

LISA C. FRANCOLINI, L.Ac., PC
STATE LICENSE # 0283
HILARY LAFERRIERE, L.Ac.
STATE LICENSE # 1168



5441 SW MACADAM AVE. STE. 200
PORTLAND, OR 97239
503-246-0103
WWW.RIVERWESTACUPUNCTURE.COM

WELCOME TO OUR OFFICE!

Thank you for choosing our office. The purpose of River West Acupuncture Clinic is to assist each individual in achieving their optimum health. We look forward to providing for your health needs, emphasizing preventative care and health maintenance. 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 and work closely with physicians, medical specialists, other complimentary practitioners as well as our patient 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.

Name: _____	Date: _____
Address: _____	Age: _____ DOB: _____
City/State/Zip: _____	
Phone: _____	E-Mail: _____
Cell Phone: _____	Marital Status: Single Married Partner Divorced Widowed
Employer: _____	Occupation: _____
Work Address: _____	Phone: _____
Emergency Contact: _____	Relation: _____ Phone: _____
Referred by: _____	Relation: _____

I voluntarily consent to be treated with acupuncture by Lisa C. Francolini and/or Hilary Laferriere, Licensed Acupuncturist at the River West Acupuncture Clinic, 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 disposable needles will be used during each treatment.

I have been made aware that certain adverse side affects 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 you 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 reassessments 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 hours 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 in the River West Acupuncture Clinic regarding my diagnosis and treatment program.

Signature (Patient/Parent/Guardian)

Date

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What are your three most important health concerns that you are seeking treatment? If you are seeking treatment for a work related injury or auto accident please list details and give location of pain.

This survey will help us to evaluate you more completely. 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.

NOW	PAST	GENERAL SYMPTOMS
<input type="checkbox"/>	<input type="checkbox"/>	Tired, Weak, Lack of energy
<input type="checkbox"/>	<input type="checkbox"/>	Depression, Melancholy, Moodiness
<input type="checkbox"/>	<input type="checkbox"/>	Worry, Anxiety, Nervousness, Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Sleeplessness, Sleep too much
<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds or other illness
<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Don't sweat enough
<input type="checkbox"/>	<input type="checkbox"/>	Sweat too much
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness, Fainting, Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	Loss or gain of weight
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

NOW	PAST	EYES
<input type="checkbox"/>	<input type="checkbox"/>	Nearsightedness, Farsightedness
<input type="checkbox"/>	<input type="checkbox"/>	Blurred, Failing vision
<input type="checkbox"/>	<input type="checkbox"/>	Dryness, Burning, Itching
<input type="checkbox"/>	<input type="checkbox"/>	Eyes water excessively
<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to light
<input type="checkbox"/>	<input type="checkbox"/>	Night blindness
<input type="checkbox"/>	<input type="checkbox"/>	Bloodshot, Puffy
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

NOW	PAST	EARS
<input type="checkbox"/>	<input type="checkbox"/>	Earaches
<input type="checkbox"/>	<input type="checkbox"/>	Noises or ringing in ears
<input type="checkbox"/>	<input type="checkbox"/>	Ear discharges
<input type="checkbox"/>	<input type="checkbox"/>	Loss of hearing
<input type="checkbox"/>	<input type="checkbox"/>	Lots of wax
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

NOW	PAST	SKIN AND HAIR
<input type="checkbox"/>	<input type="checkbox"/>	Acne, Pimples
<input type="checkbox"/>	<input type="checkbox"/>	Skin Rashes
<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	Stretch marks
<input type="checkbox"/>	<input type="checkbox"/>	Skin ulcers or sores
<input type="checkbox"/>	<input type="checkbox"/>	Dryness, Roughness, Scaling skin, Scalp
<input type="checkbox"/>	<input type="checkbox"/>	Elbows, Knees Feet, around the Nose, Ears, Eyebrows
<input type="checkbox"/>	<input type="checkbox"/>	Hair loss, Thinning
<input type="checkbox"/>	<input type="checkbox"/>	Dry, Coarse hair, Split ends
<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	Brown spots, Bronzing of skin
<input type="checkbox"/>	<input type="checkbox"/>	Moles, Warts, Skin tags
<input type="checkbox"/>	<input type="checkbox"/>	Sun burn easily
<input type="checkbox"/>	<input type="checkbox"/>	Cuts heal slowly, Scar badly
<input type="checkbox"/>	<input type="checkbox"/>	Flush easily
<input type="checkbox"/>	<input type="checkbox"/>	Hands/Feet numb or tingling
<input type="checkbox"/>	<input type="checkbox"/>	Feet burn
<input type="checkbox"/>	<input type="checkbox"/>	Athletes foot
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

NOW	PAST	NOSE AND THROAT
<input type="checkbox"/>	<input type="checkbox"/>	Hay fever, Sinusitis, Runny nose
<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth or nose
<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds
<input type="checkbox"/>	<input type="checkbox"/>	Cracks in corners of mouth
<input type="checkbox"/>	<input type="checkbox"/>	Dry or chapped lips
<input type="checkbox"/>	<input type="checkbox"/>	Sore throats, Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Clear throat a lot
<input type="checkbox"/>	<input type="checkbox"/>	Sore, Red, or Cracked tongue
<input type="checkbox"/>	<input type="checkbox"/>	Cold sores, Herpes
<input type="checkbox"/>	<input type="checkbox"/>	Inability to smell or taste
<input type="checkbox"/>	<input type="checkbox"/>	Lots of cavities
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums
<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

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NOW	PAST	RESPIRATORY
<input type="checkbox"/>	<input type="checkbox"/>	Cough frequently
<input type="checkbox"/>	<input type="checkbox"/>	Spitting up mucus or blood
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath on exertion
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

