Kumiko Shirai, DACM, LAc
info@kumikoshirai.com
Phone: (541) 729- 1164

1. Basic Patient Information

Name _____ *(first)* _____ *(middle)* _____ *(last)*

Address _____ *(street)*

City_____ State_____ Zip_____-_____

Telephone _____-_____ *(home)* _____-_____ *(cell)*

Email _____@_____

Date of Birth _____/_____/_____*(mm/dd/yyyy)*

Birth Sex: _____Male _____Female Preferred Pronouns: _____

Marital Status _____Married/Partnership _____Separated/Divorced _____Single

Education _____

Profession _____Employer _____

Work Address _____ *(street)*

City_____ State_____ Zip_____-_____

Emergency Contact _____ *(name)*

Telephone _____-_____ *(home)* _____-_____ *(work)* _____-_____ *(cell)*

Address _____ *(street)*

City_____ State_____ Zip_____-_____

Relationship _____

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Primary Care Physician _____ *(name)*

Address _____ *(clinic name)* _____ *(street)*

City_____ State_____ Zip_____-_____

Did your physician express to be kept informed on treatment progress? ____YES ___ NO
(if yes, please fill out records release form)

2. Referral Information

How did you hear about our clinic? _____ *(media, internet, etc)*

Have you been referred to our clinic? _____ YES _____ NO

May we thank the person who referred you? _____ YES _____ NO

Name _____

Address _____

Relationship _____

3. ANAMNESIS

3.1. Chief Medical Complaint

What are the chief health concerns you wish to address?

1. _____

2. _____

3. _____

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4. _____

5. _____

3.2. Current and Past Treatment

Have you received treatment for these problems? ____ YES ____ NO, if yes, which:

____ Conventional ____ Naturopathic ____ Osteopathic ____ Chiropractic

____ Acupuncture _____ Other: _____

Please list the names of the physicians you have formerly consulted with for this problem:

1. _____

2. _____

3.3. Medications and Supplements

What medications are you currently taking?

1. Prescription: _____

2. OTC: _____

3. Dietary Supplements _____

4. Raw or Dried Herbs _____

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3.4. Allergies

Are you allergic to any medications? ___ YES ___ NO, if yes, which:

1. _____

2. _____

3. _____

Are you allergic to any food products? ___ YES ___ NO, if yes, which:

1. _____

2. _____

3. _____

Are you allergic to any environmental products? ___ YES ___ NO, if yes, which:

1. _____

2. _____

3. _____

3.5. Hospitalizations and Surgeries

Have you had any surgeries in the past? ___ YES ___ NO, if yes, which:

1. _____

2. _____

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3. _____

3.6. Family History (Please check if applicable)

Illness	Father	Mother	Brother	Sister
Cancer				
Diabetes				
Heart Disease				
Stroke				
Mental Illness				

3.7. Communicable Diseases

Do you have an active contagious illness? ___ YES ___ NO, if yes, which:

Pulmonary Tuberculosis		HIV / AIDS	
Measles		Malaria	
Hepatitis A, B, C		Other	

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4. Review of Systems (ROS) (P stands for symptom in the past)

Cardiovascular-Circulatory-Hematological

Heart Disease	____Y	____N	_____P
Heart Murmurs	____Y	____N	_____P
Chest Pain	____Y	____N	_____P
Palpitations	____Y	____N	_____P
Rheumatic Fever	____Y	____N	_____P
High/Low Blood Pressure	____Y	____N	_____P
Stroke	____Y	____N	_____P
Swelling of Ankles	____Y	____N	_____P
Varicose Veins	____Y	____N	_____P
Thrombophlebitis	____Y	____N	_____P
Easy Bleeding	____Y	____N	_____P
Easy Bruising	____Y	____N	_____P
Anemia	____Y	____N	_____P

Other_____

Respiratory

Pleurisy	____Y	____N	_____P
Asthma	____Y	____N	_____P
Emphysema	____Y	____N	_____P
Tuberculosis	____Y	____N	_____P
Persistent	____Y	____N	_____P
Cough	____Y	____N	_____P
Difficulty Breathing	____Y	____N	_____P
Frequent Colds	____Y	____N	_____P
Shortness of Breath	____Y	____N	_____P
Sleep Apnea	____Y	____N	_____P
Tuberculosis	____Y	____N	_____P

