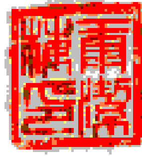

Jaime Kahn Gordon, L.Ac.

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Patient Information & Health History

Note: This is a confidential record of your medical history and will be kept in this office. Information contained herein will not be released to any person without your written authorization.

Patient Information

Name: ______________________________________ Today's Date: ____________
Street Address: ____
City, State and Zip: ____
Home Phone: ______-______-______ Work Phone: ______-______-_______
Cell Phone: _______-_______-______ *{Please circle the best phone to leave a message}*
E-Mail Address: ____
Age: ________ Birthdate: ___/___/___ Birthplace: _____________________
Height and Weight: ________________ Relationship Status: ______________
Occupation:_______________________ Employer's Name: ________________
Family Physician: __________________ Physician's Number:______________
Emergency Notification: _______________ Phone: __________ Relation: _________
Referred By: _____________________________

Please answer the following questions:

Yes	No	
❍	❍	Are you nervous about needles?
❍	❍	Do you have tendency to faint?
❍	❍	Do you bruise easily?
❍	❍	Women: are you pregnant?
❍	❍	Have you ever had acupuncture? When & for what? _________________

Yes	No	
❍	❍	Do you have hepatitis or HIV?
❍	❍	Have you ever had hepatitis?
❍	❍	Do you have a pacemaker?
❍	❍	Any bleeding disorders?

Policy Concerning Payment of Bills

1. My policy is that payment is to be made at time services are rendered, unless acceptable alternative arrangements have previously been made.
2. Please understand that your appointment time is set-aside for you. Patients canceling the same day of treatment, missing their appointment, or arriving late will be charge according to the time booked. Cancellation fees will also apply to new patients for a missed first visit. Cancellations due to weather or emergency are excused if you call prior to your appointment. So with the exception of a bona fide emergency situation, if you must cancel or change an appointment my policy is that:

   YOU WILL BE CHARGED IF YOU DO NOT GIVE AT LEAST 24 HOURS NOTICE

3. I attempt to stay on schedule and am usually successful. I ask that you please be aware that a specific amount of time is reserved for your treatment and that:

   IF YOU ARRIVE LATE, YOUR TREATMENT WILL BE ADJUSTED TO FIT INTO THAT TIME SCHEDULE

Acupuncture Consent

Please place a check mark in the circles preceding each paragraph to indicate that you have read and understand each paragraph:

❍ I, the undersigned, authorize Jaime Kahn Gordon, Registered Acupuncturist, to perform the Chinese medical treatment known as *acupuncture*. I understand that acupuncture involves the insertion of sterilized needles through the skin, or by the application of heat to the skin (moxabustion), or by both, at specific points on the body in an attempt to treat body dysfunctions or diseases, to modify or prevent the perception of pain, and to make normal the body's physiological functions.

❍ I understand that there is no implied or stated guarantee concerning its success or effectiveness of a specific treatment or series of treatments, and that I am free to discontinue treatment at any time.

❍ I am aware the certain adverse side effects may result. These could include, but are not limited to some local bruising, bleeding, fainting, pain and discomfort, burns from moxabustion treatment, and temporary aggravation of symptoms existing prior to acupuncture treatment. I am aware that if there is a worsening of my ailment or condition or if it does not improve within the time estimated by the acupuncturist, I should consult a physician.

❍ None of the foregoing provisions preclude the administration to me of conventional medical therapy by a licensed physician when in his or her discretion such therapy is deemed appropriate.

❍ I consent, too, to the submission of any data arising out of or in relation to my acupuncture treatments, without the use of my name, to any research, medical, scientific or educational body deemed appropriate by the acupuncture practitioner.

I have carefully read and understand all the foregoing and so am fully aware of what I am signing.

Signature of Patient:____ **Date:**_____________

Patient name (printed):____

Present Health

Chief Concern: ____

____

Date of onset (when you first noticed your problem): ______________________________

Is there Pain? (Please describe): ____

To what extent does this problem interfere with your daily activities? ________________

Is your condition getting: ☐ Worse ☐ Constant ☐ Comes & goes

What makes it worse? _________________________What makes it better? __________________

Have you had this in the past? ☐ Yes ☐ No When? _____________________________

Have you been given a diagnosis for your problem? If so: what, when, and by whom? ____________

____

What kinds of treatment have you tried? ____

____

Medical History

- ❍ Anemia
- ❍ Arthritis
- ❍ Asthma
- ❍ Cancer
- ❍ Chronic Fatigue
- ❍ Diabetes
- ❍ Epilepsy
- ❍ Gall Stones
- ❍ Heart Attack/Disease
- ❍ High Blood Pressure
- ❍ Rheumatic Fever
- ❍ Seizure
- ❍ Stroke
- ❍ Thyroid Disease
- ❍ Ulcer
- ❍ Venereal Disease
- ❍ Kidney/Bladder Disease

Other significant illnesses (include dates): ______________________________________

