Abate Acupuncture & Herbal Medicine

Sierra Abate, L.Ac., Dipl. OM
Licensed Acupuncturist & Certified Herbalist

*Information provided on this form is **strictly confidential***. It is very important that the information given is complete and accurate to assist you properly in your healing process. Some of the questions that follow may seem unrelated to your condition, but they are significant in helping us to make an accurate diagnosis and treatment plan.

Personal Information

Today's Date _____

Name _____ Date of Birth _____ Age_____ Gender____

Address_____ City/State/Zip_____

Phone: Home _____ Cell _____ Work _____

(Please circle which number you would prefer we contact you)

Email _____ Occupation _____

Emergency Contact Person/Relationship _____ Phone#_____

Guardian (if under 18)_____ Phone #_____

Height _____'_____" Weight_____lbs. Marital Status: _____

Social Security # _____

Primary Care Physician_____ PCP Phone #_____

How did you hear about our office? _____

Referred by _____

May we email or mail you periodically (newsletter, reminders, birthday card, etc)? Yes No

Have you received Acupuncture or Traditional Chinese Medicine before? Yes No

Main Complaint

What is your primary reason for seeking care today?_____
_____

When did this problem first begin? _____

How often does this bother you? _____

Severity of the problem on a scale of 0-10 (0=best, 10=worst) _____/10

If there is pain involved, what is the quality of the pain? (Circle all that apply)

Dull Achy Burning Sharp Stabbing Numb Tingling Throbbing Other_____

What makes the problem feel better? (Circle all that apply)

Heat Cold Rest Movement Lying Sleeping Massage/Pressure
Other_____

What makes the problem feel worse? (Circle all that apply)

Heat Cold Rest Movement Lying Sleeping Massage/Pressure Damp weather Wind Stress

Other_____

What other treatments have you received for this condition? _____

_____

Medical/Lifestyle History

List any past or future surgeries (include dates) _____

_____

List any significant trauma (Physical or Emotional), please include month/year

_____

_____

Do you have a Pacemaker? Yes No

Allergies or hypersensitivities to any foods, drugs, chemicals, or environmental substances?

_____

Medications currently taking (name & dosages) Please use back of page if needed

_____

_____

Supplements/Vitamins/Herbs (name & dosage)_____

_____

Exercise: Days per week _____ Length of workout_____ Type of Activity_____

Diet: Meals per day_____ Snacks_____ Caffeinated Drinks_____ Alcohol per week _____

Typical Meal:

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Do you have any food cravings? Yes No If so, what? _____

Water Intake per day _____ ounces Do you prefer cold, warm, or room temp drinks? _____

Are you excessively thirsty? Yes No

Please indicate if you currently have or have had any of the following conditions. Please write 'C' if you currently have or a 'P' if you have had this in the past.

_____ Arthritis	_____ Lyme Disease	_____ Kidney Disease	_____ Nervous Disorder
_____ High/Low Blood Pressure	_____ Asthma	_____ Chronic Pain	_____ Eating Disorder
_____ Hepatitis	_____ Hypo/Hyperthyroid	_____ Infertility	_____ Drug Addiction
_____ Cancer	_____ Hypo/Hyperglycemia	_____ Impotence	_____ Auto-Immune
_____ Chronic Fatigue	_____ Diabetes	_____ High Cholesterol	_____ Prolapsed Organ

____ Alcoholism	____ Seizures /Epilepsy	____ Diverticulitis/IBS	____ Ulcer
____ Gastritis/Pancreatitis	____ Anemia	____ HIV/AIDS	____ Other
____ Bleeding Tendency	____ Migraines	____ STD (which?_____)	_____
____ Meningitis	____ Stroke	____ Paralysis	
____ Liver/Gallbladder Disease	____ Heart Disease	____ Lung Illness	

List any Childhood Illnesses_____

Do you smoke (tobacco or marijuana)? Yes No

For how long?_____ How much a day?_____

Family Medical History

Please indicate any conditions that apply to your immediate family.
F=Father M=Mother S=Sister B=Brother GM=Grandmother GF= Grandfather

_____ Diabetes	_____ Asthma	_____ Stroke
_____ High Blood Pressure	_____ Heart Disease	_____ Cancer

_____Other_____

Please indicate if you currently have or had any of the following symptoms. Please write 'C' if you currently have or 'P' if you have had this in the past.

