PACIFIC COLLEGE of HEALTH AND SCIENCE

Our Mission

We, the Pacific College of Health and Science Wellness Center, 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 higher degree of satisfaction.

Thank you for selecting us for as your healthcare partner. To help us meet all your healthcare needs, please fill out this form to the best of your ability. If you have any questions or need assistance, please ask one of our clinical receptionists and we will be happy to help.

All information provided will be confidential.

Personal Information					
Name				Date	
Address				Apt./Unit	
City		State		Zip Code	
Home/ Cell Phone			Work Phone		
Gender Identified			Biological Sex		
Height		Weight		Birthdate	__ __ / __ __ / __ __ __ __
Who is responsible for your account?					
Emergency Contact		Relation		Phone	
How did you hear about us?					

Physician History			
Have you seen a primary care physician in the last year?		☐ Yes	☐ No
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			
Infectious Disease Type:				Diagnosed Psychological/ Emotional/ Behavioral Disorders			
COVID-19				Seizures			
Rheumatic Fever				Tuberculosis			
Others							

Please indicate the use and frequency of the following:											
Substance	Yes	No	Amount	Substance	Yes	No	Amount	Substance	Yes	No	Amount
Coffee/Tea				Tobacco				Water			
Recreational Drugs				Alcohol				Soda Pop			

_____

Patient Last Name, First Name, MI

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Please check the if any of the following statements are true:

I have known allergies to medications, latex, silicon, or any metal alloy: ☐ Yes ☐ No

If yes, what are your allergies: _____

I am taking blood thinners: ☐ Yes ☐ No

If yes, which blood thinner: _____

I am taking lithium: ☐ Yes ☐ No

If yes, which lithium product: _____

I have a pacemaker/defibrillator/brain shunt/cardiac stents: ☐ Yes ☐ No
I have metal implants: ☐ Yes ☐ No

Medications:					
Please list any prescription or over the counter medications or supplements and herbs you are currently taking:					
Rx/Supplement/Herb	Dosage	Reason for taking	How long?	Prescribed by?	Date Prescribed

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 food sensitivities or allergies you may have:

List any accidents, surgeries, or hospitalizations (include dates):

Mental Health Questionnaire				
Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "x" to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself- or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				
For Office Coding				
Total Score				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Please circle one.	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Office use only: Instructions https://www.pcpcc.org/sites/default/files/resources/instructions.pdf

_____
Patient Last Name, First Name, MI

Gynecological History

Age of 1st period (menarche) _____
Age of last period (menopause) _____
Number of days between periods _____
Number of days of flow _____
Color of flow_____

Are you pregnant? ☐ Yes ☐ No
# of live births____ # of abortions___ # of miscarriages____
Date of last: Gynecologic exam_____ Pap _____
Mammograms_____ Bone Density Scan_____
Results_____

Clots: ☐ Yes ☐ No Color_____ Size_____
Average number of pads/tampons 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 _____

Birth Control Method:

Pain related to menses
Before/During/After
Location of pain_____
Nature of pain_____
Other symptoms related to menses:

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:

Sexually Transmitted Diseases:

☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ Chlamydia ☐ Herpes Date:_____