**Kwan Yin Healing Arts Center East**
3115 NE Sandy Blvd, Suite 231, Portland, OR 97232
p: 503-719-4533 f: 888-972-5173

Date: _____

Patient/Client Name: _____

Date of Birth: _____ Age: _____

Previous Primary Care Provider (if any): _____
Other Physicians involved in your care (i.e. cardiologist, pulmonologist, gynecologist, ect): _____

**Reason for visit today:**

_____

_____

_____

**Please prioritize your top 3 concerns to address today:**

1. _____
2. _____
3. _____

**Allergies: (Medication/Food, indicate reaction):**

_____

_____

**Medication List: (Please list name/dose/frequency):**

_____ _____

_____ _____

_____ _____

**Family History: (Please indicate medical issues, deceased or alive and age)**

_____ _____

_____ _____

**Habits** :

Caffeine: □ None □ Yes: What kind_____ How many/day _____

Alcohol: □ None □ Yes: How many drinks/day_____ frequency/week_____
What kind_____

Tobacco: □ Never
□ Former: What type_____ How long _____
How often per day _____ When did you quit _____
□ Current: What type_____ When did you start_____
How often per day _____

Recreational Drugs: □ None □ Yes: What kind_____
(incl. Marijuana) How often_____

**Social History**:

Do you exercise? □ No □ Yes, how often/what type?_____

Work: □ Employed- Current Occupation_____
□ Unemployed □ Retired □ Disabled
Former Occupation_____

Marital Status: □ Single □ Married □ Domestic Partner □ Divorced

Sexual Preference: □ Women □ Men □ Both

Children (age):_____

**Females only**:

Date of last period:_____ Are your periods regular? Y N

Menstrual Period Duration:_____ Interval between periods:_____

Age at onset menstruation:_____ Last pap smear:_____

History of abnormal pap? Y N → If yes, date:_____

Total Pregnancies:_____ Total live births:_____ Total C-section:_____

Total Miscarriages:_____ Total abortions:_____

**Past Surgical History(indicate date)**:

□ None
□ Cataracts _____
□ LASIK _____
□ Tonsillectomy _____
□ Thyroidectomy _____
□ Adenoidectomy _____
□ Coronary Bypass _____
□ Cardiac Stents _____
□ Pacemaker _____
□ Heart Valve _____
□ Gall Bladder _____
□ Appendectomy _____
□ Bowel/Stomach Resection _____
□ Hemorrhoidectomy _____
□ Bariatric surgery _____
□ Hysterectomy _____
□ Endoscopy _____
□ Colonoscopy _____
□ Hernia _____
□ Spinal Surgery _____
□ Tubal Ligation _____
□ Bladder surgery _____
□ Prostate surgery/resection _____
□ C-section _____
□ Orthopedic/joints _____
_____
□ Other _____
_____

