Kwan-Yin Healing Arts Center
2330 NW Flanders, Suite 101
Portland, OR 97210
(503) 701-8766

Thank you for scheduling with us, we strive to provide the best possible integrative care for our clients. Here at the clinic we have a team of Naturopathic Doctors, Oriental Medical Practitioners, Licensed Acupuncturists, Body Workers, Medical Doctors, Physical Therapists and Chiropractic Physicians. 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.

We are located just west of the intersection of NW 23rd and NW Flanders (between 23rd & 24th Ave.). Parking is available in the main and lower lot; please do not park below the building in the covered area. Wheelchair access for the first floor is located through the main level parking lot. Please come a few minutes early and enjoy a cup of tea before your appointment.

We ask that all new patient paperwork is filled out prior to your appointment time. If you are unable to fill out paperwork at home, please arrive 30 minutes before your scheduled appointment time to do so.

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 incur a $45.00 fee or greater, 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:_____ PATIENT DOB:_____

Acupuncture Intake

Basic Information

Name _____ Date _____

Address_____

City _____ State _____ Zip _____ Email _____

Telephone # (home) _____ (work) _____(cell)_____

Age _____ Date of Birth _____ Gender _____ Weight _____ Height _____

How did you hear about our clinic? _____

Relationship Status: □ Single □ Married □ Partnership □ Separated □ Divorced □ Widowed

Live with: □ Spouse □ Partner □ Parent/s □ Children □ Friend/s □ Alone □ Roommate/s

Emergency Contact Name _____ Relationship _____ Phone_____

Are you currently under the care of a medical professional? Y N

If YES, please provide name and contact info: _____

If NO, when and where did you last receive health care, and for what reason? _____

_____

What are your most important health concerns? List in order of importance.

1) _____

How does this affect your life? _____

2) _____

How does this affect your life? _____

3) _____

How does this affect your life? _____

4) _____

How does this affect your life? _____

Any other health issues we should be aware of?

_____

_____

General Information

Significant traumas or illnesses (auto accidents, falls, etc) _____

Birth and childhood health (forceps delivery, childhood asthma, etc)_____

What are the current stressors in your life? _____

What do you do for exercise and self-care? _____

Drug Allergies: _____

Food Allergies:_____

Environmental Allergies: _____

KWAN-YIN HEALING ARTS CENTER
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PORTLAND, OR 97210
WWW.KWANYINHEALINGARTS.COM

Acupuncture Intake

Please list any prescription medications, over the counter medications, vitamins, or supplements you are currently taking or have taken within the past 2 months: _____

_____

_____

_____

Hospitalizations and Surgeries:
_____ year:_____ _____ year:_____
_____ year:_____ _____ year:_____

Habits: ☐ Coffee ☐ Tea ☐ Soda ☐ Alcohol ☐ Drugs ☐ Sugar ☐ Salt ☐ Other_____
Tobacco use: ☐ Never smoked ☐ Former smoker ☐ Current some day smoker ☐ Light tobacco smoker
☐ Current every day smoker ☐ Heavy tobacco smoker

Typical diet, morning _____

Afternoon _____

Evening _____

Are there foods that you avoid eating? Why? _____

Please check any that apply to you currently, underline any that you have experienced significantly in the past.

GENERAL

☐ Poor sleep ☐ Heavy sleep ☐ Insomnia ☐ Fatigue
☐ Cold back ☐ Cold abdomen ☐ Autoimmune disease ☐ Frequent colds/low immunity
☐ Sudden energy drop at _____(time) ☐ Chronic or contagious disease_____

SKIN AND HAIR

☐ Night sweats ☐ Sweat easily ☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching
☐ Eczema ☐ Pimples ☐ Dandruff ☐ Changes in hair/skin texture
☐ Loss of hair ☐ Bleed/bruise easily (where)_____ ☐ Other hair or skin problems_____

