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, Psychologists, 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 on 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 hours 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:_____

Informed Consent and Request for Care

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. Ami Kapadia MD, Dr. Cara Orscheln ND, Dr. Chloe Scheel ND/Lac, Dr. David Chang ND/LAc, Dr. David Palacios ND, Dr. Gibran Ramos ND/ LAc, Dr. Ilana Gurevich ND/LAc, Dr. Kellyn Adams ND/LAc, Dr. Kitt Guaraldi ND, Dr. Lindsay Wilkinson ND/Lac, Dr. Loren Lubin ND/Lac, Dr. Meghan Larivee ND/LAc, Dr Melissa Kuser ND/LAc, Dr. Petra Caruso ND, Dr. Stefani Hayes ND/LAc, Dr. Theo Badger ND/LAc, Dr. Whitney Hayes ND/Lac, Clifford Meeks Lac, Daniel Raider Lac, David Berkshire Lac, Jenny Netzer Lac, Joanna Present Wolfe Lac, Justin Levy Lac, Kim Klingele Lac, Leela Longson Lac, Martha Blessington Lac, Muir Ferdun Lac, Myra Theriault Lac, DA Wiley Lac, or Xiaoli Chen LAc 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 providers.

I understand that I have the right to ask questions and discuss to my satisfaction with the above mentioned providers and/ or with the allied health care provider providing backup:

- 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 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

Medical and Naturopathic Evaluation information:
I understand that Medical evaluation and/or Naturopathic evaluation treatment may include, but is 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 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 and cranio-sacral therapy)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Trigger point injection therapy with or without 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, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, 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 with regards to NDs)

PATIENT NAME:_____ PATIENT DOB:_____

Notices

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, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs, 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 suspect 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 provider of these conditions.

Please INITIAL the following:
_____ I understand that the above mentioned providers are not licensed to prescribe any controlled substances or for those providers who are licensed to prescribe controlled substances, they do not prescribe these types of medication at this facility.
_____ I understand that the above mentioned providers will only prescribe medications if they believe that they are in the best interest of myself, the patient. Referrals will be provided to manage my prescriptive medication needs when appropriate.
_____ I understand 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 providers are not psychologists or psychiatrists. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect the above mentioned providers 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 providers explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have 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 Signature of Guardian Date

PATIENT NAME:_____ PATIENT DOB:_____

Basic Information

Child's name _____ Date _____

Address_____

Date of Birth _____ Age _____ Gender _____ Weight_____ Height_____ School and Grade _____

How did you hear about us? (Referred by)_____

Name and relation of individual who is filling out this form: _____

Parent/Guardian name: _____ Email: _____

Address if different: _____ Phone:_____

Parent/Guardian name: _____ Email: _____

Address if different: _____ Phone:_____

Child lives with_____

Primary care doctor: _____Other treaters: _____

What are the most important health concerns? List in order of importance and for how long.

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

Hospitalizations, surgeries, or traumas?

_____ age:_____ _____ age:_____

_____ age:_____ _____ age:_____

Please list any prescription medications, over the counter medications, vitamins, or supplements child is currently taking or has taken **within the past 2 months including dosage**:

_____ dosage _____ _____ dosage_____

_____ dosage _____ _____ dosage_____

Any allergies? Drugs _____

Foods_____ Environmentals_____

Birth and Infancy

How was the (emotional and physical) health of the parents during conception and pregnancy?

_____

Do either of the parents have a chronic illness? □ No □ Yes, describe _____

Any history of fertility issues, miscarriages, or complications? _____

Mother's age at child's birth? _____ Length of labor: _____ Birth weight: _____

Any exposure during pregnancy to: □ Poor diet □ Tobacco □ Alcohol □ Recreational drugs □ Medications

□ Vitamins or supplements Describe _____

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PORTLAND, OR 97210
WWW.KWANYINHEALINGARTS.COM

Location of birth: ☐ Hospital ☐ Home ☐ Birthing Center ☐ Other: _____

☐ Pre-term (<37 weeks) _____ weeks ☐ Full-term (38-42) _____ weeks ☐ Post-term (>42) _____ weeks

☐ Vaginal delivery ☐ Scheduled C-section ☐ Emergency C-section

☐ Induced labor/Pitocin ☐ Epidural/Anesthesia ☐ Forceps/Vacuum extraction ☐ Episiotomy

☐ Jaundice ☐ Infection ☐ Birth injury/defect ☐ Feeding difficulty/colic/reflux ☐ Unusual APGARs

Any complications around labor/delivery (e.g., breech delivery)? _____

_____

☐ Breastmilk exclusively until age _____ ☐ Breastmilk plus formula ☐ Formula primarily

Started supplementary foods age _____ Weaned from the breast age _____

At what age did the child first: Sit up _____ Crawl _____ Walk _____ Talk _____

Baby had challenges with: ☐ Food introductions ☐ Teething ☐ Sleep ☐ Toilet training

Baby received: ☐ All recommended childhood vaccines ☐ Modified vaccination schedule ☐ Unvaccinated

☐ Showed mild or severe reactions to vaccines (describe) _____

Anything else about baby's health in the first year? _____

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	

❒ I don't know the family medical history

General Health

Y = a condition child has now **N** = never had **P** = a condition child had in the past

