Kwan Yin Healing Arts Center, Inc. East/West

3115 NE Sandy Blvd, Suite 231, Portland, OR 97232
p: 503-701-8766 f: 971-255-0727

2330 NW Flanders St., Suite 101, Portland, OR 97210
p: 503-701-8766 f: 503-241-5444

Adult ND/LAc Intake

Thank you for scheduling with us, we strive to provide the best possible integrative care for our clients. During your initial evaluation your practitioner will do their best to do a thorough evaluation and give you a treatment plan. You can assist us in that by making sure you have fully completed the intake paperwork enclosed. The advantage of the integrative office is that there are many modalities that can provide input should any of us find the need for assistance.

Please be aware that we ask patients to give us 48 hour notice if they need to reschedule or cancel an appointment. Late cancellation or missed appointments will incur a fee as we are unable to reschedule the appointment with another patient without sufficient notice.

It will be a pleasure to support you on your path towards wellness!

Patient Name:_____ Date of Birth:_____

NEW PATIENT ADULT INTAKE

Basic Information

Patient Name | **Date of Birth** | **Age** | **Gender & Preferred Pronoun**

Address | **Occupation** | Hours/week

City, State, ZIP | Employer/Address

Home Phone | Mobile Phone | Work Phone | Social Security #

Emergency Contact/Relationship | **Email:** May we contact you via email? ☐Y ☐N

Home Phone | Mobile Phone | **What is your relationship status?**

How did you hear about our clinic? | **Do you live with anyone? If so, whom?**

Medical Information

Holistic health care & preventative medicine are only possible when the physician has complete understanding of the patient physically, mentally, & emotionally. Please complete this questionnaire as thoroughly as possible. You may mark anything you don't understand with a question mark.

When & where did you last receive medical/health care? _____

For what reason? _____

Medical Concerns: Please list your health concerns, in order of importance, including what brings you in today.

1. | 4.
2. | 5.
3. | 6.

***What is your level of commitment to achieving your health goals on a scale of 1 to 10 (10 = most)?** _____

What positive attributes can you describe about your health? List as many as you can.

1. | 4.
2. | 5.
3. | 6.

Allergies/Special Health Considerations: Please list all known reactions to food, drugs, or other allergens.

1. | 3.
2. | 4.

Medical Information, continued

Medications/Supplements: Please check any that you have recently taken or are currently taking. (C = current, P = past)

Antacids	❑C ❑P	Decongestants	❑C ❑P	Pain Relievers	❑C ❑P
Antibiotics	❑C ❑P	Herbs	❑ C ❑ P	Sleeping Pills	❑ C ❑ P
Aspirin	❑C ❑P	Hormones	❑C ❑P	Thyroid Medication	❑C ❑P
Antidepressants	❑ C ❑ P	Laxatives	❑ C ❑ P	Tranquilizers	❑ C ❑ P
Cortisone	❑ C ❑ P	Minerals	❑C ❑P	Vitamins	❑C ❑P

Please list prescription medications, over the counter medications, & any supplements you are currently taking.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Hospitalizations, Surgeries, or Major Injuries: Please list the type & when it occurred.

1. _____ 3. _____

2. _____ 4. _____

X-Rays & Special Studies: Please list type & date performed (X-Rays, CT Scans, MRI/MR, PET, EKG, EEG, Ultrasound, etc)

1. _____ 3. _____

2. _____ 4. _____

Childhood Illnesses: Please check all that apply

❑ Asthma	❑ Ear Infections	❑ Pneumonia	❑ Scarlet Fever
❑ Chicken Pox	❑ Measles	❑ Polio	❑ Strep Throat
❑ Croup	❑ Mononucleosis	❑ Rheumatic Fever	❑ Tonsillitis
❑ Diphtheria	❑ Mumps	❑ Rubella/German Measles	❑ Whooping Cough

❑ Other:

Immunizations: Please check all that apply & any adverse reactions.

☐HPV	❑ MMR (measles, mumps, rubella)	❑ Polio
☐ Influenza	❑ Pertussis	❑ Rotavirus
☐ Meningococcal (MCV4)	❑ Pneumococcal	❑ Chicken Pox

❑ **DTaP (diphtheria, tetanus, pertussis)**

❑ **Hepatitis A**

❑ **Hepatitis B**

❑ Additional/Other:

Birth History:

Age of parents at conception? Mother: Father:

Brief Birth History (trauma, c-section, parental drug use, forceps, breached, etc):

Medical Information, continued

Family History: Please identify all family members who have or have had any of the following.

M = mother, MGM = maternal grandmother, MGF = maternal grandfather
F = father, PGM = paternal grandmother, PGF = paternal grandfather; S = sibling, C = child

- ❑ Allergies:
- ❑ Alzheimer's:
- ❑ Anemia:
- ❑ Arthritis:
- ❑ Asthma:
- ❑ Autoimmune:
- ❑ Birth Defects:
- ❑ Bleeding Disorder:
- ❑ Cancer (type):
- ❑ Diabetes:
- ❑ Eczema/Psoriasis:
- ❑ Food Intolerances:
- ❑ Heart Disease:
- ❑ High Blood Pressure:
- ❑ Juvenile Arthritis:
- ❑ Hypoglycemia:
- ❑ Kidney Disease:
- ❑ Mental Illness (type):
- ❑ Osteoporosis/Osteopenia:
- ❑ Seizures:
- ❑ Stroke:
- ❑ Thyroid Disorder:
- ❑ Tuberculosis:
- ❑ Other: _____

Please list each Age or Age of Death with (cause) where applicable: If multiples, please separate with a comma.

Mother: _____ Father: _____ Sibling(s): _____

General Health History: Please check all that apply (C = current, P = past)

GENERAL
- Current weight _____
- Weight 1 year ago _____
- Maximum weight/when _____
- Height _____
- Fatigue ❑C ❑P
- Night Sweats ❑C ❑P

SKIN
- Rashes ❑C ❑P
- Itching ❑C ❑P
- Eczema ❑C ❑P
- Acne ❑C ❑P
- Color Changes ❑C ❑P
- Lumps ❑C ❑P
- Bruising ❑C ❑P

HEAD
- Headaches ❑C ❑P
- Head Injury ❑C ❑P

EYES
- Impaired Vision ❑C ❑P
- Glasses/Contacts ❑C ❑P
- Eye Pain ❑C ❑P
- Dryness ❑C ❑P
- Double Vision ❑C ❑P
- Glaucoma ❑C ❑P
- Cataracts ❑C ❑P
- Floaters ❑C ❑P
- Tearing ❑C ❑P

EARS
- Impaired Hearing ❑C ❑P
- Ringing/Tinnitus ❑C ❑P
- Earache ❑C ❑P
- Dizziness/Vertigo ❑C ❑P

NOSE & SINUSES
- Frequent Colds ❑C ❑P
- Nose Bleeds ❑C ❑P
- Sinus Congestion ❑C ❑P
- Post Nasal Drip ❑C ❑P
- Sinus Infections ❑C ❑P
- Hay Fever/Allergies ❑C ❑P

MOUTH & THROAT
- Frequent Sore Throat ❑C ❑P
- Sore Tongue ❑C ❑P
- Gum Problems ❑C ❑P
- Hoarseness ❑C ❑P
- Dental Problems ❑C ❑P

NECK
- Lumps ❑C ❑P
- Swollen Glands ❑C ❑P
- Goiter (Thyroid) ❑ C ❑ P
- Pain/Stiffness ❑ C ❑ P

RESPIRATORY
- Cough ❑C ❑P
- Sputum ❑C ❑P
- Coughing Blood ❑C ❑P
- Bronchitis ❑ C ❑ P
- Pleurisy ❑ C ❑ P
- Emphysema ❑C ❑P
- Wheezing ❑C ❑P
- Asthma ❑C ❑P
- Shortness of Breath:
  - • At night ❑C ❑P
  - • Lying down ❑C ❑P
  - • With exertion ❑ C ❑ P
- Difficulty Breathing ❑ C ❑ P
- Pain w/ Breathing ❑C ❑P

Medical Information, continued

RESPIRATION, continued

- Pneumocystis ❑C ❑P
- Tuberculosis ❑C ❑P

CARDIOVASCULAR

- Heart Disease ❑C ❑P
- Chest Pain/Pressure ❑C ❑P
- Angina (diagnosed) ❑C ❑P
- Palpitations/Flutters ❑C ❑P
- High Blood Pressure ❑C ❑P
- Murmurs ❑C ❑P
- Rheumatic Fever ❑C ❑P
- Swelling/Edema ❑C ❑P

GASTROINTESTINAL

- Bowel movement frequency: _____
  - Is this a change? ❑Y ❑N
- Blood in Stool ❑C ❑P
- Diarrhea/Loose Stool ❑C ❑P
- Constipation ❑C ❑P
- Nausea/Vomiting ❑C ❑P
- Vomiting Blood ❑C ❑P
- Gallbladder Disease ❑C ❑P
- Liver Disease ❑C ❑P
- Jaundice (yellow skin) ❑C ❑P
- Change in Thirst ❑C ❑P
- Change in Appetite ❑C ❑P
- Trouble Swallowing ❑C ❑P
- Belching/Gas/Bloating ❑C ❑P
- Heartburn ❑C ❑P
- Ulcer ❑C ❑P
- Hemorrhoids ❑C ❑P

