



Kwan Yin Healing Arts Center East

3115 NE Sandy Blvd, Suite 231, Portland, OR 97232

p: 503-701-8766 f: 888-972-5173

Adult ND 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	<input type="checkbox"/> C <input type="checkbox"/> P	Decongestants	<input type="checkbox"/> C <input type="checkbox"/> P	Pain Relievers	<input type="checkbox"/> C <input type="checkbox"/> P
Antibiotics	<input type="checkbox"/> C <input type="checkbox"/> P	Herbs	<input type="checkbox"/> C <input type="checkbox"/> P	Sleeping Pills	<input type="checkbox"/> C <input type="checkbox"/> P
Aspirin	<input type="checkbox"/> C <input type="checkbox"/> P	Hormones	<input type="checkbox"/> C <input type="checkbox"/> P	Thyroid Medication	<input type="checkbox"/> C <input type="checkbox"/> P
Antidepressants	<input type="checkbox"/> C <input type="checkbox"/> P	Laxatives	<input type="checkbox"/> C <input type="checkbox"/> P	Tranquilizers	<input type="checkbox"/> C <input type="checkbox"/> P
Cortisone	<input type="checkbox"/> C <input type="checkbox"/> P	Minerals	<input type="checkbox"/> C <input type="checkbox"/> P	Vitamins	<input type="checkbox"/> C <input type="checkbox"/> 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

<input type="checkbox"/> Asthma	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Polio	<input type="checkbox"/> Strep Throat
<input type="checkbox"/> Croup	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella/German Measles	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Other:			

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

<input type="checkbox"/> DTaP (diphtheria, tetanus, pertussis)	<input type="checkbox"/> HPV	<input type="checkbox"/> MMR (measles, mumps, rubella)	<input type="checkbox"/> Polio
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pertussis	<input type="checkbox"/> Rotavirus
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Meningococcal (MCV4)	<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> 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

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

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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/Flutter 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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NEW PATIENT INTAKE FORM

What are your main interests & hobbies?

Do you sleep well?	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you wake rested?	<input type="checkbox"/> Y <input type="checkbox"/> N	Average hours of sleep/night:	_____
Do you enjoy your work?	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you watch TV?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how many hours/day?	_____
Do you take vacations?	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you read?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how many hours/day?	_____
Do you spend time outside?	<input type="checkbox"/> Y <input type="checkbox"/> N	Tobacco use?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, # of cigarettes/day:	_____
Recreational drugs?	<input type="checkbox"/> Y <input type="checkbox"/> N	Alcohol use?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, # of drinks/week:	_____
Treated for drug abuse?	<input type="checkbox"/> Y <input type="checkbox"/> N	Treated for alcoholism?	<input type="checkbox"/> Y <input type="checkbox"/> N		
Other (cola, sugar, salt, etc):	_____				

Please check all that apply to you currently:

<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Heavy appetite	<input type="checkbox"/> Cravings	<input type="checkbox"/> Tremors
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Heavy sleep	<input type="checkbox"/> Fevers	<input type="checkbox"/> Chills
<input type="checkbox"/> Cold back	<input type="checkbox"/> Cold abdomen	<input type="checkbox"/> Sweat easily	<input type="checkbox"/> Poor coordination
<input type="checkbox"/> Sudden energy drop at _____ (time)	<input type="checkbox"/> Peculiar tastes/smells _____		
<input type="checkbox"/> Strong thirst for <input type="checkbox"/> cold or <input type="checkbox"/> 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: _____

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NEW PATIENT INTAKE FORM

Informed Consent and Request for Care (Naturopathic)

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 with Dr. Amalia Treadwell, ND/LAc, Dr. Ashlie Hempstead ND/LAc, Dr. Clara Fashana ND/LAc, Dr. Ilana Gurevich ND/LAc, Dr. Rebecca Principe ND, Dr. Natalie Hanan ND/LAc, Dr. Kathryn Kloos ND/ LMT having had the opportunity to discuss the potential benefits, risks, and hazards involved.

I, _____, hereby request and consent to examination and treatment with the above-mentioned provider.

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 East**. 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 Evaluation Information:

I understand that a Naturopathic 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)

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NEW PATIENT INTAKE FORM

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 medications 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 from 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