Sivan Dirks L.Ac

Acupuncture, Herbal Medicine, Pediatrics

3821 NE MLK Blvd. Portland, OR 97212
ph~503-954-1660 fax~971-266-8183

Congratulations and Welcome!

You've just taken the first steps towards reclaiming your whole health and experiencing the vitality that is possible. I am honored and delighted to guide you through the process of feeling more empowered to take the steps necessary to heal from any illness, trauma or loss that may be holding you back. Through our work together you will activate your very own self-healing mechanisms and watch transformation occur from the inside out.

This intake form is designed to get you to think in a different way. It is meant to offer us some insight into the potential root causes of your health challenges, to start the healing process and to begin to guide you to the place within where all your answers lie.

Please REMEMBER, your body is magnificent and within you are the keys you need to heal**. I am here to guide, inspire you and help you access your own healing potential!**
I look forward to bearing witness to your journey!

With nourishing wishes, love and gratitude,

Sivan Dirks

Note: Please fill out the formal intake and be sure to answer the additional questions at the end. These really are important! Holistic and preventative healthcare is enhanced dramatically when the practitioner has a complete picture of the patient physically, mentally, emotionally and spiritually. I ask for your cooperation and patience as you complete this health history questionnaire. You may find that some of the information is difficult to recall. I only ask that you do your best. The more information you provide, the better I will be able to serve your needs.
Thank you for your cooperation and thoroughness!

Other questions to ponder before we meet---

What are your expectations for your first visit?
What are your expectations for our work together in general?

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PATIENT INFORMATION

PATIENT:

Last Name: ___________________________ First Name: _____________________ Middle initial: _____

Gender: M F Date of Birth: ____ / ____ / ______ Age: ______ SS#: __________________________

Home Address: ____ Apt # __________

City ______________________________________ State ________________ Zip ____________________

Phone: (h) ______________________ (w) ________________________ (c) _______________________

*Email ____________________________________ What is the best way to contact you? ____________

May I send you my e-newsletters? Y N (We never share info. You may request removal at any time.)

Employer Name: _______________________________ Occupation: ____________________________

Work Address: ____

Relationship status: Married ___ Separated ___ Divorced ___ Widowed ___ Partner ___ Single ___

Live with: Spouse ___ Partner ___ Parents ___ Children ___ Friends ___ Alone ___ Other ___

How did you hear about our clinic? ____

SPOUSE/PARTNER OR GUARDIAN: *Please circle one.*

Last Name: ______________________________ First Name: __________________ Middle initial: _____

Phone: (h) _______________________ (w) ________________________ (c) ______________________

Do you live at the same address? Y N Email ____

RESPONSIBLE PARTY: *Fill out if the above is not the patient but is responsible for the bill.*

Home Address: ____

What is the best way to contact you? ____

EMERGENCY: *Name and address of nearest relative or friend* **not living with you**:

Last Name: _______________________________ First Name: __________________ Middle initial: ____

Phone: (h) _______________________ (w) ________________________ (c) ______________________

Relationship to Patient: ____

INSURANCE: *Please present your insurance card(s) and ID to the receptionist.*

Insured's Name: __________________________ Insured's DOB: ___/ ___/ ____ PH: ______________

Primary Insurance: ________________________ Type: ( ) GRP ( ) PRIV ( ) WC ( ) MVA

Policy #: ________________________________ Group #: _____________________________________

SIGNATURE: (Patient, Parent, Legal Guardian or Responsible Party)

I request services X ____

Patient's Initials____________

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***Patient Health History and Information*:** Today's date: _______________

Legal Name First:______________________________ Last:________________________________

I prefer to be called: _______________________________Date of Birth: _______________________

How do you rate your overall health? **Excellent** **Good** **Fair** **Poor**

What is **your primary** GOAL or **desired outcome** right now concerning your health and well-being? (Please state in the positive). ____

____

How will you know you have achieved this outcome? What does success look like for you? Please share how you would like to be experiencing your life when you are feeling your best in your body and mind. i.e. **How will you feel**, what will you be doing, who would you be in relationship with?. (I'm looking for tangible and identifiable evidence that you have reached your current goal.)

____

____

____

____

How would your life be different if you felt fully vibrant, energized and happy IN your body?