HEAD, EYES, EARS, NOSE AND THROAT

☐ Dizziness ☐ Eye strain ☐ Eye pain ☐ Night blindness ☐ Spots in eyes
☐ Color blindness ☐ Cataracts ☐ Glaucoma ☐ Changes in vision
☐ Earaches ☐ Ringing in ears ☐ Poor hearing
☐ Nose bleeds ☐ Sinus problems ☐ Mucus ☐ Dry mouth or throat ☐ Copious saliva
☐ Tooth/gum problems ☐ Jaw problems ☐ Grinding teeth ☐ Facial pain
☐ Recurrent sore throats ☐ Migraines ☐ Sores on lips or tongue ☐ Peculiar tastes/smells
☐ Headaches (where and when) _____
☐ Other head or neck problems_____

CARDIOVASCULAR

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Irregular heartbeat
☐ Fainting ☐ Cold hands/feet ☐ Swelling in hands/feet ☐ Anemia
☐ Blood clots ☐ Phlebitis ☐ Difficulty breathing ☐ Other_____

RESPIRATORY

☐ Cough ☐ Allergies ☐ Coughing blood ☐ Fevers ☐ Chills
☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐ Difficulty breathing when lying down
☐ Tight chest ☐ Production of phlegm (color) _____

PATIENT NAME:_____ PATIENT DOB:_____

Acupuncture Intake

GASTROINTESTINAL

Bowel movements: Frequency _____ Color _____ Texture/shape _____

☐ Poor appetite ☐ Heavy appetite ☐ Change in appetite ☐ Cravings
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation
☐ Bad breath ☐ Gas or burping ☐ Abdominal pain or cramps
☐ Rectal pain ☐ Hemorrhoids ☐ Foul smelling stools ☐ Black or bloody stools
☐ Laxative use ____/week; type _____ ☐ Strong thirst (cold/hot drinks)

GENITO-URINARY

☐ Pain on urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate
☐ Unable to hold urine ☐ Kidney stones ☐ Sexually transmitted disease ☐ Prostate trouble
☐ Wake up to urinate _____/night; time _____

PREGNANCY AND GYNECOLOGY

Age at first menses_____ Date of most recent menses _____ Days of flow_____ Days from one cycle to next _____
Last PAP_____ Number pregnancies_____ Number births_____ ☐ Miscarriage/termination
☐ Heavy flow ☐ Light flow ☐ Cramps or clots ☐ Vaginal discharge
☐ Breast lumps ☐ Vaginal sores or pain ☐ Irregular periods ☐ Fertility challenges
Birth control: type and duration_____
Changes in body/psyche prior to menstruation_____

MUSCULSKELETAL

☐ Neck pain ☐ Upper back pain ☐ Lower back pain ☐ Sciatica pain ☐ Arthritis
☐ Muscle pains (where) _____ ☐ Joint pains (where) _____
☐ Old muscle, bone, or joint injuries _____ ☐ Other joint or bone problems_____

NEUROPSYCHOLOGICAL

☐ Tremors ☐ Vertigo ☐ Localized weakness ☐ Areas of numbness
☐ Poor coordination ☐ Poor memory ☐ Brain fog ☐ Concussion ☐ Seizures
☐ Depression ☐ Anxiety ☐ Anger ☐ Trouble managing stress
☐ Treated for emotional problems_____ ☐ Considered/attempted suicide
☐ Other neurological or psychological problems_____

Family History

Please indicate if a close relative (parent, grandparent, sibling) has any of the following:

Condition	Relative	Condition	Relative
❒ Allergies/Asthma		❒ Eczema/Psoriasis	
❒ Anemia		❒ Food Intolerances	
❒ Arthritis		❒ Heart Disease	
❒ Autoimmune Disease		❒ High Blood Pressure	
❒ Birth Defects		❒ Kidney Disease	
❒ Bleeding Disorder		❒ Mental Illness	
❒ Cancer		❒ Seizures	
❒ Depression/Anxiety		❒ Stroke	
❒ Diabetes		❒ Tuberculosis	
❒ Other:		❒ Other:	

❒ I don't know the family medical history

Thank you for choosing Kwan Yin Healing Arts Center

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