



Pacific College of Oriental Medicine Clinic

Our Mission:

- "We, the Pacific College of Oriental Medicine Clinic, a nationally recognized educational facility, provide:*
- Exemplary clinical training for our students,*
 - Personalized Oriental medical treatments for our patients, and*
 - Supportive services for our staff so that each experiences a high degree of satisfaction."*

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have questions, please ask. Thank you.

Personal Information

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Email _____ Work Phone _____

Occupation _____ Person Responsible for your account _____

Emergency Contact: Name _____ Phone _____

Who should we thank for referring you to this office? _____

Sex: Male Female Trans MTF FTM Height _____ Weight _____ Birthdate _____ Age _____

Marital Status: Married Single Divorced Widowed Partnered Number of children _____

Have you received acupuncture therapy before? Yes No

When? _____ With whom? _____

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexually Transmitted Diseases:							
	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Syphilis	<input type="checkbox"/> HIV	<input type="checkbox"/> HPV	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Herpes	Date _____

List any medications and supplements your are currently taking: (Continue on back if necessary.)

Medicine	Dosage	Reason	How long	Prescribed by	Date of last checkup

Check the Box if any of the following statements are true:

- I have known allergies I am taking Coumadin/warfarin
 I have a pacemaker I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Please indicate the use and frequency of the following:

	Yes	No	How much		Yes	No	How much		Yes	No	How much
Coffee/black tea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____	Water Intake	<input type="checkbox"/>	<input type="checkbox"/>	_____
Non-medical drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Soda pop	<input type="checkbox"/>	<input type="checkbox"/>	_____

OB/GYN History

Age of 1st period (menarche) _____ Are you pregnant? Yes No # of pregnancies _____

Age of last period (menopause) _____ # of live births _____ # Abortions _____ # of Miscarriages _____

Number of days between periods _____ Date of last: Gynecologic exam _____ Pap Smear _____

Number of days of flow _____ Mammogram _____ Bone Density Scan _____

Color of flow _____ Results _____

Clots? Yes No Color _____

Average number of pads you use per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ + days _____

Have you been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts PID Other _____

Location of Pain: Lower abdomen Lower back Thighs Other _____

Nature of Pain (Please indicate before, during or after menses) Other Symptoms related to menses:

Cramping _____	Stabbing _____	<input type="checkbox"/> Discharge	<input type="checkbox"/> Vaginal dryness	<input type="checkbox"/> Headache
Burning _____	Aching _____	<input type="checkbox"/> Nausea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea
Dull _____	Bloating _____	<input type="checkbox"/> Swollen breasts	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Ravenous appetite
Consistent _____	Intermittent _____	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Night sweats
Bearing down sensation _____		<input type="checkbox"/> Increased libido	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Insomnia

Urogenital History

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____

Lab results _____

Frequency of Urination: daytime _____ nighttime _____ Color of urine: clear murky odor: _____

Symptoms related to prostate

<input type="checkbox"/> prostate problems	<input type="checkbox"/> Delayed stream	<input type="checkbox"/> Post void dribbling	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Retention of Urine
<input type="checkbox"/> Erectile dysfunction (ed)	<input type="checkbox"/> Increased libido	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Premature ejaculation	<input type="checkbox"/> Impotence
<input type="checkbox"/> Back pain	<input type="checkbox"/> Groin pain	<input type="checkbox"/> Testicular pain	<input type="checkbox"/> Decreased force of stream	<input type="checkbox"/> BPH/Enlarged prostate
<input type="checkbox"/> other _____				

Symptom Survey

*The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
no mark () = never experience check mark (a) = sometimes experience plus sign (+) = frequently experience*

___ lack of appetite	___ abdominal pain	___ eye problems	___ fatigue
___ excessive appetite	___ chest pain	___ jaundice (yellowish eyes or skin)	___ edema
___ loose stool or diarrhea	___ sciatic pain	___ difficulty digesting oily foods	___ blood in stool
___ digestive problems, indigestion	___ headaches	___ gall stones	___ black tarry stool
___ vomiting	___ pain or coldness in the genital area	___ light colored stool	___ easily bruised
___ belching, burping	___ cough	___ soft or brittle nails	___ difficult to stop bleeding
___ heartburn/reflux	___ shortness of breath	___ easily angered or agitated	___ asthma
___ feeling the retention of food in the stomach	___ decreased sense of smell	___ difficulty in making plans or decisions	___ tendency to catch colds easily
___ tendency to become obsessive in work, relationships...	___ nasal problems	___ spasms or twitching of muscles	___ intolerance to weather changes
___ insomnia, difficulty sleeping	___ skin problems	___ low back pain	___ allergies
___ heart palpitations	___ feeling of claustrophobia	___ knee problems	___ hay fever
___ cold hands and feet	___ bronchitis	___ hearing impairment	___ dizziness
___ nightmares	___ colitis or diverticulitis	___ kidney stones	___ tendency to faint easily
___ mentally restless	___ constipation	___ decreased sex drive	___ high cholesterol levels
___ laughing for no apparent reason	___ hemorrhoids	___ hair loss	___ sudden weight loss
___ angina pains	___ recent use of antibiotics	___ urinary problems	



