PACIFIC COLLEGE of HEALTH AND SCIENCE

Our Mission

The Pacific College of Health and Science New York Clinic is a nationally recognized educational facility. We provide exemplary clinical training for our students, personalized Oriental medicine and bodywork treatments for our patients, and supportive services for our staff so that each experiences the highest degree of satisfaction.

Thank you for selecting us 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.

Patient 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	☐	☐		Diagnosed Psych/Emotional/Be	☐	☐	
COVID-19	☐	☐		Seizures	☐	☐	
Rheumatic Fever	☐	☐		Tuberculosis	☐	☐	
Others	☐	☐		Other			

Substance	Yes	No	Amount	Substance	Yes	No	Amount	Substance	Yes	No	Amount
Coffee/Tea	☐	☐		Tobacco	☐	☐		Water	☐	☐	
Recreational Drugs	☐	☐		Alcohol	☐	☐		Soda Pop	☐	☐	

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Please check 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): _____

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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	☐	☐	☐	☐

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 select one.	Not difficult	Mildly difficult	Moderately difficult	Very difficult
	☐	☐	☐	☐

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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 _____ # abortions _____ # miscarriages _____

Date of last Gynecologic exam _____ Pap _____

Mammograms _____ Bone Density Scan _____

Results _____

Clots: ☐ Yes ☐ No Color _____ Size _____

Average number of pads/tampons 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: _____