GENERAL

____ Poor or Change in Appetite
____ Weight loss
____ Weight gain
____ Poor Sleep
____ Fatigue / Low Energy
____ Fevers
____ Chills
____ Bleed/Bruise Easily
____ Anemia
____ Night Sweats or Hot Flashes
____ Sweat Easily
____ Colder than those around you (easily cold)
____ Warmer than those around you (easily hot)
____ Libido Low, Med or High
____ High Stress
____ Easily Stressed
____ Previous Organ Prolapse
____ Heavy feeling of body

NEUROLOGIC

____ Seizures or Tremors
____ Paralysis
____ Muscle Weakness
____ Numbness or tingling
____ Vertigo or Dizziness
____ Loss of Balance
____ Fainting

CARDIOVASCULAR

____ Chest Pain or Pressure
____ Shortness of Breath
____ Irregular Heart Beat
____ Blood Clots
____ Palpitations at Rest
____ Palpitations/ Fluttering
____ Swelling of Hands or Feet
____ Low Blood Pressure
____ High Blood Pressure
____ Spontaneous sweating
____ Raynaud's Disease

CIRCULATION

____ Deep Leg Pain
____ Cold hands/feet

ENDOCRINE

____ Hypothyroid
____ Hyperthyroid
____ Heat or Cold Intolerance
____ Hypoglycemia
____ Diabetes
____ Excessive Thirst
____ Excessive Hunger
____ Seasonal Depression

IMMUNE

____ Chronic Fatigue Syndrome
____ Chronic Infections

HEAD / NECK

____ Headaches
____ Migraines
____ Jaw Pain
____ Teeth Grinding
____ Swollen Glands
____ Goiter
____ Dizziness
____ Facial pain
____ Hair loss
____ Heavy feeling of head
____ Mental fogginess

MOUTH AND THROAT

____ Sore Throat
____ Copious Saliva
____ Teeth Grinding
____ Sores on Tongue/Lips
____ Mouth/Canker sores
____ Bad breath
____ Gum Problems
____ Hoarseness
____ Difficulty swallowing
____ Dental problems
____ Jaw click/locks
____ Feeling of lump in throat

. NOSE AND SINUSES

____ Frequent Colds
____ Nose Bleeds
____ Sinus Congestion
____ Frequent Runny Nose
____ Sinus Problems
____ Loss of Smell

RESPIRATORY

____ Chest Congestion
____ Chest Tightness
____ Asthma/ Wheezing
____ Difficulty inhale/exhale
____ Phlegm/Mucus...
What color? _____
____ Cough ___ Wet ___ Dry
____ Coughing Blood
____ Bronchitis
____ Pneumonia

EYES AND EARS

____ Itchy Eyes
____ Watery Eyes
____ Eye pain
____ Dry Eyes
____ Swollen/painful eyes
____ Red Eyes
____ Blurred Vision
____ Spots in Front of Eyes (floaters)
____ Cataracts
____ Color Blindness
____ Night Blindness
____ Double Vision
____ Glaucoma
____ Hearing Difficulty
____ Ear Ringing
____ Earaches/ Infection

DIGESTION

____ Abdominal Pain/Cramps
____ Heartburn/Acid Reflux
____ Change in Appetite/Thirst
____ Nausea
____ Vomiting
____ Gas/Bloating
____ Belching or Passing Gas
____ Diarrhea
____ Constipation
____ Mucous in Stools
____ Black/Bloody Stool
____ Hemorrhoids
____ Itchy/Burning Anus
____ Bad Breath
____ Strong Smelling Stools
____ Undigested food in Stools
____ IBS
____ Crohn's Bowel Movements

Number of Stools a day _____
___ Well formed
___ Hard ___ Firm ___ Soft ___ Loose
____Alternating diarrhea/constipation

SKIN

____ Rashes
____ Eczema or Psoriasis
____ Acne, Boils
____ Redness of Skin
____ Facial Flushing
____ Itching
____ Fungal Infections
____ Skin Discoloration
____ Hair Loss
____ Dry Skin/Scalp
____ Greasy Hair
____ Hair loss
____ Change in Hair texture
____ Night Sweats
____ Weak or ridged nails
____ Varicose/spider veins
____ Recent Moles

Muscle/Joint/Bones

____ Neck Pain
____ Jaw Pain
____ Shoulder Pain
____ Arm/Wrist Pain
____ Knee Pain
____ Back Pain:Low Middle Upper
____ Sciatica
____ Heaviness of Limbs
____ Muscle Pain/Tension
____ Muscle spasms / cramps

Genito-Urinary

____ Pain/Burning when urinating
____ Frequent Urination
____ Dark or Pale Yellow
____ Cloudy Urine
____ Night Urination
____ Copious or Scanty Urination
____ Inability to hold Urine
____ Urinary Tract Infections
____ Kidney Stones
____ Blood in Urine

Males Only

____ Hernias
____ Testicular Masses
____ Testicular Pain
____ Varicoceles
____ Sexually Transmitted Disease
____ Premature Ejaculation
____ Prostate Disease
____ Sexual Dysfunction
____ Infertility
____ Semen Analysis Results ?

____ Restless Leg Syndrome ____ Weak/Sore Lower Body ____ Areas of Numbness ____ Loss of Strength ____ Tingling Sensations	**MENTAL / EMOTIONAL** ____ Mood Swings ____ Anxiety or Nervousness ____ Depression ____ Poor Concentration ____ Poor Memory ____ Angry Outbursts ____ Weepy ____ Sadness or Grief ____ Irritability ____ Worry or overthinking	

Female Only
Gynecological/Reproductive

Currently pregnant? Yes No If yes, how far along _____

Attempting to get pregnant? Yes No If yes, for how long? _____

Currently breastfeeding? Yes No If yes, how long?_____ Difficult scanty or painful lactation? Yes No

Post-partum difficulties? Yes No If yes, Describe_____

Number of Pregnancies _____ Number of Live Births _____
Number of Miscarriages _____ Number of Abortions _____ Number of Ectopic Pregnancies _____
Difficulty Conceiving: Yes No Difficult or Premature Births: Yes No
Describe_____

_____

Date of last menstrual period: ____/_____/_____ Age of first menses_____ Age of last menses_____

Recent menstrual changes If so, what ?_____

How many days do you normally bleed? _____ How many days between periods? _____

How heavy is the bleeding? Heavy Average Light

How many pads/tampons per day?_____

What color is the blood? ☐Pale red ☐Red ☐Pink ☐Dark red ☐Purple ☐Brown ☐Black

Is the blood: ☐Watery ☐Clotted ☐Mucous ☐Thick ☐Strong odor

If Clotted: # of clots_____ Size of clots: ☐small ☐dime size ☐nickel size ☐quarter size ☐> quarter size

Painful periods: Yes No ☐Before ☐During ☐After menstruation

Pain quality: ☐Dull ☐Achy ☐Sharp ☐Stabbing

How many days does pain last? _____

What makes the pain better? _____

Heaviness or pressure in pelvis with periods: Yes No

PMS: Yes No What symptoms_____ When do they start?_____

Bleeding/Spotting between periods: Yes No When in cycle _____

Do you ovulate regularly? Yes No Unsure If yes, on what day of your cycle?_____

Is ovulation painful? Yes No Do you observe cervical mucus changes with ovulation? _____

Bleeding with ovulation? Yes No

Menopausal Symptoms: Yes No Describe_____

Currently taking birth control pills? Yes No Medication Name: _____

Currently using an IUD ? Yes No Which IUD type: _____

Do you do Breast Self Exams ? Yes No
Date of last PAP/Pelvic Exam _____ Abnormal PAP ? Yes No Date: _____

Please indicate symptoms you currently have or have had in the past. Please write 'C' if you currently have or 'P' if you have had this in the past.