____

____

In your mind? ____

How committed are you to improving your health? Scale of 1-10 ______________________________

How much change are you willing to make at this time? Scale of 1-10 and describe briefly. __________

____

Are you willing to change your diet? Y N If not, why? _____________________________________

____

Do you believe you can heal and experience vibrant health? _________________________________

Do you feel you have control or command over your outcome? _________________________________

What do you imagine is the first step toward achieving this outcome? __________________________

____

What do you consider your biggest obstacle to your own optimal health? ________________________

____

Medical History:

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Currently, what are your most important physical, emotional or mental health concerns?

1.________________________________ 4. ________________________________
2.________________________________ 5. ________________________________
3.________________________________ 6. ________________________________

Are you currently receiving health care? Yes / No

If yes, where, and from whom? ____

If no; when, where, and why did you last receive health care? ___________________________

____

Have you been happy with the health care you have received? Yes / NO If not, will you tell me what was missing?____

Have you worked with other alternative or holistic care practitioners? Please explain. __________

____

Medication History:

Please list **type and dosage** of any prescription or over the counter **medications, vitamins or other supplements** you are **currently** taking. Please attach a list if necessary.

1. ________________________________ 5. ________________________________
2. ________________________________ 6. ________________________________
3. ________________________________ 7. ________________________________
4. ________________________________ 8. ________________________________

Please list type, dosage and time frame for any prescription or over the counter medication you have regularly taken **in the past**. (ex: steroid 2x/day- asthma 1972-1976, advil- back pain 1997-1999.)

1. ________________________________ 5. ________________________________
2. ________________________________ 6. ________________________________
3. ________________________________ 7. ________________________________
4. ________________________________ 8. ________________________________

Medication Allergies: ____

What happens if you have an allergic reaction? ___________________________________

____

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X-rays and Special Studies: If you have had any imaging studies (x-ray, ultra sound, MRI, DEXA etc), blood work or special testing done list the test, approximate date, and outcome.

1. ____________________ 3. ____________________

2. ____________________ 4. ____________________

Injuries/Surgeries, Hospitalizations:

1. ____________________ 3. ____________________

2. ____________________ 4. ____________________

Immunizations:

Are there any recommended immunizations you have not had? ____________________

Any atypical immunizations you have had? ____________________

Have you ever had an adverse (bad) reaction to an immunization? Y / N if so, which? __________

Which childhood diseases have you had? Ex. measles, chicken pox etc. ____________________

____

Were you often sick as a kid? Y/ N ____________________

Did you take many antibiotics growing up? Y/N If yes, what for? ____________________

How is your Dental health? Cavities? Root Canals? ____________________

____

Family Medical History: IF KNOWN. (If you were adopted, please check here: _______)

Please specify M=mother, F=father, S=sister, B=brother A=aunt, U=uncle, PGM or PGF=paternal grandparent, MGM or MGF=maternal grandparent

Allergies or hay fever ____________________ High Cholesterol____________________

Arthritis ____________________ Cancer (type?)____________________

Heart Attack/MI ____________________ Diabetes ____________________

High blood pressure ____________________ Mental Emotional____________________

Digestive____________________ Thyroid/Endocrine ____________________

Other ____________________

Review of Systems: *Although this section is lengthy, it assures that as much time as needed during the visit to address current concerns. It also allows me to make possible connections between symptoms that have not been noted before. The more I know, the more I can assist you. Thank you for your patience.*

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Please circle: Y = current condition, N = never had this condition, P = past condition

Emotional

History of counseling	Y	N	P	Eating Disorder	Y	N	P
Mood swings	Y	N	P	Anxiety or nervousness	Y	N	P
Considered/attempted suicide	Y	N	P	Tension or high stress	Y	N	P

Endocrine

Thyroid Problems	Y	N	P	Heat or cold intolerance	Y	N	P
High Blood	Y	N	P	Diabetes	Y	N	P
Low Blood sugar	Y	N	P	Excessive thirst or hunger	Y	N	P

Neurologic

Seizures	Y	N	P	Loss of balance	Y	N	P
Muscle weakness	Y	N	P	Vertigo or dizziness	Y	N	P
Loss of memory	Y	N	P	Numbness or Tingling	Y	N	P
Paralysis	Y	N	P	Fainting	Y	N	P

Nose and Sinuses

Sinus Pain	Y	N	P	Post nasal drip	Y	N	P
Sinus Infection	Y	N	P	Chronic Stuffy nose	Y	N	P
Hay fever/other nasal allergies	Y	N	P	Loss of smell	Y	N	P

Eyes/Ears

Floaters/spots	Y	N	P	Eye pain/strain	Y	N	P
Corrective lenses /Lasix	Y	N	P	Blurriness or double vision	Y	N	P
Glaucoma or cataracts	Y	N	P	Hearing impairment	Y	N	P
Ringing in the ears	Y	N	P	Excessive ear wax	Y	N	P
Pain in the Ears	Y	N	P	Tearing or dryness	Y	N	P

Mouth and Throat

Frequent sore throat	Y	N	P	Hoarse voice	Y	N	P
Grinding teeth, awake or asleep	Y	N	P	Excess saliva or dry mouth	Y	N	P
Gum problems	Y	N	P	Mouth sores, inside or out	Y	N	P

Respiratory

Cough	Y	N	P	Shortness of breath	Y	N	P
Wheezing or Asthma	Y	N	P	Bronchitis	Y	N	P
Pain with breathing	Y	N	P	Tuberculosis	Y	N	P

Urinary/Kidney

Painful urination	Y	N	P	Inability to hold urine /Incontinence	Y	N	P
Increased frequency (day or night)	Y	N	P	Kidney stones	Y	N	P
Urgency	Y	N	P	Urinary tract infections	Y	N	P
For women: vaginal yeast infections	Y	N	P	For men: Prostatitis	Y	N	P

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Skin

Rashes/eczema	Y	N	P	Lumps	Y	N	P
Acne or boils	Y	N	P	Itching or fungus	Y	N	P
Color changes	Y	N	P	Psoriasis	Y	N	P
When was your last skin check?				Skin Cancer	Y	N	P

Head

Headaches	Y	N	P	Migraines	Y	N	P
TMJ issues	Y	N	P	Head Injury	Y	N	P

Cardiovascular

Heart Disease	Y	N	P	Vein problems	Y	N	P
Murmur or valve problems	Y	N	P	Chest Pain	Y	N	P
Blood clots	Y	N	P	High blood pressure	Y	N	P
Low blood pressure	Y	N	P	Palpitations or fluttering	Y	N	P

Immune

Chronic fatigue syndrome	Y	N	P	Chronically swollen glands	Y	N	P
Get sick often	Y	N	P	Slow wound healing	Y	N	P
Frequent infections	Y	N	P	Autoimmune disease	Y	N	P

Gastrointestinal

Trouble swallowing	Y	N	P	Change in bowel habits	Y	N	P
Change In appetite	Y	N	P	Nausea or vomiting	Y	N	P
Diarrhea	Y	N	P	Heartburn or ulcer	Y	N	P
Constipation	Y	N	P	Pain or cramps	Y	N	P
Black,green or white stool	Y	N	P	Hemorrhoids or blood in the toilet	Y	N	P
Liver disease	Y	N	P	Gallbladder disease	Y	N	P
Mucus in your stool	Y	N	P	Gas or bloating	Y	N	P

How often do you have a bowel movement? ____

Do you get tired after eating? Y N Do you crave sugar in the afternoon? Y N

Bloating? Y N Does it get worse as the day goes on? Y N If not, what time of day? ___________

Do you skip meals? Y N If hungry, do you get moody? Y N Headaches? Y N

Have you ever had food poisoning? Y N If so, when, how bad? ___________________________

Have you ever had digestive issues while or after traveling? Y N If so, please explain.

____

Anything else you need to tell me about your digestion?

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Musculoskeletal

If you answer yes to any of the below please describe where you have symptoms and the severity or intensity on a scale of 1-10.

Joint pain and stiffness	Y	N	P	Arthritis	Y	N	P
Broken bones	Y	N	P	Low bone density	Y	N	P
Muscle pain, spasm, cramping	Y	N	P	Nerve pain	Y	N	P

Other areas of physical Pain or tension you would like me to know about?

____

____

General Reproductive

Are you sexually active?	Y	N	P	Genital warts	Y	N	P
Chlamydia or gonorrhea	Y	N	P	Low sex drive	Y	N	P
Herpes	Y	N	P	Sexual orientation			

Type of contraceptive (if applicable) ____

Have your been recently tested for sexually transmitted infections? ______________________

Would you like to be tested for sexually transmitted infections? _________________________

Female Reproductive

Age when menstruation began. ___________ Did you have a normal puberty? Y N

Are you still menstruating? Y N **If not menstruating when was your last?** __________

Date of 1st day of LAST Menstrual cycle _________________ Are your cycles regular? Y N

# of days between cycles? ______ # days of bleeding (typically)? ____________

Have you used birth control pills? Y N For how long? _____________________________

