

# G&L ACUPUNCTURE AND WELLNESS CENTER

9520 SW Beaverton-Hillsdale HWY Beaverton, OR 97005 Phone 503-643-1788 Fax 503-643-4699  
18670 Willamette Drive, Ste. #102, West Linn, OR 97068 Phone 503-635-4888 Fax 635-4424

The following information is important to the maintenance of your account and/or your care. Please complete to the best of your ability. Some of the questions may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. Do not hesitate to ask for assistance, we will be happy to help.  
*ALL information is strictly confidential.*

## PATIENT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M / F Marital Status: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Living With: Spouse: \_\_\_\_\_ Partner: \_\_\_\_\_ Parents: \_\_\_\_\_ Children: \_\_\_\_\_ Friends: \_\_\_\_\_ Alone: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Phone: (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

## HEALTH HISTORY INFORMATION

Major Complaints: List them in the order importance:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

Main problem(s) you would like us to help you with: \_\_\_\_\_

Are there other Physicians/therapists for this condition you are seeing? (Please circle one) Yes No

If YES, what is the result of treatment? \_\_\_\_\_

Name of your Physician(s): \_\_\_\_\_

Are you presently taking any medication-prescription or over-the-counter? (Please circle one) Yes No

If yes, what drug: \_\_\_\_\_

Are you taking any supplements? (Vitamins, Herbal, Minerals, ect.)? \_\_\_\_\_

Allergies (drugs, chemicals, foods): \_\_\_\_\_

Have you ever had any operations/surgeries? (Please circle one) Yes No

If yes, what and when: \_\_\_\_\_

Hospital Stay/Visit: \_\_\_\_\_ Last Physical Exam Date: \_\_\_\_\_

How did you hear about us? (please, check at least one):  Friend,  Doctor referral,  Yellow pages,  provider list,

Drive by,  Web,  One of our patients; Name \_\_\_\_\_  Other \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient** or Guardian of Patient

\_\_\_\_\_  
Date