NOW	PAST	MUSCULO-SKELETAL
<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain or stiffness Where? _____
<input type="checkbox"/>	<input type="checkbox"/>	Swollen, Painful, Stiff joints
<input type="checkbox"/>	<input type="checkbox"/>	Bone pain
<input type="checkbox"/>	<input type="checkbox"/>	Feet, Ankle, Calve pain
<input type="checkbox"/>	<input type="checkbox"/>	Tremors, Twitches
<input type="checkbox"/>	<input type="checkbox"/>	Loss of strength
<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	Muscle wasting
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

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

NOW	PAST	CARDIOVASCULAR
<input type="checkbox"/>	<input type="checkbox"/>	Heart beats fast or irregular
<input type="checkbox"/>	<input type="checkbox"/>	Tightness in chest
<input type="checkbox"/>	<input type="checkbox"/>	Discomfort at high altitude
<input type="checkbox"/>	<input type="checkbox"/>	Dizzy or weak when standing up
<input type="checkbox"/>	<input type="checkbox"/>	Swollen feet, ankles, or legs
<input type="checkbox"/>	<input type="checkbox"/>	Cold hands or feet
<input type="checkbox"/>	<input type="checkbox"/>	Hands or feet turn blue
<input type="checkbox"/>	<input type="checkbox"/>	Blue fingernails
<input type="checkbox"/>	<input type="checkbox"/>	Leg pains when walking
<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to anemia
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

NOW	PAST	URINARY
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating
<input type="checkbox"/>	<input type="checkbox"/>	Urinate frequently at night
<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting
<input type="checkbox"/>	<input type="checkbox"/>	Incomplete urination or dribbling
<input type="checkbox"/>	<input type="checkbox"/>	Pain when urinating
<input type="checkbox"/>	<input type="checkbox"/>	Bladder infections
<input type="checkbox"/>	<input type="checkbox"/>	Kidney infections
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	Low back pain
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

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NOW	PAST	FEMALE
<input type="checkbox"/>	<input type="checkbox"/>	Irregular menstruation
<input type="checkbox"/>	<input type="checkbox"/>	Pain prior to or with periods
<input type="checkbox"/>	<input type="checkbox"/>	Depressed, Tense, Irritable with periods
<input type="checkbox"/>	<input type="checkbox"/>	Painful or swollen breasts
<input type="checkbox"/>	<input type="checkbox"/>	Discharge from breasts
<input type="checkbox"/>	<input type="checkbox"/>	Lumps in breasts
<input type="checkbox"/>	<input type="checkbox"/>	Symptoms occur in monthly pattern
<input type="checkbox"/>	<input type="checkbox"/>	Diminished or excessive sexual desire
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty having orgasm
<input type="checkbox"/>	<input type="checkbox"/>	Inability to conceive
<input type="checkbox"/>	<input type="checkbox"/>	Miscarriages, Abortions
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge
<input type="checkbox"/>	<input type="checkbox"/>	Pain, Discomfort, Itching in genital area
<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Date if 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 a IUD? _____
 What type and how long? _____

NOW	PAST	MALE
<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems
<input type="checkbox"/>	<input type="checkbox"/>	Difficult or unusual urination
<input type="checkbox"/>	<input type="checkbox"/>	Discomfort or pain in genital area
<input type="checkbox"/>	<input type="checkbox"/>	Diminished or excessive sexual desires
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty maintaining an erection
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

ALLERGIES

Food: _____
 Medications: _____
 Plants: _____
 Pollens: _____
 Insects: _____
 MSG: _____
 Chemicals: _____
 Other: _____

HABITS – ESTIMATE FREQUENCY OR QUANTITY

Cigarettes or Tobacco _____ packs a day
 Coffee or Black Tea _____ cups a day
 Alcohol _____ drinks per week
 Marijuana or other drugs _____ times per week
 Vitamins (Please list)

Over the counter supplements (Please list)

Prescription medications (Please list)

Do you get regular exercise? What and how often?

SURGERIES/HOSPITALIZATIONS/VACCINATIONS

Have you had the following vaccinations?

Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you had any of the following removed? Date? _____
 Tonsils: _____ Cysts/Tumors: _____
 Appendix: _____ Uterus/Ovaries: _____
 Gallbladder: _____ Other: _____

Have you ever been hospitalized or had a serious accident or illness? Please list what, when, and where.

MISCELLANEOUS

Have you traveled outside the USA within the last two years?
 Yes No
 Where? _____

Have you even been diagnosed with:
 Yes No Yes No
 AIDS Exposed to AIDS
 HIV TB

If yes, please give diagnosis/treatment dates:

Have you ever been expose in significant or long term doses to:
 Yes No
 Chemicals Toxins
 Radiation Other: _____

If so, please explain: _____

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FAMILY HISTORY:

Have you or any of you family members had any of the problems in this chart? Please indicate by checking the appropriate space.

	YOUR FATHER	YOUR MOTHER	YOUR SIBLINGS			YOUR CHILDREN		
			1	2	3	1	2	3
Age (if living)								
Age at death								
Cause of Death								
Health - A = Good B = Bad								
Cancer								
Heart Problems								
Digestive Problems								
Respiratory Problems								
Urinary Tract Problems								
Diabetes								
Hypoglycemia								
Thyroid Problems								
Gall Bladder Problems								
High Blood Pressure								
Anemia								
Migraines								
Stroke								
Epilepsy								
Tuberculosis								
Allergies								
Asthma								
Psychological Problems								
Birth Defects								
Other:								

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