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 code _____

Telephone # (home)_____ _____ (work) _____

(cell)_____ Email Address _____

Age _____ Date of Birth _____ Gender _____

How did you hear about our clinic?_____

Emergency Contact: Name_____ Relationship_____

Phone _____

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

If yes, whom and where from?_____

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

_____

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

1) _____
2) _____
3) _____
4) _____
5) _____

General Information

Weight_____lbs. Height_____

Significant Traumas (auto accidents, falls, etc) _____

Birth history (prolonged labor, forceps delivery, etc)_____

Occupational Stresses (chemical, physical, psychological)_____

Exercise_____

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

1)_____ 2)_____
3)_____ 4)_____
5)_____ 6)_____

Do you have allergies? If yes, what kind?
Drugs _____
Foods_____
Environmentals_____

What hospitalizations or surgeries have you had?

KWAN-YIN HEALING ARTS CENTER 2330 NW FLANDERS ST. SUITE 101 PORTLAND, OR 97210
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Acupuncture Intake

_____ year:_____ _____ year:_____
_____ year:_____ _____ year:_____

Habits: Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other_____

Average Daily Diet:

Morning _____

Afternoon _____

Evening _____

Please check any that apply to you currently

☐ Poor appetite ☐ Heavy appetite ☐ Poor sleep ☐ Heavy sleep

☐ Insomnia ☐ Fatigue ☐ Tremors ☐ Vertigo

☐ Cold hands ☐ Cold feet ☐ Cold back ☐ Cold abdomen

☐ Fevers ☐ Chills ☐ Night sweats ☐ Sweat easily

☐ Cravings ☐ Localized weakness ☐ Poor coordination ☐ Change in appetite

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

☐ Strong thirst (cold/hot drinks) _____☐ Bleed or bruise easily (where)_____

Family History

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

Condition	Relative	Condition	Relative
❒ Allergies/Hay fever		❒ Eczema/Psoriasis	
❒ Anemia		❒ Food Intolerances	
❒ Arthritis		❒ Heart Disease	
❒ Asthma		❒ High Blood Pressure	
❒ Autoimmune Disease		❒ Juvenile Arthritis	
❒ 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

SKIN AND HAIR

☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching
☐ Eczema ☐ Pimples ☐ Dandruff ☐ Changes in hair/skin texture
☐ Loss of hair ☐ Purpura ☐ Other hair or skin problems_____

HEAD, EYES, EARS, NOSE AND THROAT

☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses
☐ Eye strain ☐ Eye pain ☐ Poor vision ☐ Night blindness
☐ Color blindness ☐ Cataracts ☐ Blurry vision ☐ Earaches
☐ Ringing in ears ☐ Poor hearing ☐ Nose bleeds ☐ Sinus problems
☐ Mucus ☐ Dry throat ☐ Dry mouth ☐ Copious saliva

PATIENT NAME:_____ PATIENT DOB:_____

Acupuncture Intake

□ Teeth problems □ Jaw clicks □ Grinding teeth □ Facial pain
□ Gum problems □ Spots in eyes □ Recurrent sore throats _____/month
□ Sores on lips or tongue □ Headaches (where and when)_____
□ Other head or neck problems_____

CARDIOVASCULAR

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

RESPIRATORY

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

GASTROINTESTINAL

□ Nausea □ Vomiting □ Diarrhea Bowel movements:
□ Gas □ Belching □ Black stools _____Frequency
□ Bad breath □ Rectal pain □ Hemorrhoids _____Color
□ Constipation □ Bloody stools □ Sensitive abdomen _____Odor
□ Pain or cramps □ Laxative use _____/week; type _____Texture/form

GENITO-URINARY

□ Pain on urination □ Frequent urination □ Blood in urine □ Urgency to urinate
□ Unable to hold urine □ Kidney stones □ Venereal disease □ Impotency
□ Wake up to urinate _____/night; time _____

PREGNANCY AND GYNECOLOGY

□ Number pregnancies_____ □ Age at first menses_____ □ Flow _____ □ Clots
□ Vaginal discharge □ Period (days)_____ □ Duration_____
□ Last menses_____ □ Menopause_____ □ Last PAP_____
□ Number births_____ □ Premature births_____ □ Miscarriages_____
□ Breast lumps □ Vaginal sores
Birth control: type and duration_____
Changes in body/psyche prior to menstruation_____

MUSCULSKELETAL

□ Neck pain □ Muscle pains □ Back pain (where)_____
□ Joint pain (where)_____ □ Other joint or bone problems_____

NEUROPSYCHOLOGICAL

□ Seizures □ Areas of numbness □ Poor memory □ Concussion
□ Depression □ Anxiety □ Bad temper □ Easily stressed
□ Treated for emotional problems_____
□ Considered/attempted suicide
□ Other neurological or psychological problems_____

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_____

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