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Patient Information Sheet

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____) _____

Date of Birth: _____ Age: _____ Sex: Male Female Marital Status: _____

Occupation: _____ Employer: _____

Emergency Information

Emergency Contact: _____ Relationship: _____

Emergency Phone Number: (____) _____

Medical Information

Primary Care Doctor: _____ Last seen: _____ Referred by: _____

Chief Complaint(s): _____

Has this condition been diagnosed by a DO/MD? Yes No If Yes, Diagnosis: _____

Have you been treated for this condition by anyone else? Yes No If Yes, who? _____

How long have you had this condition? _____ Have you had acupuncture before? Yes No

Name of Acupuncturist: _____ Have these treatments helped? Yes No Somewhat

Known or suspected allergies: _____

Do you have any current or past infectious disease(s)? Yes No Possibly. **If Yes, please identify:**

HIV + Hepatitis B Hepatitis C Streptococcus Mononucleosis Tuberculosis Flu / Cold

Other: _____

Are you pregnant right now? Yes No Trying Maybe

I am taking Coumadin / Warfarin or other anticoagulant medication: Yes No

I have a pacemaker? Yes No

Do you have Implants? Yes No If yes, Please specify: _____ (Breast, Buttocks, ect.)

Dominant hand: Left Right Height _____ Weight _____

Initial _____ Date _____

Medical Information (Continued, page 2 and 3)

Cardiovascular Conditions:

Past / Present

- Myocardial Infarction
- Myocarditis
- Angina
- Congestive Heart Failure
- High Blood Pressure
- Low Blood Pressure
- Chest Pain
- Palpitations
- Tachycardia (H/R > 100)
- Bradycardia (H/R < 60)
- CVA (stroke)
- Varicose Veins
- Edema
- Other: _____

Gastrointestinal:

Past / Present

- Stomach Ulcers
- Colitis
- Crohn's Disease
- Nausea
- Vomiting
- Abdominal Pain
- Bloating
- Heart Burn
- Belching
- Gall Bladder Disease
- Gall Bladder Stones
- Hemorrhoids
- Constipation
- Diarrhea
- Irritable Bowel Syndr.
- Leakey Gut Syndrome
- Other: _____

Eye, Ear, Nose & Throat:

Past / Present

- Impaired Vision
- Blurred Vision
- Eye Pain/Strain
- Glaucoma
- Dryness
- Tearing
- Impaired Hearing
- Ear Ringing
- Earaches
- Ear Infections
- Sinus Problems
- Nose Bleeds
- Teeth Grinding
- Hay Fever
- Other: _____

Respiratory:

Past / Present

- Pneumonia
- Asthma
- Bronchitis
- Persistent/Chronic Cough
- Difficulty Breathing
- Shortness of Breath
- Emphysema
- Pleurisy
- Frequent Common Colds
- Other: _____

Neurological:

Past / Present

- Migraine
- Headaches
- Vertigo / Dizziness
- Paralysis
- Numbness / Tingling
- Epilepsy
- Loss of Balance
- Seizures
- Dyslexia
- Other: _____

Emotional / Mental:

Past / Present

- Clinical Depression
- Mild Depression
- Mood Swings
- Panic Attacks
- Excessive dreams
- Nightmares
- Nervousness
- Anxiety
- Autism
- ADD or ADHD
- Other: _____

Energy & Immunity:

Past / Present

- Chronic Fatigue Syndrome
- General Fatigue
- Morning Fatigue
- Fatigue after Exercise
- Slow Wound Healing
- Easy Bruising
- Frequent Sore Throat
- Frequent Flu or Cold
- Chronic Infections
- Autoimmune Disease
- Other: _____

Urinary Tract:

Past / Present

- Kidney Disease
- Kidney Stones
- Painful Urination
- Dribbling Urination
- Frequent UTI
- Frequent Urination
- Blood in Urine
- Discharge
- Incontinence
- Other: _____

Muscle-Skeletal:

