Our Mission

"We, the Pacific College of Health and Science 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.

Personal Information

Name ____ Date ____________________

Home Address ____ City ____________________

State ____ Zip ____________ Home Phone __________________ Work ____________________

Occupation ________________ Person responsible for your account ___________________________

Emergency Contact _____________________________________ Phone ______________________

How you heard of us: ❑ newspaper ❑ PCOM student ❑ PCOM patient ❑ family member ❑ acupuncturist
❑ physician ❑ other PCOM clinic ❑ open house ❑ friend ❑ other _____________________________

May we thank someone in particular? ______________________________

Sex: ❑M ❑ F Height: __________ Weight: __________ Birth date: _____________ Age:_____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed Number of children _______

Previous Acupuncture? ❑ yes ❑ no When?________________ With whom? ____________________

Physician History

Have you seen a physician in the last year? ❑ Yes ❑ No If yes:

Physician's name: _______________________________ Phone ______________________

Approximate date of most recent examination/visit? __________________________

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

Illness	You	Relative	When?	Illness	You	Relative	When?
Cancer	❑	❑	_______	Diabetes	❑	❑	_______
Hepatitis	❑	❑	_______	Heart Disease	❑	❑	_______
High blood pressure	❑	❑	_______	Seizures	❑	❑	_______
Rheumatic Fever	❑	❑	_______	Emotional Disorders	❑	❑	_______
Infectious Diseases	❑	❑	_______	Tuberculosis	❑	❑	_______

Sexually Transmitted Diseases: ❑ gonorrhea ❑ syphilis ❑ HIV ❑ HPV ❑ chlamydia ❑ herpes Date:_______

Please indicate the use and frequency of the following:

	Yes	No	Amount		Yes	No	Amount		Yes	No	Amount
Coffee/black tea	❑	❑	______	Tobacco	❑	❑	______	Water	❑	❑	______
Recreational drugs	❑	❑	______	Alcohol	❑	❑	______	Soda Pop	❑	❑	______

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

I have known allergies: ❑ Yes ❑ No I am taking Coumadin/warfarin/Plavix: ❑ Yes ❑ No

I have a pacemaker: ❑Yes ❑ No I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs) ❑Yes ❑ No

Medications:

Please list any prescription or OTC medications or supplements and herbs you are currently taking:

Rx/Supplement/Herb	Dosage	Reason for taking the item	How long?	Prescribed by?	Date last check up?

Patient Last Name, First Name, MI

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What are the main health problems for which your 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 craving 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 ❑

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	Your Comments
Significant Other	❑	❑	❑	❑	❑	______________
Family	❑	❑	❑	❑	❑	______________
Diet	❑	❑	❑	❑	❑	______________
Sex	❑	❑	❑	❑	❑	______________
Self	❑	❑	❑	❑	❑	______________
Work	❑	❑	❑	❑	❑	______________
Exercise	❑	❑	❑	❑	❑	______________
Spirituality	❑	❑	❑	❑	❑	______________

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For Women

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

For Men

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 ❑ Dribbling ❑ Incontinence ❑ Retention of Urine
❑ Rectal dysfunction ❑ Increased libido ❑ Decreased libido ❑ Premature ejaculation ❑ Impotence
❑ Back pain ❑ Groin pain ❑ Testicular pain other______________________________

Symptom Survey (For Everyone)

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 the 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
_____gall stones
_____light colored stool
_____soft or brittle nails
_____easily angered or agitated
_____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

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

Are you taking any medication FOR THIS PROBLEM? Please circle: YES/NO

<u>IF YES:</u>
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

<u>IF NO:</u>
Is avoiding medication for this problem:

Not important   a bit important   very important   not applicable

GS 8/19/10