Pacific College of Oriental Medicine

WELCOME

Dear Patient,

On behalf of our staff, clinic supervisors and students, we'd like to welcome you to Pacific College Clinic. Our clinic strives to provide caring and efficient treatments for all of our patients. In order to do this, we have a few guidelines:

Appointments:

We strive to run "on-time". Occasionally, however, an emergency will disrupt the schedule and we apologize in advance should that occur and delay your visit. Your prompt arrival for scheduled appointments will also help keep us running smoothly. Sometimes you may be late; understanding that, we will make every effort to accommodate you. However, in the event that we are fully booked and you are 15 (or more) minutes late, you may receive a modified treatment/visit or need to be rescheduled. This decision will be at the discretion of the clinic and you will still be responsible for the full amount of the visit fee. Lateness will be treated in the same manner as missed appointments, as indicated below.

Cancellations:

We understand that circumstances arise which may prevent you from keeping an appointment. While 48 hours notice is preferred, 24 hours notice of cancellation is required. If cancellation occurs without proper notice, you will be charged the full cost of the visit for missing your scheduled appointment.

If repeated cancellations occur, your next few visits will only be made on a "walk-in" or same day basis. Thereafter, upon reevaluation, advance appointments would again be available

Insurance:

We currently do not bill insurance, however, we do accept Flex Cards. Otherwise, you may elect to bill the insurance company yourself and pay the "time-of-service" fee. The clinic staff can provide an itemized statement that can be submitted to your insurance company. Feel free to discuss what's best for you with our office manager.

Pacific College's Herbal Pharmacy

The outcome of an herbal consultation is a personalized prescription that may be filled elsewhere or at our pharmacy. Prices at Pacific College's onsite pharmacy are competitive with other locations and we offer several forms of herbs for your convenience, which are available at an average cost of \$9.00 – 25.00 per week.

Prescription Refills:

If your prescription was written for refills, simply call us at least 24 hours before the day you would like to pick up your prescription.

The Initial Visit:

Generally, your first visit will be the longest. Please be sure to have eaten within 2-3 hours of your visit and wear loose, comfortable clothing. We request that you arrive at least 30 minutes prior to your appointment time to complete new patient paperwork. This will also enable us to run on time.

What to bring:

- A complete list and dosage of your recent & current medications and/or supplements (herbal or nutritional) that you are taking.
- Medical records, including past x-rays, lab work or other diagnostic studies, if applicable.

Financial Hardship

Despite the favorable rates found in our teaching clinic, we understand that even these can be restrictive. Pacific College's mission includes benefiting the community at large; therefore, we can offer several options for those in need. Please ask our clinic staff for more information.

We look forward to addressing your medical concerns in an empowering and creative way. Please feel free to give us feedback on any aspect of our service, so that we may provide the best care possible.

In Health,

Pacific College Clinic and Staff

Please sign to indicate that you have read and understand the information provided above:

Patient Signature

Patient Name (Printed)

Date

Name: _____

Today's date: _____

*** MYMOP2 ***

Choose one or two symptoms (physical or mental) which bother you the most. Write them on the lines. Now consider how bad each symptom is, over the last week, and score it by circling your chosen number.

SYMPTOM 1: _____

0	1	2	3	4	5	6
As good as it could be						As bad as it could be

SYMPTOM 2: _____

0	1	2	3	4	5	6
As good as it could be						As bad as it could be

Now choose one activity (physical, social or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.

Activity: _____

0	1	2	3	4	5	6
As good as it could be						As bad as it could be

Lastly how would you rate your general feeling of wellbeing during the last week?

0	1	2	3	4	5	6
As good as it could be						As bad as it could be

How long have you had Symptom 1, either all the time or on and off? Please circle: _____

0 - 4 weeks	4 - 12 weeks	3 months - 1 year	1 - 5 years	over 5 years
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Are you taking any medication FOR THIS PROBLEM? Please circle: YES/NO

IF YES:

1. Please write in name of medication, and how much a day/week

2. Is cutting down this medication: Please circle:

Not important	a bit important	very important	not applicable
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IF NO:

Is avoiding medication for this problem:

Not important	a bit important	very important	not applicable
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GS 8/19/10