**Past Medical History:**

| | | | |
|---|---|---|---|
| Head Aches | ☐ No | ☐ Yes | Date:_____ |
| Stroke | ☐ No | ☐ Yes | _____ |
| Seizures | ☐ No | ☐ Yes | _____ |
| Pneumonia | ☐ No | ☐ Yes | _____ |
| Diabetes (Type 1 or 2) | ☐ No | ☐ Yes | _____ |
| Thyroid Disease | ☐ No | ☐ Yes | _____ |
| Glaucoma | ☐ No | ☐ Yes | _____ |
| Macular Degeneration | ☐ No | ☐ Yes | _____ |
| Hearing Loss | ☐ No | ☐ Yes | _____ |
| High Blood Pressure | ☐ No | ☐ Yes | _____ |
| Blood Clots | ☐ No | ☐ Yes | _____ |
| Pulm Emboli (lung) | ☐ No | ☐ Yes | _____ |
| DVT (leg) | ☐ No | ☐ Yes | _____ |
| Heart Burn, Reflux | ☐ No | ☐ Yes | _____ |
| Stomach Ulcers | ☐ No | ☐ Yes | _____ |
| Heart Disease | ☐ No | ☐ Yes | _____ |
| Coronary Disease | ☐ No | ☐ Yes | _____ |
| MI/Heart attacks | ☐ No | ☐ Yes | _____ |
| Congestive Heart Failure | ☐ No | ☐ Yes | _____ |
| Atrial Fibrillation | ☐ No | ☐ Yes | _____ |
| Angina | ☐ No | ☐ Yes | _____ |
| Valve Disorder | ☐ No | ☐ Yes | _____ |
| High Cholesterol | ☐ No | ☐ Yes | _____ |
| Gastrointestinal Bleeding | ☐ No | ☐ Yes | _____ |
| Hepatitis (A, B, C) | ☐ No | ☐ Yes | _____ |
| HIV/AIDS | ☐ No | ☐ Yes | _____ |
| Chronic Wounds | ☐ No | ☐ Yes | _____ |
| Cancer (type) | ☐ No | ☐ Yes | _____ |
| Urinary Tract Infections | ☐ No | ☐ Yes | _____ |
| Incontinence | ☐ No | ☐ Yes | _____ |
| Kidney Stones | ☐ No | ☐ Yes | _____ |
| COPD (Emphysema, Bronchitis) | ☐ No | ☐ Yes | _____ |
| Asthma | ☐ No | ☐ Yes | _____ |
| Depression | ☐ No | ☐ Yes | _____ |
| Bipolar Disorder | ☐ No | ☐ Yes | _____ |
| Anxiety | ☐ No | ☐ Yes | _____ |
| Fibromyalgia | ☐ No | ☐ Yes | _____ |
| Chronic Fatigue Syndrome | ☐ No | ☐ Yes | _____ |
| Arthritis | ☐ No | ☐ Yes | _____ |
| Gout | ☐ No | ☐ Yes | _____ |
| Osteoporosis | ☐ No | ☐ Yes | _____ |
| Prostate Disease | ☐ No | ☐ Yes | _____ |
| Breast Disease | ☐ No | ☐ Yes | _____ |
| Erectile Dysfunction | ☐ No | ☐ Yes | _____ |

Other_____

## Review of Systems (√ Yes or No for symptoms in the past **6 months**, circle for symptoms **today**)

### Constitutional/Endocrine

| | | |
|---|---|---|
| ◻ Yes | ◻ No | Fever |
| ◻ Yes | ◻ No | Chills |
| ◻ Yes | ◻ No | Weakness/Fatigue |
| ◻ Yes | ◻ No | Weight Loss |
| ◻ Yes | ◻ No | Weight Gain |
| ◻ Yes | ◻ No | Insomnia |
| ◻ Yes | ◻ No | Snoring |
| ◻ Yes | ◻ No | Excessive thirst |
| ◻ Yes | ◻ No | Excessive urination |
| ◻ Yes | ◻ No | Cold or Heat intolerance |

Other: _____

### HEENT

| | | |
|---|---|---|
| ◻ Yes | ◻ No | Sore throat |
| ◻ Yes | ◻ No | Stiff Neck |
| ◻ Yes | ◻ No | Change in your voice |
| ◻ Yes | ◻ No | Sinus Drainage |
| ◻ Yes | ◻ No | Sinus Headache |
| ◻ Yes | ◻ No | Nose Bleeds |
| ◻ Yes | ◻ No | Ear ache/drainage |
| ◻ Yes | ◻ No | Hearing loss |
| ◻ Yes | ◻ No | Ringing in your ears |
| ◻ Yes | ◻ No | Blurred/Loss of Vision |
| ◻ Yes | ◻ No | Wear glasses or contacts |
| ◻ Yes | ◻ No | Itchy/watery eyes |
| ◻ Yes | ◻ No | Dental Problems |

Other: _____

### Gastrointestinal

| | | |
|---|---|---|
| ◻ Yes | ◻ No | Nausea/Vomiting |
| ◻ Yes | ◻ No | Difficulty swallowing |
| ◻ Yes | ◻ No | Hemorrhoids |
| ◻ Yes | ◻ No | Diarrhea |
| ◻ Yes | ◻ No | Constipation |
| ◻ Yes | ◻ No | Bloody or Black Stools |
| ◻ Yes | ◻ No | Abdominal pain |
| ◻ Yes | ◻ No | Heartburn/indigestion |
| ◻ Yes | ◻ No | Frequent use of Laxatives |