Other_____

Musculoskeletal

Pain	____Y	____N	_____P
Muscle Spasms	____Y	____N	_____P
Arthritis	____Y	____N	_____P
Arm Pain	____Y	____N	_____P
Upper Back Pain	____Y	____N	_____P
Mid-back Pain	____Y	____N	_____P
Lower Back Pain	____Y	____N	_____P
Leg Pain	____Y	____N	_____P
Joint Pain	____Y	____N	_____P

Other_____

Neurological

Dizziness	____Y	____N	_____P
Loss of Balance	____Y	____N	_____P
Paralysis	____Y	____N	_____P
Muscle Weakness	____Y	____N	_____P
Atrophy	____Y	____N	_____P
Numbness	____Y	____N	_____P
Tingling	____Y	____N	_____P
Seizures	____Y	____N	_____P
Epilepsy	____Y	____N	_____P
Memory Loss	____Y	____N	_____P
Insomnia	____Y	____N	_____P
Somnolence	____Y	____N	_____P

Other_____

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Head

Headaches	____Y	____N	_____P
Migraines	____Y	____N	_____P
Teeth Grinding	____Y	____N	_____P
TMJ/Jaw Problems	____Y	____N	_____P
Head Injury	____Y	____N	_____P

Other_____

Neck

Lumps	____Y	____N	_____P
Goiter	____Y	____N	_____P
Swollen Glands	____Y	____N	_____P
Neck Pain	____Y	____N	_____P
Whiplash	____Y	____N	_____P

Other_____

Gastrointestinal

Ulcers	____Y	____N	_____P
Changes in Appetite	____Y	____N	_____P
Nausea / Vomiting	____Y	____N	_____P
Epigastric Pain	____Y	____N	_____P
Passing Gas	____Y	____N	_____P
Heartburn	____Y	____N	_____P
Belching	____Y	____N	_____P
Gall Bladder Disease	____Y	____N	_____P
Liver Disease	____Y	____N	_____P
Hepatitis B or C	____Y	____N	_____P
Abdominal Pain	____Y	____N	_____P
Hemorrhoids	____Y	____N	_____P
Blood in Stool	____Y	____N	_____P
Undigested Food	____Y	____N	_____P
Diarrhea	____Y	____N	_____P
Constipation	____Y	____N	_____P
Mucus	____Y	____N	_____P

Other_____

Endocrine

Hypothyroid	____Y	____N	_____P
Hyperthyroid	____Y	____N	_____P
Hypoglycemia	____Y	____N	_____P
Diabetes	____Y	____N	_____P
Excessive Thirst	____Y	____N	_____P
Excessive Hunger	____Y	____N	_____P
Night Sweats	____Y	____N	_____P
Feelings of Hot or Cold	____Y	____N	_____P
Fatigue	____Y	____N	_____P

Other_____

Integumentary

Rashes	____Y	____N	_____P
Acne, Boils	____Y	____N	_____P
Skin Color Change	____Y	____N	_____P
Lumps	____Y	____N	_____P
Eczema	____Y	____N	_____P
Hives	____Y	____N	_____P
Psoriasis	____Y	____N	_____P
Itching	____Y	____N	_____P
Hair Loss	____Y	____N	_____P
Brittle Nails	____Y	____N	_____P

Other_____

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Nose, Ear, Throat, Mouth

Sinus Problems	____Y ____N _____P
Hay Fever	____Y ____N _____P
Stuffy Nose	____Y ____N _____P
Loss of Smell	____Y ____N _____P
Nose Bleeds	____Y ____N _____P
Impaired Hearing	____Y ____N _____P
Ear Ringing	____Y ____N _____P
Earaches	____Y ____N _____P
Dry Throat	____Y ____N _____P
Sore Throat	____Y ____N _____P
Chapped Lips	____Y ____N _____P
Mouth Fissures	____Y ____N _____P

