BORN™ CLINIC

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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

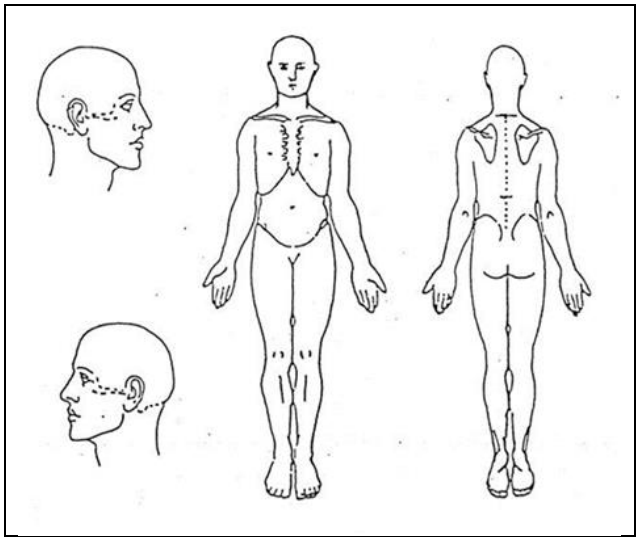
☐Pressure ☐Moisture ☐Massage ☐Nothing

What aggravates the pain? ☐Ice ☐Heat ☐Movement

☐Rest ☐Pressure ☐Moisture ☐Massage ☐Nothing

Do any medications help your pain? ☐Yes ☐

HIGHLIGHT AREAS OF PAIN BELOW:



No If, Yes Name of medication:_____

Other treatments you have had for your pain? _____

Describe the onset of your pain: _____

Family History

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

☐ Alzheimer's/Depression: _____
☐ Anxiety/Depression: _____
☐ Arthritis: _____
☐ Asthma: _____
☐ Bleeding Disorder: _____
☐ Cancer, Type: _____
☐ Diabetes: _____
☐ Heart Disease: _____
☐ High Blood Pressure: _____
☐ High Cholesterol: _____
☐ Kidney Disease: _____
☐ Liver Disease: _____
☐ Lung Disease: _____
☐ Osteoporosis: _____
☐ Stroke/TIA: _____
☐ Thyroid Disease: _____
☐ 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: _____

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