Other: _____

### Urinary

| | | |
|---|---|---|
| ◻ Yes | ◻ No | Pain or burning w/ urination |
| ◻ Yes | ◻ No | Urinary Frequency (Night or Day) |
| ◻ Yes | ◻ No | Blood in urine/ Dark urine |
| ◻ Yes | ◻ No | Incontinence |
| ◻ Yes | ◻ No | Slow starting or stopping urine |

Other: _____

### Genital/Sex Organs

| | | |
|---|---|---|
| ◻ Yes | ◻ No | Penile Discharge |
| ◻ Yes | ◻ No | Testicular lump/pain |
| ◻ Yes | ◻ No | Breast pain/discharge/lump |
| ◻ Yes | ◻ No | Painful Intercourse |
| ◻ Yes | ◻ No | Lack of Sexual Desire |
| ◻ Yes | ◻ No | Problems with Performance |

Other: _____

### Female reproductive

| | | |
|---|---|---|
| ◻ Yes | ◻ No | Hot Flashes |
| ◻ Yes | ◻ No | Bleeding after menopause |
| ◻ Yes | ◻ No | Excessive menstrual bleeding |
| ◻ Yes | ◻ No | Unusual Vaginal Discharge |
| ◻ Yes | ◻ No | Menstrual pain/cramps |
| ◻ Yes | ◻ No | Spotting between periods |

Other: _____

### Cardiac

| | | |
|---|---|---|
| ◻ Yes | ◻ No | Chest pain |
| ◻ Yes | ◻ No | Palpitation |
| ◻ Yes | ◻ No | Irregular Heartbeat |
| ◻ Yes | ◻ No | Exercise intolerance |
| ◻ Yes | ◻ No | Leg swelling |

Other: _____

### Respiratory

| | | |
|---|---|---|
| ◻ Yes | ◻ No | Persistent Cough |
| ◻ Yes | ◻ No | Coughing up Blood |
| ◻ Yes | ◻ No | Shortness of Breath |
| ◻ Yes | ◻ No | Wheezing |
| ◻ Yes | ◻ No | Difficulty breathing lying flat |

Other: _____

### Skin

| | | |
|---|---|---|
| ◻ Yes | ◻ No | Rashes/Hives |
| ◻ Yes | ◻ No | Skin discoloration |
| ◻ Yes | ◻ No | Lesions/moles/warts |
| ◻ Yes | ◻ No | Ulcers |
| ◻ Yes | ◻ No | Itching |
| ◻ Yes | ◻ No | Nail Problems |
| ◻ Yes | ◻ No | Unusual Hair Loss |
| ◻ Yes | ◻ No | Easy Bruising |

Other: _____

### Psych

| | | |
|---|---|---|
| ◻ Yes | ◻ No | Depressed Mood |
| ◻ Yes | ◻ No | Suicidal Thoughts/Plans |
| ◻ Yes | ◻ No | Agitation/Irritability |
| ◻ Yes | ◻ No | Insomnia |
| ◻ Yes | ◻ No | Anxiety |
| ◻ Yes | ◻ No | Frequent Crying Spells |

Other: _____

### Musculoskeletal

| | | |
|---|---|---|
| ◻ Yes | ◻ No | Joint pains or stiffness |
| ◻ Yes | ◻ No | Joint Swelling |
| ◻ Yes | ◻ No | Muscle Weakness |
| ◻ Yes | ◻ No | Back Pain |
| ◻ Yes | ◻ No | Muscle Spasms/Cramps |
| ◻ Yes | ◻ No | Falling |

Other: _____

### Neurologic

| | | |
|---|---|---|
| ◻ Yes | ◻ No | Frequent Headache |
| ◻ Yes | ◻ No | Seizures |
| ◻ Yes | ◻ No | Syncope (fainting) |
| ◻ Yes | ◻ No | Limb Weakness |
| ◻ Yes | ◻ No | Dizziness |
| ◻ Yes | ◻ No | Difficulty Swallowing |
| ◻ Yes | ◻ No | Balance Issues |
| ◻ Yes | ◻ No | Tremors |
| ◻ Yes | ◻ No | Rigidity |

Other: _____

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# Informed Consent and Request for Care (Naturopathic, Medical Doctor, or Family Nurse Practitioner)

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 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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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 |
|---|---|---|