____ Irregular Cycles	____ Menopausal Symptoms	____ Pelvic/Tubal Infection
____ Bleeding between Cycles	____ Vaginal Dryness	____ Pelvic Inflammatory Disease
____ Pain during Intercourse	____ Vaginal Discharge ? Color ? ____	____ Pelvic Adhesions/Scarring
____ Clotting	____ Vaginal Itching/Burning	____ Sexually Transmitted Disease
____ Painful Menses	____ Vaginal Odor	____ Chlamydia
____ Heavy or Excessive Flow	____ Nipple Discharge	____ Herpes
____ PMS	____ Breast Lumps	____ Bacterial Vaginosis
____ Breast Pain / Tenderness	____ Ovarian Cysts	____ Genital Warts
____ Irritability with menses	____ Endometriosis	
____ Water retention	____ Uterine Fibroids/Polyps	
____ Headaches with menses	____ Polycystic Ovarian Syndrome	

Sleep

How long do you normally sleep? _____ hours per night Snoring? Yes No Sleep Apnea? Yes No

I have difficulties with (check all that apply): ☐Falling asleep ☐ Staying asleep ☐ Dream-disturbed sleep ☐Waking up at about _____am/pm and not being able to fall back asleep

☐Waking up to use the bathroom ____ times a night

Emotional Health

Please rate your overall stress level: ☐Low ☐Medium ☐High
Have you ever been treated for a psychological concern? Yes No
Have you experienced sexual, emotional, or physical abuse? Yes No

Have you ever considered or attempted suicide? Yes No

Have you ever been treated for substance abuse? Yes No

Are you currently working with a counselor? Yes No If so, who?_____

Muscles, Joints & Bones Continued:

Do you have pain or tightness? Yes No Recent injuries? _____

The pain is (check all that apply):

☐superficial pain	☐worse with heat	☐better with heat
☐worse with cold	☐better with cold	☐worse in AM
☐worse in PM	☐worse with movement	☐better with movement
☐worse with pressure		☐better with pressure

Quality of Pain: ☐ Dull ☐ Sharp ☐Stabbing ☐Burning ☐Deep ☐Shooting ☐Aching ☐Numb ☐Tingling

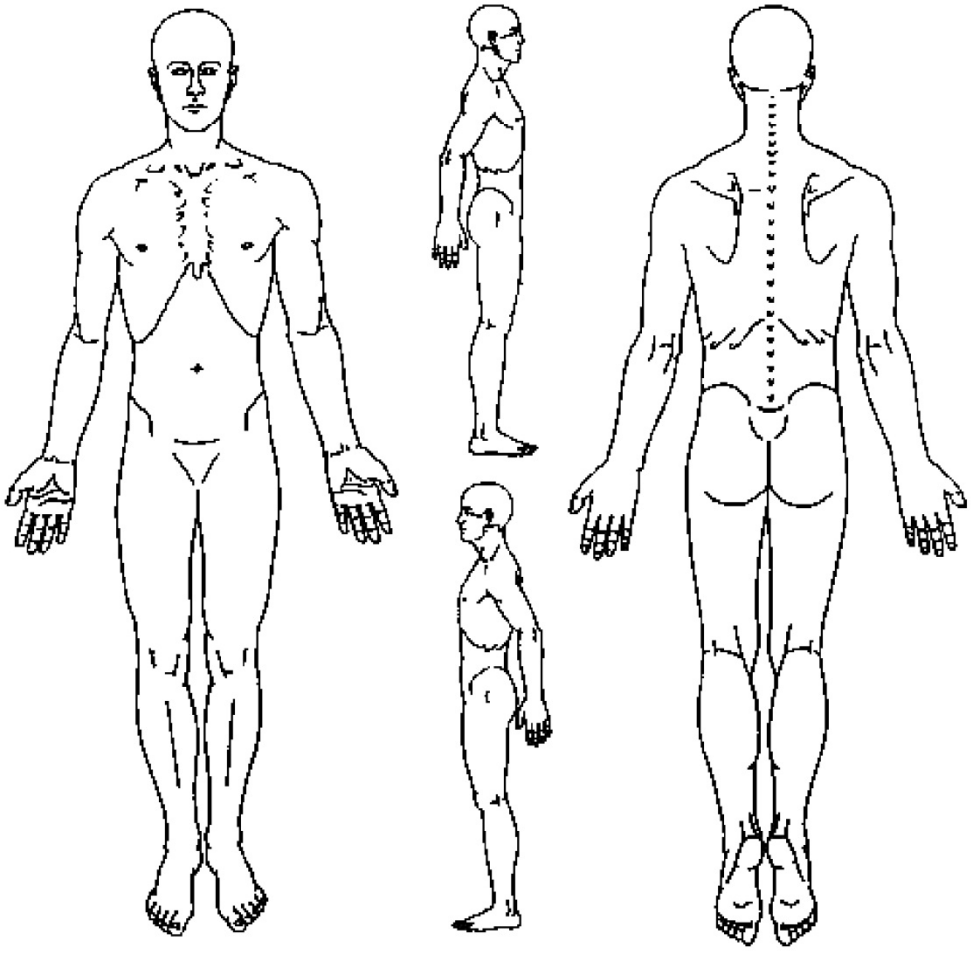
I have (check all that apply): ☐Bone pain ☐Swollen joints ☐Arthritis/joint pain ☐Muscle cramping ☐Muscle pain