URINARY

- Pain w/ Urination ❑C ❑P
- Increased Frequency ❑C ❑P
- Urination at Night ❑C ❑P
- Inability to Hold Urine ❑C ❑P
- Difficult urination ❑C ❑P
- Kidney Stones ❑C ❑P
- Frequent infections ❑C ❑P
- Kidney Disease ❑C ❑P

FEMALE

REPRODUCTIVE

- Date of last menses: _____
- Avg# of bleeding days: _____
- Days between cycles: _____
- Date of last annual/PAP: _____
- Irregular PAP Smear ❑C ❑P
- Bleeding Between Cycle ❑C ❑P
- Painful Menses; Clots ❑C ❑P
- Excessive Flow ❑C ❑P
- Pain w/ Intercourse ❑C ❑P
- Birth Control ❑C ❑P
  - Type: _____
- Pregnancies ____ Miscarriages ____
- Live Births ____ Abortions ____
- Difficulty Conceiving ❑C ❑P
- Menopausal Symptoms ❑C ❑P
- Sexually Active ❑C ❑P
- Sexual Difficulties ❑C ❑P
- Vaginal Discharge ❑C ❑P
- STDs/STIs ❑C ❑P
- Sexual Orientation: _____
- Other: _____

Breasts

- Self-Exams ❑C ❑P
- Lumps ❑C ❑P
- Fibrocystic Breasts ❑C ❑P
- Pain/Tenderness ❑C ❑P
- Nipple Discharge ❑C ❑P

MALE REPRODUCTIVE

- Hernias ❑C ❑P
- Testicular Masses ❑C ❑P
- Prostate Disease ❑C ❑P
- Testicular Pain ❑C ❑P
- Sexually Active ❑C ❑P
- Sexual Difficulties ❑C ❑P
- Discharge or Sores ❑C ❑P
- STDs/STIs ❑C ❑P
- Sexual Orientation: _____
- Other: _____

MUSCULOSKELETAL

- Joint Pain ❑C ❑P
- Joint Stiffness ❑C ❑P
- Arthritis ❑C ❑P
- Broken Bones ❑C ❑P
- Spasms/Cramps ❑C ❑P
- Weakness ❑C ❑P

PERIPHERAL VASCULAR

- Thrombophlebitis ❑C ❑P
- Cold Hands/Feet ❑C ❑P
- Varicose Veins ❑C ❑P

NEUROLOGICAL

- Fainting ❑C ❑P
- Memory Loss ❑C ❑P
- Seizures ❑C ❑P
- Paralysis ❑C ❑P
- Muscle Weakness ❑C ❑P
- Numbness/Tingling ❑C ❑P

EMOTIONAL

- Tension ❑C ❑P
- Depression ❑C ❑P
- Mood Swings ❑C ❑P
- Anxiety ❑C ❑P

ENDOCRINE

- Hypothyroid ❑C ❑P
- Hyperthyroid ❑C ❑P
- Heat/Cold Aversion ❑C ❑P
- Excessive Thirst ❑C ❑P
- Excessive Hunger ❑C ❑P
- Diabetes ❑C ❑P

BLOOD

- Anemia ❑C ❑P
- Easy Bleeding ❑C ❑P
- Easy Bruising ❑C ❑P

SCREENING EXAMS

- Mammogram _____
- Colonoscopy _____
- Dental Exam _____
- Eye Exam _____

NEW PATIENT INTAKE FORM

What are your main interests & hobbies?

Do you sleep well? ❑ Y ☐ N | Do you wake rested? ❑Y ☐ N | Average hours of sleep/night: _____

Do you enjoy your work? ❑ Y ☐ N | Do you watch TV? ❑ Y☐N | If yes, how many hours/day? _____

Do you take vacations? ❑ Y ☐ N | Do you read? ❑ Y☐N | If yes, how many hours/day? _____

Do you spend time outside? ❑ Y ☐ N | Tobacco use? ❑ Y☐N | If yes, # of cigarettes/day: _____

Recreational drugs? ❑ Y ☐ N | Alcohol use? ❑ Y☐N | If yes, # of drinks/week: _____

Treated for drug abuse? ❑ Y ☐ N | Treated for alcoholism? ❑ Y☐N

Other (cola, sugar, salt, etc): _____

Please check all that apply to you currently:

☐ Poor appetite ☐ Heavy appetite ☐ Cravings ☐ Tremors

☐ Insomnia ☐ Heavy sleep ☐ Fevers ☐ Chills

☐ Cold back ☐ Cold abdomen ☐ Sweat easily ☐ Poor coordination

❑ Sudden energy drop at _____(time) ☐ Peculiar tastes/smells _____

❑ Strong thirst for ☐ cold or ☐ hot drinks.

Preferences:

Season	Most liked:		Least liked:	
Taste	Most liked:		Least liked:	
Climate	Most liked:		Least liked:	
Time of Day	Most liked:		Least liked:	
Temperature	Most liked:		Least liked:	

Exercise

Do you exercise? ❑Y ☐ N If so, how often? _____

What type(s)? _____

Do you enjoy it? ❑Y ☐ N Do you feel more fatigued or energized after exercise? _____

Diet & Nutrition

Do you have at least three meals a day? ❑ Y☐N Do you have any dietary restrictions? ☐Y☐N

If so, what are they?

Please describe your typical diet:

Breakfast:	Dinner:
Lunch:	Beverages:
Snacks:	Other:

Patient Name:_____ Date of Birth:_____

Informed Consent and Request for Care (Naturopathic or Medical Doctor)

As a patient, I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care having had the opportunity to discuss the potential benefits, risks, and hazards involved.
I hereby request and consent to examination and treatment with Kwan-Yin Healing Arts Center, Inc. practitioners.

I understand that I have the right to ask questions and discuss my case, to my satisfaction, with the above-mentioned provider and/or with the backup allied health care provider at **Kwan Yin Healing Arts Center.** This information may include, but is not limited to:

- My suspected diagnosis(es) or condition(s)
- The nature, purpose, goals and potential benefits of the proposed care
- The inherent risks, complications, potential hazards or side effects of the treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/or nothing is done

Naturopathic and/or Medical Evaluation Information:
I understand that a Naturopathic and/or medical evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic, and neurological assessments)
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory)
- Evaluation of blood, urine, stool, and saliva
- Soft tissue and osseous (bone) manipulation (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic/osseous manipulation of the spine and extremities, pregnancy massage [to relieve muscular discomfort associated with pregnancy], muscle energy technique, CranioSacral therapy, and Visceral Manipulation)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements, and intra-muscular vitamin injections)
- Trigger point injection therapy with vitamin substances
- Botanical/herbal medicines, prescribing of various therapeutic substances (including plant, mineral, and animal materials). Substances may be given in the forms of teas, pills, creams, powders, and/or tinctures, which may contain alcohol, suppositories, topical creams, pastes, plasters, washes or other forms.
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, which may include transcutaneous electrode stimulation)
- Counseling (including, but not limited to, visualization for improved lifestyle strategies)
- Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians or the Formulary of Oregon Medical Doctors, depending on Practitioner's particular license

Continued……..

Potential Benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential Risks: Pain, discomfort, blistering, minor bruising, discoloration of skin, infections, burns, or itching; Loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs or supplements; Soft tissue or bony injury from physical manipulations; Aggravation of pre-existing symptoms.

Notice to Pregnant Women: All female patients must alert the provider if they have confirmed or suspected pregnancy, as some of the therapies prescribed could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. Any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

Notice to Individuals with: bleeding disorders, pace makers and/or cancer: For your safety, it is vital to alert your healthcare provider of these conditions.

Please INITIAL the following:

_____ I understand that the above-mentioned provider(s) are not licensed to prescribe any controlled substances.

_____ I understand that the above-mentioned provider(s) will only prescribe mediations if they believe that they are in the best interest of myself, the patient. Appropriate referrals will be provided to manage my prescription medication needs.

_____ I understand that the US Food and Drug Administration has not approved nutritional, herbal, and homeopathic substances, however, these have been used widely in Europe, China, and the USA for years.

_____ I understand that the above-mentioned provider(s) is not a psychologist or psychiatrists. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect the above-mentioned provider(s) and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that the above-mentioned provider(s) explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services has been made to me concerning the results intended form any treatment provided to me. By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

Printed Name of Patient	Signature of Patient	Date
Printed Name of Guardian/Guarantor	Signature of Guardian/Guarantor	Date

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Name of Patient	Signature of Patient	Date
Printed Name of Guardian/Guarantor	Signature of Guardian/Guarantor	Date

Patient Name:_____ Date of Birth:_____