What kind? _____________________ Any problems? _____________________________

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Symptoms (if no longer menstruating, for the first box, give me info for when you did) :

Pain or cramps Y N P	PMS Y N P
Clotting Y N P	Endometriosis Y N P
Heavy flow Y N P	Fibroids Y N P

Ovarian cysts Y N P	Yeast infections Y N P
Menopausal symptoms Y N P	Nipple discharge Y N P
Breast pain /lumps Y N P	Hot flashes Y N P
Hysterectomy Y N if yes, when?	Night sweats Y N P
Date of last Pap : **Was it normal? Y N**	**Abnormal Pap in the past? Y N** If yes, when?
Do you do self breast exams? Y N	**When was your last mammogram?**

# pregnancies	**# abortions**	**# miscarriages**	**# live births**

Male Reproductive

Hernia Y N P	Testicle pain Y N P
Premature ejaculation Y N P	Testicle lump Y N P
Prostate issues Y N P	Impotence Y N P

***LIFESTYLE HABITS*: (*please take the time to answer these questions, these are important)**

Please share with me your main interests and hobbies: ______________________________________

____

Do you get regular **SLEEP**? ________________ Is it quality sleep? __________________________

Average hours of sleep per night: _________ Do you wake? Y N Do you fall back easily? Y N

How would you describe your **ENERGY** on a scale of 1-10, **1** being exhausted? ________________

How much TV do you watch dally/weekly? ______________

Do you have a personal history of addiction? Y N Type? ______________________________

Do you use recreational drugs now? Y N Do you smoke? Y N If yes, how long? ________

Do you live in a healthy, healing and nurturing environment? Y N I'm not sure

If you could change anything in your living environment what would it be? ______________________

____

On a scale of 1-10, how 'green' would you consider yourself? (Do you recycle, ect). ________________

Hours of **Exercise** per week: ________________ Types: _________________________________

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Are you happy with your weight? Y N Do you think you are overweight? Y N Underweight? Y N

What is your weight now? _______ One year ago?______ Maximum Weight? _______ When? ______

How often do you diet? ____________________

Do you have a history with disordered eating or emotional eating? Y N

How much COFFEE to you drink per day? _________________ Cups of tea? _______________

Do you drink soda? Y N Sparkling water? Y N Do you consume diet sweeteners? Y N

How much water do you drink? _________________________ Tap / Filtered / Bottled

Do you drink alcohol, if so how much, how often? _______________________________________

Do you have any food intolerances or allergies? ____

Please tell me about your diet (typical day):

Breakfast:____ snack? ________________________

Lunch:____ snack? _______________________

Dinner: ____ evening snack? ________________

Do you have any cravings? If so, what are they? ____

Any food intolerances? ____

Occupation: _____________________________Do you enjoy your work? _______________

Do you consider your work stressful? _______________

Do you have a stress management practice in place? Y N If so please describe:

____

Do you feel financially secure? Y N Are you stressed about money? Y N

Do you feel like money concerns are affecting your health? Y N

Describe your general **MOOD**? ____

Do you experience anxiety or depression? Y N Is this new? Y N

Do you consider yourself "stressed out" in general? Y N

Do you have children? Y N If so, how many/ages? ________________________________

Are you in a supportive relationship? Y N

Do you feel happy and connected in your relationship? Y N If not why not? _________________

____

Are you satisfied sexually? Y N **Are you orgasmic?** Y N **Issues with Libido?** Y N

Do you have a history of sexual abuse? Y N

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Do you have concerns about your sexual health? Y N

Anything more you want to share with me on this topic? Y N

Do you have a good support network? Y N Are you close to your family? Y N

Do you take regular vacations? ____

Have you traveled abroad? Where/when? ______________________________________

Do you express yourself creatively? Y N If so, how? _________________________

***Please keep going…you're almost there and these are important questions!**

What do you think your body is trying to tell you right now?

What do you think your body needs in order to heal?

Do you have a spiritual practice? Y N If yes, can you tell me more?

Do you believe in a higher power or something greater than yourself? Y N

If so, what do you call that higher power? ____________________________________

Do you feel connected to this higher power? Y N

If not, do you wish you did? ____

Do you feel like there's anything calling you right now? If so please describe. This could be a greater purpose, or something inside of you wishing to be expressed.

What would you do if you knew you could not fail?

Is there anything missing from your life? If so, what?

THANK YOU SO MUCH FOR TAKING THE TIME TO HELP ME KNOW YOU BETTER!!! - Sivan

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