Headaches	Y	N	P	Jaw problems	Y	N	P	Hay fever/Allergies	Y	N	P
Trouble with eyes	Y	N	P	Smoker in family	Y	N	P	Hearing trouble	Y	N	P
Dizziness/Vertigo	Y	N	P	Sinus problems	Y	N	P	Nose bleeds	Y	N	P
High Fever	Y	N	P	Ear infections	Y	N	P	Asthma/Wheezing	Y	N	P
Frequent colds	Y	N	P	Swollen glands	Y	N	P	Bronchitis/Pneumonia	Y	N	P
Chicken Pox	Y	N	P	Strep throat	Y	N	P	Lyme	Y	N	P

PATIENT NAME:_____ PATIENT DOB:_____

Steroids	Y N P	Inhalers	Y N P	Frequent antibiotics	Y N P
Fainting	Y N P	Bleeding/Bruising	Y N P	Murmurs	Y N P
Fever reducing meds	Y N P				
Vomiting	Y N P	Poor appetite	Y N P	Pain or cramps	Y N P
Nausea	Y N P	Constipation	Y N P	Diarrhea	Y N P
Issues around urination	Y N P	Anemia	Y N P	Stomachaches	Y N P
Bedwetting	Y N P	Jaundice	Y N P	Gas or colic	Y N P
Joint pain or stiffness	Y N P	Broken bones	Y N P	Slow wound healing	Y N P
Seizures	Y N P	Loss of balance	Y N P	Cold hands or feet	Y N P
Sleep challenges	Y N P	Concussion	Y N P	Fatigue/low energy	Y N P
Rashes/Hives	Y N P	Dandruff	Y N P	Body/breath odor	Y N P
Itching	Y N P	Eczema	Y N P	Unusual sweats	Y N P
Depression	Y N P	Bad temper	Y N P	Easily stressed	Y N P
Anxiety	Y N P	Nervous/moody	Y N P	Nightmares	Y N P
Cries easily	Y N P	Unusual fears	Y N P	History of abuse	Y N P

Any concerns around sleeping? _____

What time does the child usually go to bed? _____Wake? _____ Nap? _____ Total hours _____

Any concerns around eating? _____

Eating habits (good appetite, picky eater, tastes, textures, etc.)? _____

Any (known or suspected) food allergies or intolerances? _____

Bowel movements frequency: _____ Color _____ Form _____

Average Daily Diet: _____

_____

Any concerns around social development and moods? _____

Child is in: □ School □ Group daycare □ Home daycare □ Not in care

Behavior at school? _____

Behavior at home? _____

Extra-curricular or recreational activities? _____

How often/what kind of exercise? _____

How much television does the child watch? _____ hours a week.

Any concerns about environmental factors? _____

Any toxins or other hazards that the child is/was exposed to? □ No □ Yes _____

Is there anything that you feel is important that has not been covered?_____

_____

PATIENT NAME:_____ PATIENT DOB:_____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

This Physician-Patient Arbitration Agreement ("Agreement") is entered into by and between patient _____ **("Patient")** and _____ **("Physician").** As used herein, "Physician" refers to the physician(s), medical group(s) and/or association(s) named below and also includes their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers.

Article 1: **Agreement to Arbitrate:** It is understood that any dispute between Patient and Physician as to medical malpractice will be determined by submission to arbitration as provided by Oregon law, and not by a lawsuit or resort to court process, except as Oregon law provides for judicial review of arbitration proceedings. As used in this Agreement, "medical malpractice" refers to disputes relating to whether any medical services rendered were unnecessary, unauthorized or was improperly, negligently or incompetently rendered. Patient and Physician hereby expressly acknowledges that each is giving up their constitutional right to have medical malpractice disputes between them decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated:** Patient and Physician understand that this Agreement shall apply to all malpractice claims or controversies between them whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided, or not provided, by Physician to Patient. The parties agree that this Agreement extends and applies to any spouse, heirs or children of Patient, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "Patient" as used herein shall mean both the mother and the mother's expected child or children.

Filing of any action in any court by Physician to collect any fee from Patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the name(s), address(es) and telephone numbers of Patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator to preside over the matter. In the event the parties cannot agree on a neutral arbitrator, either party may petition a Circuit Court of Oregon to appoint a neutral arbitrator. In resolving the dispute, the arbitrator shall issue a written reasoned opinion. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and in no event can he/she pursue a claim that is barred by the applicable statute(s) of limitation. The arbitration shall be governed pursuant to Oregon Revised Statutes §§ 36.600-36.740 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

PATIENT NAME:_____ PATIENT DOB:_____

Article 4: **Retroactive Effect:** Patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.
Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with Oregon Law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Kwan-Yin Healing Arts Center

_____ _____

Print or Stamp Name of Physician, Medical Group or Association Name

Patient's Signature (Date)

_____

Print Patient's Name

_____

Patient's Representative's Signature (Date)
(if applicable)

_____

Print Name and Relationship to Patient

A signed copy of this document is available at the patient's request. The original copy will be archived in the patient's medical file

PATIENT NAME:_____ PATIENT DOB:_____