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.

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 will incur a fee, 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.

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 practitioners of Kwan Yin Healing Arts Center, Inc. having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____, hereby request and consent to examination and treatment with Kwan-Yin Healing Arts Center, Inc. practitioners.

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)

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

Basic Information

Name _____ Date _____

Address_____

City _____ State _____ Zip code _____

Telephone # (home)_____ (work) _____

(cell)_____ Email Address _____

Age _____ Date of Birth _____ Gender Identity_____ Preferred Pronouns_____

Relationship Status: ☐ Single ☐ Married ☐ Partnership ☐ Separated ☐ Divorced ☐ Widowed

Live with: ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone ☐ Roommates

Occupation _____ Hours per week ____ Retired _____

How did you hear about our clinic?_____

Emergency Contact: Name_____ Relationship_____

Phone _____

What are your most important health concerns? List in order of importance and for how long you have had each of these concerns or conditions.

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

Are you currently under the care of a medical professional?
If yes, whom and where from?_____

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

_____

General Information

Weight_____lbs. Weight one year ago_____lbs. Maximum Weight_____lbs.

When?_____ 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 including dosage** (attach additional sheet if necessary):

1)_____Dosage_____2)_____Dosage_____
3)_____Dosage_____4)_____Dosage_____
5)_____Dosage_____6)_____Dosage_____
7)_____Dosage_____8)_____Dosage_____

Do you have allergies? If yes, what kind?

Drugs _____
Foods_____
Environmentals_____

What hospitalizations, surgeries, or traumas have you had?

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

How many hours of screen time (TV, Phone, Computer) per day/week?_____ /_____

Habits: ☐Cigarettes ☐Coffee ☐Tea ☐Cola ☐Alcohol ☐Drugs ☐Sugar ☐Salt Other_____

Average Daily Diet: _____

Morning _____

Afternoon _____

Evening _____

Snacks/Desserts _____

Please check any that apply to you currently

☐ Poor appetite	☐ Heavy appetite	☐ Poor sleep	☐ Heavy sleep
☐ Insomnia	☐ Change in appetite	☐ Tremors	☐ Vertigo
☐ Cold hands	☐ Fatigue	☐ Cold back	☐ Cold abdomen
☐ Fevers	☐ Cold feet	☐ Night sweats	☐ Sweat easily
☐ Cravings (sweet/salty)	☐ Chills	☐ Localized weakness	☐ Poor coordination

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

For the following sections (please circle)

Yes/now = a condition you have now **Blank** = never had **Previously** = a condition you had previously

Childhood Illnesses					
Scarlet Fever		Diphtheria		Rheumatic Fever	
Mumps		Measles		German Measles	
Chicken Pox					
Immunizations					
Polio		Pertussis		Flu	
Tetanus		Diphtheria	Yes/now	Chicken Pox	
Measles/Mumps/Rubella		Hep B		H. Influnzae (HIB)	
Head					
Headaches		Migraines		Head Injury	
Jaw/TMJ problems					
Eyes					
Spots in Eyes		Cataracts		Impaired vision	
Glasses or contacts		Blurriness		Eye pain/strain	
Color blindness		Tearing or dryness		Double vision	
Glaucoma					
Ears					
Impaired hearing		Ringing		Earaches	
Dizziness					
Nose and Sinuses					
Frequent colds		Nose bleeds		Stuffiness	
Hay fever		Sinus problems		Loss of smell	
Neck					
Lumps		Swollen glands		Goiter	
Pain or stiffness					

For the following sections (please circle)

Yes/now = a condition you have now **Blank** = never had **Previously** = a condition you had previously

Mouth and Throat					
Frequent sore throat		Copious saliva		Teeth grinding	
Sore tongue/lips		Gum problems		Hoarseness	
Dental cavities		Jaw clicks			
Cardiovascular					
Heart disease		Angina		Murmurs	
High/Low blood pressure		Blood clots		Fainting	
Palpitations/fluttering		Phlebitis		Rheumatic fever	
Swelling in hands/feet		Chest pain			
Blood/Peripheral Vasc.					
Easy bleeding/bruising		Varicose veins		Cold hands/feet	
Deep leg pain		Anemia		Thrombophlebitis	
Gastrointestinal					
Trouble swallowing		Heartburn		Change in thirst	
Change in appetite		Nausea		Vomiting	
Vomiting blood		Blood in stool		Pain or cramps	
Belching or passing gas		Constipation		Diarrhea	
Gall bladder disease		Black stools		Ulcer	
Jaundice (yellow skin)		Liver disease		Hemorrhoids	
Sensitive Abdomen		Bloody Stools		Laxative Use	
Bowel movements:	Frequency?				
	Color?				
	Formed?				
Respiratory					
Cough		Sputum		Spitting up blood	
Wheezing		Asthma		Bronchitis	
Short of breath lying down		Pleurisy		Emphysema	
Difficulty breathing		Pain on breathing		Shortness of breath	
Short of breath at night		Tuberculosis		Pneumonia	
History of smoking					
Urinary					
Pain on urination		Incr. frequency		Incontinence	
Frequency at night		Frequent infections		Kidney stones	
Condyloma (genit. warts)		Chlamydia		Gonorrhea	
Herpes		Syphilis		Blood in Urine	
Female Reprod./Breast					
Age of first menses		Are cycles regular?		Length of cycle	
Age of last menses		Duration of menses		Clotting	
First day of most recent menses?		Date of last Pap?			
Bleeding between cycles		Painful menses		Discharge	
Heavy or excessive flow		Light flow		PMS	

For the following sections (please circle)

Yes/now = a condition you have now **Blank** = never had **Previously** = a condition you had previously

PMS symptoms		Endometriosis		Ovarian cysts	
Pain during intercourse		Abnormal PAP		Breast self-exams	
Are you sexually active		Breast pain/tenderness		Nipple discharge	
Breast lumps		Mastitis		Sexual orientation?	
Breast feeding		Menop. symptoms		# of Live births	
Birth control		What type?		# of miscarriages	
Menopause		# of Abortions		#of pregnancies	
Male Reproduction					
Testicular masses		Hernias		Prostate disease	
Testicular pain		Discharge		Sores	
Premature ejaculation		Impotence			
Are you sexually active?		Sexual orientation?		Birth control type?	
Musculoskeletal					
Joint pain or stiffness		Broken bones		Weakness	
Muscle spasms/cramps		Arthritis		Sciatica	
Immune					
Chronic fatigue synd.		Chronic Infections		Slow wound healing	
Chronic swollen glands					
Neurologic					
Seizures		Paralysis		Muscle weakness	
Numbness or Tingling		Loss of memory		Vertigo or dizziness	
Loss of balance		Concussion			
Endocrine					
Hypothyroid		Diabetes		Heat/Cold intoler.	
Hyperthyroid		Excessive thirst		Weight loss/gain	
Hypoglycemia		Fatigue		Seasonal Depression	
Skin					
Rashes		Acne, Boils		Hives	
Itching		Color Change		Dandruff	
Perpetual hair loss		Ulcerations		Acne	
Psychological					
Depression		Bad temper		Easily Stressed	
Anxiety		Considered Suicide		Attempted Suicide	
Eating Disorder		Treated for psychological problems		History of abuse?	
Treated for emotional problems					