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_____

May we contact you by phone for appointment reminders or appointment changes? ❑yes ❑no

May we leave a message if you are not available? ❑yes ❑no May we contact you by email? ❑yes ❑no

Would you like to receive newsletters or notices by email? ❑yes ❑no

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 illness you or a blood relative (grandparent, parent, or sibling) have had:

Illness	***You***	***Your Relative***	***Approx. Date***	***Illness***	***You***	***Your Relative***	***Approx. Date***
Cancer	❑	❑	_____	Diabetes	❑	❑	_____
Hepatitis	❑	❑	_____	Heart Disease	❑	❑	_____
High Blood Pressure	❑	❑	_____	Seizures	❑	❑	_____
Rheumatic Fever	❑	❑	_____	Emotional Disorders	❑	❑	_____
Infectious Diseases	❑	❑	_____	Tuberculosis	❑	❑	_____

Sexually Transmitted Diseases: ❑ Gonorrhea ❑ Syphilis ❑ HIV ❑ Chlamydia ❑ Herpes Date _____

List any medications and supplements you 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	❑	❑	_____	Tobacco	❑	❑	_____	Water	❑	❑	_____
Non-medical drugs	❑	❑	_____	Alcohol	❑	❑	_____	Soda pop	❑	❑	_____

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health problems you now have.

List any allergies, food sensitivities, or food cravings that you have.

List any accidents, surgeries, or hospitalizations (include date).

Lab results (please include copies):

Clinical Notes

(Intern's Use)

HPI:

❑ Onset ❑ Location ❑ Duration ❑ Characteristics

❑ Aggravate/allev ❑ Related factors ❑ Treatment ❑ Significance

How do you FEEL about the following areas of your life?

Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	***Good***	***Fair***	***Poor***	***Bad***
Significant Other	❑	❑	❑	❑	❑
Family	❑	❑	❑	❑	❑
Diet	❑	❑	❑	❑	❑
Sex	❑	❑	❑	❑	❑
Self	❑	❑	❑	❑	❑
Work	❑	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	❑
Spirituality	❑	❑	❑	❑	❑

Your Comments

Other information you would like to report / may be relevant to your medical history?

OB/GYN History

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

Age of last period (menopause) _____ # of live births_____ # of 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)

Cramping _____ Stabbing _____

Burning _____ Aching _____

Dull _____ Bloating _____

Consistent _____ Intermittent _____

Bearing down sensation _____

Other symptoms related to menses:

❑ Discharge	❑ Vaginal dryness	❑ Headache
❑ Nausea	❑ Constipation	❑ Diarrhea
❑ Swollen breasts	❑ Mood swings	❑ Ravenous appetite
❑ Poor appetite	❑ Hot flashes	❑ Night sweats
❑ Increased libido	❑ Decreased libido	❑ 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

❑ Prostate problems	❑ Delayed stream	❑ Post-void dribbling	❑ Incontinence	❑ Retention of urine
❑ Erectile dysfunction (ED)	❑ Increased libido	❑ Decreased libido	❑ Premature ejaculation	❑ Impotence
❑ Back pain	❑ Groin pain	❑ Testicular pain	❑Decreased force of stream	❑ BPH/Enlarged prostate

❑ 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 ✓ = sometimes experience, plus sign + = frequently experience

___lack of appetite
___excessive appetite
___loose stool or diarrhea
___*digestive problems, indigestion*
___*vomiting*
___*belching, burping*
___*heartburn/reflux*
___*feeling retention of food in the stomach*
___*tendency to become obsessive in work, relationships…*

___*insomnia, difficulty sleeping*
___*heart palpitations*
___*cold hands and feet*
___*nightmares*
___*mentally restless*
___*laughing for no apparent reason*

___*angina pains*
___*abdominal pain*
___*chest pain*
___*sciatic pain*
___*headaches*
___*pain or coldness in the genital area*

___*cough*
___*shortness of breath*
___*decreased sense of smell*
___*nasal problems*
___*skin problems*
___*feeling of claustrophobia*
___*bronchitis*
___*colitis or diverticulitis*
___*constipation*
___*hemorrhoids*
___*recent use of antibiotics*

___*eye problems*
___*jaundice (yellowish eyes or skin)*
___*difficulty digesting oily foods*
___*gallstones*
___*light colored stool*
___*soft or brittle nails*
___*easily angered or*
___
___*difficulty in making plans or decisions*
___*spasms or twitching of muscles*

___*low back pain*
___*knee problems*
___*hearing impairment*
___*ear ringing*
___*kidney stones*
___*decreased sex drive*
___*hair loss*
___*urinary problems*

___*fatigue*
___*edema*
___*blood in stool*
___*black tarry stool*
___*easily bruised*
___*difficult to stop bleeding*
___*asthma*
___*tendency to catch colds easily*
___*intolerance to weather changes*
___*allergies*
___*hay fever*
___*dizziness*
___*tendency to faint easily*
___*high cholesterol levels*
___*sudden weight loss*

Pacific College of Oriental Medicine – Chicago
65 East Wacker Place, 21st Floor
Chicago, IL 60601
773-477-1900

NOTICE OF PRIVACY POLICIES – August 19, 2004

Our office is dedicated to providing services with respect for human dignity. Protecting your privacy and healthcare information is fundamental to our relationship with you. This notice will remain in effect until it is replaced or amended by changes in the law.