Other_____

Eyes

Impaired Vision	____Y ____N _____P
Night Blindness	____Y ____N _____P
Double Vision	____Y ____N _____P
Blurriness	____Y ____N _____P
Spots in Eyes	____Y ____N _____P
Eye Pain/Strain	____Y ____N _____P
Glaucoma	____Y ____N _____P
Cataracts	____Y ____N _____P
Glasses/Contacts	____Y ____N _____P
Tearing Eyes	____Y ____N _____P
Dry Eyes	____Y ____N _____P

Other_____

Genitourinary

Kidney Disease	____Y ____N _____P
Painful Urination	____Y ____N _____P
Difficult Urination	____Y ____N _____P
Frequent Urination	____Y ____N _____P
Urination at Night	____Y ____N _____P
Kidney Stones	____Y ____N _____P
Blood in Urine	____Y ____N _____P
Urinary Tract Infections	____Y ____N _____P
Venereal Disease	____Y ____N _____P

Other_____

Male Reproductive

Hernia	____Y ____N _____P
Sexual Orientation	_____
Sexually Active	____Y ____N _____P
Sexual Difficulties	____Y ____N _____P
Irregular Libido?	_____High _____Low
Impotence	____Y ____N _____P
Premature Ejaculation	____Y ____N _____P
Penile Discharge	____Y ____N _____P
Genital Warts	____Y ____N _____P
Chlamydia	____Y ____N _____P
Gonorrhea	____Y ____N _____P
Syphilis	____Y ____N _____P
Herpes	____Y ____N _____P
Prostrate Problems	____Y ____N _____P
Testicular Pain	____Y ____N _____P
Testicular Swelling	____Y ____N _____P

Other_____

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Female Reproductive

Age of first menses? _____
Age of menopause? _____
Length of cycle? _____
Duration of menses? _____
Irregular Cycles ____Y ____N _____P
PMS? ____Y ____N _____P
Heavy Flow ____Y ____N _____P
Spotting ____Y ____N _____P
Clotting ____Y ____N _____P
Menopausal Symptoms ____Y ____N _____P
Vaginal Discharge ____Y ____N _____P
Date of last exam/PAP? _____
Endometriosis ____Y ____N _____P
Ovarian Cysts ____Y ____N _____P
Breast Lumps ____Y ____N _____P
Breast Tenderness ____Y ____N _____P
Nipple Discharge ____Y ____N _____P
Sexual Orientation? _____
Sexually active? ____Y ____N _____P
Irregular Libido? _____High _____Low
Pain with intercourse ____Y ____N _____P
Vaginal Dryness ____Y ____N _____P
Cervical Dysplasia ____Y ____N _____P
Genital Warts ____Y ____N _____P
Chlamydia ____Y ____N _____P
Gonorrhea ____Y ____N _____P
Herpes ____Y ____N _____P
Syphilis ____Y ____N _____P
Birth Control ____Y ____N _____P
What type? _____
Number of pregnancies? _____
Number of live births? _____
Number of miscarriages? _____
Number of abortions? _____
Difficulty Conceiving ____Y ____N _____P
Other_____

Mental, Emotional

Mood Swings ____Y ____N _____P
Depression ____Y ____N _____P
Nervousness ____Y ____N _____P
Bi-polar ____Y ____N _____P
Psychosis ____Y ____N _____P
Neurosis ____Y ____N _____P
ADHD ____Y ____N _____P
Hallucinations ____Y ____N _____P
Suicidal Tendencies ____Y ____N _____P
Mental Tension ____Y ____N _____P
Seasonal Depression ____Y ____N _____P
Other_____

Immune

Chronic Fatigue ____Y ____N _____P
Low-grade Fever ____Y ____N _____P
Chronic Infections ____Y ____N _____P
Slow Wound Healing ____Y ____N _____P
Other_____

Immunizations

Tetanus ____Y ____N
Diphtheria ____Y ____N
Polio ____Y ____N
Measles/ Mumps/ Rubella ____Y ____N
Other_____