Shirai Clinic, LLC
3024 SE 59th Ave
Portland, OR 97206

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

1. Basic Patient Information

Name ____________________ *(first)* _________ *(middle)* ___________________ *(last)*

Address ____ *(street)*

City____ State_____ Zip______-______

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

Email ________________________@____

Date of Birth _____/_____/_____ *(mm/dd/yyyy)* ___________ Male __________ Female

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 ____

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 duly fill out records release form)

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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. ____

4. ____

5. ____

3.2. Current and Past Treatment

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

____ Conventional ____ Naturopathic ____ Osteopathic ____ Chiropractic____ Oriental

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

1. ____

2. ____

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3.3. Medications and Supplements

What medications are you currently taking?

1. Prescription: ____

2. OTC: ____

3. Dietary Supplements ____

4. Raw or Dried Herbs ____

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. ____

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3.5. Hospitalizations and Surgeries

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

1. ____

2. ____

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	