

Patient Profile



ACUPUNCTURE • MASSAGE • NUTRITION

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Name _____ Date _____

Date of Birth _____ Age _____ Height _____ Weight _____

Please complete this form to the best of your ability.

Chief Complaint _____

Other Health Concerns _____

MEDICAL HISTORY:

Cancer _____ Seizures _____ Heart Disease _____ Other _____

Previous Treatment _____

Current Medications _____

Allergies _____

Shortness of Breath _____ Palpitations _____ Dizziness _____ Sensory Changes _____

DIE T { Breakfast _____
Lunch _____
Dinner _____
Cravings _____ Avoidance _____

Amount of Water _____ Alcohol _____ Caffeine _____ Cigs _____

Exercise _____

Digestion: Gas _____ Bloating _____ Heartburn _____ Nausea _____ Pain _____

Urination: Times per Day _____ Color _____ Difficulty _____ Pain _____

Bowel Movements: How Often _____ Form _____ Color _____ Pain _____
Tendency to Diarrhea _____ or Constipation _____

Sleep: Hours/Day _____ Difficulty getting to _____ Difficulty staying _____
Difficulty rising _____ Dream quality/themes _____

	PAIN	CONGESTION	DRYNESS	DISCHARGE	ITCHING	(circle if applies)
Ear	_____	_____	_____	_____	_____	Ringings
Eye	_____	_____	_____	_____	_____	Floaters
Nose	_____	_____	_____	_____	_____	Snoring
Throat	_____	_____	_____	_____	_____	

Skin: Dryness _____ Itching _____ Acne _____ Moles _____ Rashes _____

Temperature: Chill easily _____ Cold Hands/Feet _____ Overheat Easily _____
Night Sweats _____ Hot Flashes _____ Sweat Easily _____

Menses: Age Began _____ Cycle Length _____ Flow Length _____ Clots _____

PMS: If, YES, list symptoms _____

Pregnancies _____ Births _____ Birth Control _____ What Type _____

Perimenopause or Menopause _____ Symptoms _____

PLEASE MARK AREAS of PAIN