____

____

Allergies (drug, chemical, food): ____

Surgeries (type and date): ____

____

Trauma (type and date): ____

____

Medications currently being taken (include drugs, vitamins, & herbs): ____________________

____

____

____

Family History

	Father	Mother	Siblings	Children
Age if living				
Cause of death & age				
Health: Good/Poor				
Cancer				
Diabetes				
Heart Disease				
Hypertension				
Stroke				
Epilepsy				
Mental Illness				
Asthma, Hay Fever				
Kidney Disease				
Tuberculosis				
Hepatitis				
Other, please list				

Lifestyle

Employment activities: ____

____

Exercise (kind, frequency): ____

____

How much sleep do you average each night? ____________ Do you have difficulty getting to or staying asleep?
(Please describe) ____

Energy level: Highest at what time of day? ______________________________
Lowest at what time of day? ______________________________

Are you satisfied with your current diet (explain): ______________________________

____

Please describe your average daily diet and time of day you eat:
Morning: ____
Afternoon: ____
Evening: ____
Do you eat "on the go" or sit down to a meal? _____________ Do you eat when you're not hungry? _________
Do you snack often? (How much and what) ______________________________
How much water do you drink each day? (In 12 oz. Glasses) ______________________________
How much coffee, tea, or soft drinks do you consume a day? ______________________________
How much alcohol do you consume a day/week? ______________________________
Do you smoke? If yes, how many cigarettes each day? ______________________________
Did you quit smoking? When? ______________________________
Other non-pharmaceutical/recreational drugs used now or in the past, and how often? ____________________

____

____

Review of Systems

Please check any that you are experiencing now or have experienced in the past three months.

Skin and Hair:
❍ Dry
❍ Oil
❍ Itchy
❍ Moist/Clammy
❍ Rashes/Hives
❍ Pimples
❍ Bruise easily
❍ Hair loss
❍ Sores/Ulcers

Cardiovascular:
❍ High blood pressure
❍ Low blood pressure
❍Chest pain/pressure
❍Blood clots
❍Cold hands or feet
❍Swelling feet/hands
❍Fainting
❍Varicose veins
❍Pain or cramping in legs

Neuropsychological:
❍ Poor memory
❍Seizure
❍Depression
❍Fear/anxiety
❍Bad temper
❍Crying spells
❍Overwhelming joy
❍Concussion
❍Easily stressed

Respiratory:
❍ Daily cough
❍ Cough with blood
❍ Asthma
❍ Bronchitis
❍ Difficulty breathing
❍ Shortness of breath
❍ Tight chest
❍ Frequent chest colds
❍ Pneumonia
❍ Production of phlegm/sputum. What color?______________

Ears, Eyes, Nose Throat:
❍ Dizziness/Vertigo
❍ Headaches/Migraine
❍ Facial pain
❍ Ringing in ears
❍ Earaches
❍ Poor hearing
❍ Teeth grinding
❍Gum bleeding
❍ Poor vision
❍ Eye pain/strain
❍ Night blindness
❍ Nose bleeds
❍ Nasal stuffiness
❍ Constant head colds
❍ Loss of smell
❍ Sores on lips/tongue
❍ Frequent sore throats

Gastrointestinal:
❍ Nausea
❍ Vomiting
❍Poor appetite
❍ Belching
❍ Indigestion
❍ Bad breath
❍ Abdominal pain
❍ Flatulence
❍ Loose stools
❍ Constipation
❍ Diarrhea
❍ Hemorrhoids
❍ Blood in Stool
❍ Mucus in Stool
❍ Black Stool
❍ Rectal Pain

Musculoskeletal:
❍ Joint pain/stiffness
❍ Muscle pain
❍ Numbness/tingling
❍ Neck pain
❍ Back pain
❍ Shoulder pain
❍ Hip pain
❍ Knee pain

Genito-Urinary:
❍ Burning urination
❍ Blood in urine
❍ Urgency to urinate
❍ Frequent urination
❍Difficulty urinating
❍Incontinence
❍Kidney stones
❍Venereal disease
❍Wake at night to urinate

Women Ob/Gyn:
Age first menses:_______
Time between menses:___
Date last menses:___/___/__
Duration:_____ days long
Blood color: ___________
Quantity of blood (circle):
Excess/Normal/Scanty?
❍ Clots in menses blood
❍ Pain with menses
❍ PMS
Pregnancies: #_____
Births: #_____
Miscarriages: #_____
Abortions: #_____
Last Pap:_____________
❍ Vaginal discharge
❍ Vaginal Sores
❍ Breast lumps
❍ Nipple discharge
❍ Birth control?
What kind: ___________

General:
❍ Chills/fever
❍ Sweat easily
❍ Night sweats
❍ Weight loss/gain
❍ Strong thirst (hot/cold)
❍ Tremors
❍ Fatigue
❍ Sudden energy drop. What time of day?____
❍ Swollen glands
❍ Unusual tastes or smells? What?__________

Please use this page for any additional comments, questions or notes:

Learn more at: **www.InnerLandscapeAcupuncture.com**