Where?_____ Was this from an auto accident or work related?_____

Broken or fractured bones in the past? Yes No Where? _____ When? _____

Pain Diagram (please mark all areas of pain on diagram below)

A= aching B= burning N=numbness P= pins and needles S= stabbing pain O= other type of sensation



To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may be dangerous to my health. It is my responsibility to inform the practitioner of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Patient's Signature_____ Date_____

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Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or on the patient names below, for whom I am legally responsible) by Sierra Abate L.Ac. and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a back-up for Sierra Abate L.Ac.

I understand that methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, moving cupping, gua sha, electrical stimulation, breathing techniques, exercise therapy, Tui-Na (Chinese massage), Chinese or Western herbal medicine, supplement recommendations, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness, dizziness, fainting, or tingling near the needling site that may last a few days. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Although rare, unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including pneumothorax. Infection is another possible risk, although the acupuncturist uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are potential risks of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The Herbs and nutritional supplements (which are from plants, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, and rash.

I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant smell or taste. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of the treatments which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent.

I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

By voluntarily signing below I show that I have read, or had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover my entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

X_____ _____

Signature of Patient (or Representative) Printed Name of Patient

Today's Date _____

Notice of Privacy Practices

Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information.:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g*. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 520-907-6339.

Yours truly,

Sierra Abate, L.Ac.

I hereby acknowledge that I have read and understand this acupuncture practice's Notice of Privacy Practices.

Signed: _____ Date: _____

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Payment and Cancellation Policy

Payment: Payment is expected in *full* at the time of service. Cash, checks, and most major credit cards are accepted forms of payment.

You are responsible for any portion of your charges remaining unpaid by your insurance company. This includes non-covered services and any patient responsibility.

Returned Checks: If your check is returned for insufficient funds, there will be a $25 Returned Check fee added to your account, in addition to the amount the check was for.

Cancellation/Late Arrival Policy: In order to provide high quality healthcare to all patients, a 24 hours advanced notice is requested in order to cancel or reschedule an appointment. If you are unable to cancel your appointment 24 hours in advance, a cancellation charge of 65% of the *full* price of service for which you were originally scheduled will be charged to the credit card provided below or added as an outstanding balance to your account if card is not provided or unable to be charged. The appointment will be considered a missed appointment after 10 minutes of the original scheduled time and the cancellation fee will be charged. Those with packages will forfeit their visit for late cancellations or missed appointments.

The credit card number provided below will only be charged in the event of late cancellations and missed appointments.

I have read, understand, and agree to the policies outlined above.

_____ _____ ____/____/_____
Printed Name of Patient Patient's Signature Date

_____ _____ _____
Credit Card # Expiration Date Verification code

Thank you for understanding our policies.