Past / Present

- Muscle Spasms / Cramps
- Fibromyalgia
- Osteoporosis
- Osteochondritis
- Tennis Elbow
- Carpal-Tunnel Syndrome
- TMJ / Jaw Problems
- Arthritis Joint Pain: _____
- Other: _____

Initial _____ Date _____

Women Only Check all that apply:

Hysterectomy: Yes No Date: _____
 Have your ovaries been removed:
 Yes No
 Age at first period: _____
 Date of last menses: _____
 Typical length of menses (days): _____
 Typical length of cycle (from 1st day to 1st day of menses): _____
 Number of: Pregnancies: __ Births: __
 Abortions: _____ Miscarriages: _____
 Method of Birth Control: _____
 Menopause: Yes No Age: _____
 Menopausal Symptoms: Yes No
 Explain: _____

Past / Present

Premenstrual Problems
 Irregular Cycles

Women Only (Cont.):**Past / Present**

Heavy Flow
 Scanty Flow
 Painful Periods
 Blood Clots
 Bleeding Between Cycles
 Fibroids
 Painful Intercourse
 Infertility
 Endometriosis
 Vaginal Discharge
 Breast Lumps
 Breast Tenderness
 Nipple Discharge
 Fibrocystic Breasts
 Ovarian Cysts
 Abnormal Pap Smear
 Low libido
 Excessive libido

Endocrine/Other Conditions:**Past / Present**

Hypothyroidism
 Hyperthyroidism
 Hypoglycemia
 Diabetes Type I
 Diabetes Type II
 Night Sweats
 Unusual Sweating
 Feeling Hot or Cold
 Cold Hand / Feet
 Thin / Graying hair
 Loss of hair
 High Cholesterol
 Cancer, Type: _____
 Candida
 Hemophilia
 Bleeding Problems
 Anemia
 Rashes
 Eczema / Hives
 Other: _____

Men Only:**Past / Present**

Impotence
 Vasectomy
 Prostate problems
 Testicular Pain/Inflammation
 Low libido
 Excessive libido
 Seminal emissions

Surgeries and hospitalizations:**Reason and Date.**

Medications and supplements:**Reason, Dose, How Long.**

Social Life

Daily amount:

Tobacco: Yes No Amount: _____
 Alcohol: Yes No Amount: _____
 Coffee: Yes No Amount: _____
 Recreational Drugs: Yes No Amount: _____
 Daily Water intake: _____

How would you rate your health in the past month:

Energy: Great Good Fair Poor
 Digestion: Great Good Fair Poor
 Urination: Great Good Fair Poor
 Appetite: Great Good Fair Poor
 Sleep: Great Good Fair Poor

Daily Soda intake: _____ Hours of sleep / night: _____

Are you vegetarian or vegan? Yes No Physical exercise Yes No Regularly Yes No

How would you rate your current stress level? Extreme Very High High Moderate Low None

Initial _____ Date _____

Pain Chart

Quality of pain: Fixed Constant Sharp Cramping

Burning Migrating Stabbing Sore Dull

On a scale of 1 – 10 (10 being worst) how strong is your pain?

Now _____ Best Day _____ Worst Day _____

Does the pain radiate? Yes No Where? _____

What helps the pain? Ice Heat Rest Movement

Pressure Moisture Massage Nothing

What aggravates the pain? Ice Heat Movement

Rest Pressure Moisture Massage Nothing

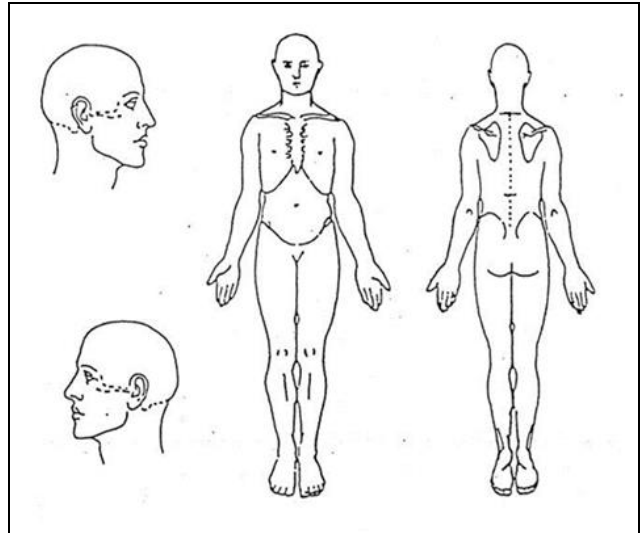
Do any medications help your pain? Yes

No If, Yes Name of medication: _____

Other treatments you have had for your pain? _____

Describe the onset of your pain: _____

HIGHLIGHT AREAS OF PAIN BELOW:



Family History

Please check all that apply to family medical history (if checked, please specify which relative):

- | | |
|--|---|
| <input type="checkbox"/> Alzheimer's/Depression: _____ | <input type="checkbox"/> High Blood Pressure: _____ |
| <input type="checkbox"/> Anxiety/Depression: _____ | <input type="checkbox"/> High Cholesterol: _____ |
| <input type="checkbox"/> Arthritis: _____ | <input type="checkbox"/> Kidney Disease: _____ |
| <input type="checkbox"/> Asthma: _____ | <input type="checkbox"/> Liver Disease: _____ |
| <input type="checkbox"/> Bleeding Disorder: _____ | <input type="checkbox"/> Lung Disease: _____ |
| <input type="checkbox"/> Cancer, Type: _____ | <input type="checkbox"/> Osteoporosis: _____ |
| <input type="checkbox"/> Diabetes: _____ | <input type="checkbox"/> Stroke/TIA: _____ |
| <input type="checkbox"/> Heart Disease: _____ | <input type="checkbox"/> Thyroid Disease: _____ |
| <input type="checkbox"/> Other: _____ | |

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Born Clinic 24 hours prior to any cancellations or changes to my appointment times and that if I do not, I may be charged for the appointment.

X Signature: _____ Date: _____

Parent / Guardian (if applicable): _____

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with medical and Traditional Chinese acupuncture, moxibustion, electro-acupuncture, cupping, and Chinese massage and Medical Massage by a National Board-Certified and State of Michigan Registered Acupuncturist, **Arkadiy Sarkisov, R.Ac/LMT**. I understand that acupuncturists practicing in the State of Michigan are not primary care providers.

Initial here _____ Pregnancy: I understand that it is my responsibility to notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant, so that my practitioner can avoid points and certain techniques that could induce a miscarriage. Otherwise, acupuncture can be very beneficial in the pregnancy and birthing process.

Initial here _____ Acupuncture / Moxibustion: I understand that acupuncture is a technique of inserting and manipulating filiform, sterile, disposable needles into acupuncture points on the body to restore health and well-being. The moxibustion is the application of heat to the skin at certain points on the body to restore health and well-being. Acupuncture and moxibustion are typically safe methods of treatment; however, certain adverse side effects may result. These could include but are not limited to, local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment.

Initial here _____ Acupressure / Tui-Na Massage and other Massage Modalities: I understand that I may also be given acupressure / Tui-na massage or other massage modalities as part of my treatment to improve or prevent symptoms and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include but are not limited to, bruising, sore muscles or aches, and the possible aggravation of symptoms existing before treatment.

Initial here _____ Cupping: I understand that I may also be given cupping (the application of glass cups with a vacuum to the skin) as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. ***I am aware that these treatments are intended to cause minor bruising and though unsightly, are not normally painful.*** However, certain adverse side effects may result from this treatment. These could include but are not limited to, bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment.

Initial here _____ Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include but are not limited to, electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment.

Initial here _____ I understand that results are individual, and there are no guarantees. I understand that I may decline or discontinue the treatment at any time for any reason.

Initial here _____ Medicare Patient Only: Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for the service. Acupuncture is not a covered service for Medicare, and Medicare will not pay for it.

I do not expect **Arkadiy Sarkisov R.Ac/LMT** and/or **Born Clinic** staff to be able to anticipate and explain all the possible risks and complications of treatment. I have carefully read and understood all of the above information and I am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment. I give my permission and consent to treatment.

Signature: _____ **Date:** _____