We gather personal information and health information in several ways:

- Information we receive from you
- Information we receive from other healthcare providers
- Information we receive from third party payers

Protected Health Information is any information that includes demographic information; information gathered by PCOM as relates to your past, present, and future physical or mental health or condition; or past, present, or future payments for healthcare services.

You should be aware that during the course of our relationship with you, we will likely use and disclose health information about you for the treatment, payment, and healthcare operations we perform.

Without your consent or authorization, this office may disclose information about you only to the following groups for the specified purposes:

- to a public health agency, for a purpose such as controlling disease.
- in case of suspected child abuse, to the appropriate governmental authority.
- in other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.
- to health oversight authorities, for regulatory, licensing, and other legal purposes.
- in litigation, subject to certain requirements controlling the terms of the disclosure.
- to law enforcement agencies, subject to applicable legal requirements and limitations.
- for medical research purposes, subject to your authorization or approval by an institutional review board.
- if you are in the United States military, national security, or intelligence for Foreign Service, to your authorized superiors or other authorized federal officials.

We may not use or disclose information about you for any other purpose without your authorization, provided separately from your written consent. You may submit written authorization to disclose Protected Health Information to a person or group specified by you.

Marketing

This office will not use your health information for marketing communications without your written authorization. Marketing communications may include birthday cards, newsletters, and appointment reminders, by calls, postcards, or letters.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

Upon written request, you have the right to access, review, or receive copies of your healthcare records.

Upon written request, unless prohibited by law, you have the right to receive a list of items this office disclosed about your healthcare information.

You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.

You have the right to request restrictions on the use and disclosure of your Protected Health Information for the purposes of treatment or payment for healthcare operations, but PCOM is not required to agree to these restrictions. However, if PCOM agrees to a restriction that you request, the restriction is binding to PCOM.

You have the right to request that we amend your Protected Health Information. This request must be in writing.

You have the right to receive all notices in writing.

More Information

If you have any questions or complaints, or would like to receive more information, contact our Privacy Officer Jennifer Voudrie at 773-477-1900, or at the address above.

Complaints

Complaints about your privacy rights or how your privacy is handles at this office can be directed to our Privacy Officer by calling our office or directing a letter to her attention.

If you are not satisfied with how our office handles your complaint, you may submit a formal complaint to:

DDHS (Office of Civil Rights)
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201

Pacific College of Oriental Medicine Chicago
65 East Wacker Place, 21st Floor
Chicago, IL 60601
773-477-1900

Acknowledgement of Receipt of

NOTICE OF PRIVACY POLICIES – May 20, 2003

I, the undersigned, have received a copy of, read, reviewed, understand, and agree to the "Notice of Privacy Policies" for healthcare services at the Pacific College of Oriental Medicine, Chicago Campus.

Patient Signature: _____

Date: _____

Pacific College of Oriental Medicine, Chicago

Pacific College of Oriental Medicine Clinic Policies

Pacific College Clinic operates for two vital purposes: to provide our students with a valuable, varied practical clinical experience; and to provide our patients with high-quality, reasonably priced acupuncture and massage treatments. Working together, we are creating an environment of learning and healing.

In order to best serve both interns and patients, we request that patients contact us at least 24 hours in advance if they need to cancel an appointment. **The Clinic will charge $15 for late cancellations or "no shows" less than 24 hours prior to your scheduled appointment.**

Patients who accumulate three late cancellations and/or no-shows may schedule only same-day appointments.

We try our best to accommodate late arrivals, but may only be able to offer consultations and/or shortened treatments.

Patients are requested to arrive hygienic, and not wear heavy perfumes or aromas that may cause adverse reactions in others.

The clinic is not able to offer massage treatments to patients who:

- Are pregnant
- Have active cancer

Written permission from a physician is needed BEFORE massage is administered to:

- Patients who have had surgery in the past six months
- Patients who have ever had cancer

Patients who can't be treated with massage are encouraged to consider acupuncture treatments.

Massage patients are asked to wear comfortable, loose fitting clothing such as sweat pants, or yoga pants to all of their appointments in order to accommodate massage modalities which include stretching exercises. Patients dressed otherwise will need to rent appropriate clothing for a fee.

Acupuncture patients with uncontrolled high blood pressure may be required to obtain written permission from a physician before they can receive acupuncture treatments. Decisions will be made on a case by case basis.

Herbs may be suggested for acupuncture patients. There is an extra charge for them, usually between $12.00 and $30.00 a week. We cannot accept returns for raw herbs, customized granule formulas or opened bottles of patent herbs.

At times, calls may be routed to voicemail. We return calls as quickly as possible, in the order they were received.

We appreciate our patients' generosity, but our interns may not accept gratuities or gifts.

Thank you,

Jennifer Voudrie, L.Ac.
Director of Clinical Services

_____

Patient Signature Date