands/Feet		☐ Difficulty Conceiving
☐ Other?_____		☐ Sexual Difficulties
		☐ Sexually Transmitted Infections
		Other?_____

Female Reproductive/Menstrual History:

Age of first menses:	# of Pregnancies:	# of Miscarriages:
# of days of flow:	# of Live Births:	# of Abortions:
Length of cycle:	Birth Control:	

Lifestyle:

Diet: Are you (circle one): Vegetarian Vegan Omnivorous Other?_____

Fluid Intake (amount and type): _____

Exercise: _____

Education: _____

Occupation: _____ Do you enjoy your work? Y N Why/Why Not? _____

Nicotine/Alcohol/Caffeine Use: _____

Have you experienced any major traumas? Y N Please explain: _____

FINANCIAL POLICIES

- Payment must be made at the time of service. Payment may be made in the form of cash, check, debit or credit card.
- A $25 fee will be assessed for all returned checks.
- If you should need to reschedule or cancel an appointment, please do so at least 24 hours prior to your appointment time. If an appointment is cancelled within 24 hours or missed, please note that a $30 missed appointment fee will be charged to your account.
- We may be able to bill your insurance company for your treatment. If we are unable to directly bill your insurance company, we will provide you with a receipt that contains all of the information needed by an insurance company to reimburse you.
- You are financially responsible for your account, regardless of insurance coverage. Accounts more than 30 days past due (after receipt of insurance payments, if applicable) will be assessed a 2% monthly fee.

I have read and understand the above financial policies.

Signature: _____ Date: _____