Pacific College of Oriental Medicine

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.

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

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