Kwan Yin Healing Arts Center East
3115 NE Sandy Blvd, Suite 231, Portland, OR 97232
p: 503-701-8766 ~ f: 888-972-5173
Adult Acu Intake

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, Licensed Acupuncturists and Massage Therapists. 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 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!

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NEW PATIENT INTAKE FORM

Basic Information

Patient Name | **Date of Birth** | **Age** | **Gender**

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.

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NEW PATIENT INTAKE FORM

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.

❑ DTaP (diphtheria, tetanus, pertussis)	☐ HPV	❑ MMR (measles, mumps, rubella)	❑ Polio
❑ Hepatitis A	☐ Influenza	❑ Pertussis	❑ Rotavirus
❑ Hepatitis B	☐ Meningococcal (MCV4)	❑ Pneumococcal	❑ Chicken Pox
❑ Additional/Other:			

Birth History:

Age of parents at conception? Mother: _____ Father: Birth Order: _____ of

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

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NEW PATIENT INTAKE FORM

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:	❑ Cancer (type):	❑ Kidney Disease:
❑ Alzheimer's:	❑ Diabetes:	❑ Mental Illness (type):
❑ Anemia:	❑ Eczema/Psoriasis:	❑ Osteoporosis/Osteopenia:
❑ Arthritis:	❑ Food Intolerances:	❑ Seizures:
❑ Asthma:	❑ Heart Disease:	❑ Stroke:
❑ Autoimmune:	❑ High Blood Pressure:	❑ Thyroid Disorder:
❑ Birth Defects:	❑ Juvenile Arthritis:	❑ Tuberculosis:
❑ Bleeding Disorder:	❑ Hypoglycemia:	❑ 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		Dryness	❑ C ❑ P	Hoarseness	❑ C ❑ P
Current weight	_____	Double Vision	❑ C ❑ P	Dental Problems	❑ C ❑ P
Weight 1 year ago	_____	Glaucoma	❑ C ❑ P	**NECK**	
Maximum weight/when	_____	Cataracts	❑ C ❑ P	Lumps	❑ C ❑ P
Height	_____	Floaters	❑ C ❑ P	Swollen Glands	❑ C ❑ P
Fatigue	❑ C ❑ P	Tearing	❑ C ❑ P	Goiter (Thyroid)	❑ C ❑ P
Night Sweats	❑ C ❑ P	**EARS**		Pain/Stiffness	❑ C ❑ P
SKIN		Impaired Hearing	❑ C ❑ P	**RESPIRATORY**	
Rashes	❑ C ❑ P	Ringing/Tinnitus	❑ C ❑ P	Cough	❑ C ❑ P
Itching	❑ C ❑ P	Earache	❑ C ❑ P	Sputum	❑ C ❑ P
Eczema	❑ C ❑ P	Dizziness/Vertigo	❑ C ❑ P	Coughing Blood	❑ C ❑ P
Acne	❑ C ❑ P	**NOSE & SINUSES**		Bronchitis	❑ C ❑ P
Color Changes	❑ C ❑ P	Frequent Colds	❑ C ❑ P	Pleurisy	❑ C ❑ P
Lumps	❑ C ❑ P	Nose Bleeds	❑ C ❑ P	Emphysema	❑ C ❑ P
Bruising	❑ C ❑ P	Sinus Congestion	❑ C ❑ P	Wheezing	❑ C ❑ P
HEAD		Post Nasal Drip	❑ C ❑ P	Asthma	❑ C ❑ P
Headaches	❑ C ❑ P	Sinus Infections	❑ C ❑ P	Shortness of Breath:	
Head Injury	❑ C ❑ P	Hay Fever/Allergies	❑ C ❑ P	• At night	❑ C ❑ P
EYES		**MOUTH & THROAT**		• Lying down	❑ C ❑ P
Impaired Vision	❑ C ❑ P	Frequent Sore Throat	❑ C ❑ P	• With exertion	❑ C ❑ P
Glasses/Contacts	❑ C ❑ P	Sore Tongue	❑ C ❑ P	Difficulty Breathing	❑ C ❑ P
Eye Pain	❑ C ❑ P	Gum Problems	❑ C ❑ P	Pain w/ Breathing	❑ C ❑ P

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NEW PATIENT INTAKE FORM

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 _____

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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: