

Welcome to Saguaro Clinic Policies

We want the Clinic to be welcoming and comfortable for everyone.

Many people come to this Clinic for treatment of environmental or other allergies.

For that reason, we ask that you refrain from wearing scented personal products (for example perfume, aftershave, lotion, essential oils) when visiting the office.

Thank you for your consideration of others.

Saguaro Clinic of Oriental Medicine

639 East Speedway Blvd.
Tucson, AZ 85705
(520) 319-9711

Patient Confidential Information

Name _____ Birthdate _____ Age _____ Sex _____
 First Middle Last

Address _____ City _____ State _____ Zip _____

Telephone: Home _____ Work _____ Cell _____ Marital: M S D W P

Have you been previously treated by Acupuncture or Oriental Medicine? _____

(Child under 18?) If yes, please list both parents' name and address

ADULT CONSENT: I hereby voluntarily consent to be treated by acupuncture and/or other Oriental Medicine modalities by Helene C. Sorkin, L.Ac. MSOM, NCCAOM National Board Certified.

Patient's/Parent's Signature _____ **Date** _____

Financial Arrangements

How will you handle your account? Cash Check Credit Card Health Savings Account/Flex Plan

Part I

I was referred by _____

Who is your Health Care Provider/MD? _____ Phone _____

In Emergency Notify _____ Phone _____

Relationship with person above _____

Nearest relative _____ Address/Phone _____

HEALTH PROJECT/MAIN COMPLAINT _____

Is condition due to: Auto accident? Injury? Job related? Other

Please explain _____

When did this problem begin? _____

The diagnosis for this problem, if given one? _____

Have you seen a doctor for this problem? Doctor's Name _____

Address _____ Phone number _____

What kinds of treatment have you tried? _____

Are you currently receiving treatment for this problem? _____

What causes improvement? _____

What makes the condition worse? _____

Your Past Medical History (please include date when possible)

Childhood or other illness:

Surgeries _____

Significant Trauma (i.e., car accidents, falls, concussion)

Do you have any infectious disease, i.e. HIV, or hepatitis? If so, please list:

Prescription medications, over-the-counter drugs, vitamins, herbs, etc. taken within the last month:

Usual blood pressure ____/____ Pulse rate _____ Cholesterol _____

Allergies: food, inhaling, other: _____

Family Medical History and General Health:

Mother's side: _____

Father's side: _____

Number of siblings: _____ if any deceased, cause of death: _____

Your own birth: (prolonged labor?) _____

Your childhood health: _____

Where were you brought up? _____

Current Emotional Health: _____

Current Quality of Life: _____ Current Relationship Quality: _____

Current Health Therapies or Regimens: _____

Current Predominant Emotions: _____

Occupation: _____ Employer _____ Stress level _____

Have you experienced any unusual stresses recently? _____

Favorite time of year: _____ Worst time of year _____ Hobbies/recreation _____

Do you have a regular exercise program? _____

Height _____ Weight _____ Sweat: constantly easily normal lightly never

Travel abroad within the past year? ____ Two years? ____ Where? _____

Have you ever been on a restricted diet? ____ Purpose/describe: _____

Please describe your typical meals:

Morning	Afternoon	Evening	Snacks
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Proportion of raw food _____ to cooked food _____

Food cravings? ____ If so, what? _____ When? _____

Preferred Tastes: _____ Bitter Spicy Sour Salty Sweet

How many cigarettes do you smoke **a day**? _____

How much coffee, tea or soda do you drink **per day**? _____

How much alcohol do you drink **per week**? _____

Does your family have a history of the following? Indicate (S) for yourself, (M) Mother's side, (F) Father's side

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> HIV | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Herpes | <input type="checkbox"/> Addictive Disorders |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mental Illness |

YOUR OWN SYMPTOMS OVER LAST TWO WEEKS:

- Generally chilly
- Fatigue
- Feverish in the afternoon or flushes
- Heat sensation in hands, feet, chest
- Day sweats
- Night sweats
- Thirsty
- Catch colds easily
- Shortness of breath
- Sweat easily
- General weakness
- Feel worse after exercise
- Dizziness
- See floating black spots
- Poor balance
- Palpitations
- Irregular heart beat
- Chest pain
- Swelling of hands
- Sores on tip of tongue
- Restlessness
- Anxiety
- Chest pain travelling to shoulder
- Insomnia
- Dream disturbed sleep
- Mental confusion
- Emotional changes
- Cough
- Cough blood
- Nasal discharge
- Nose bleeds
- Sinus congestion
- Dry mouth, throat, nose, or skin
- Sore in lips, tongue
- Teeth problems
- Grinding teeth
- Facial pain
- Allergies
- Chills alternating with fever
- Sneezing
- Headache
- Feel achy
- Stiff neck/shoulders
- Sore throat
- Difficult breathing
- Fever
- Chills
- Asthma
- Shortness of breath
- Phlegm, color _____
- Bruise easily
- General feeling of heaviness in body
- Mental heaviness, sluggishness or fogginess
- Swollen hands
- Swollen feet
- Nausea
- Diarrhea/Loose stool
- Constipation
- Hemorrhoids
- Blood in stool/black stool
- Indigestion
- Ulcer
- Hernia
- Burning sensation after eating
- Abdominal bloating and/or gas after eating
- Large appetite
- Bad breath
- Mouth (canker) sores
- Bleeding, swollen or painful gums
- Heartburn
- Belching
- Stomach pain
- Low appetite
- Change in appetite
- Fatigue after eating
- Prolapsed organs (diagnosed)
- Diarrhea alternating with constipation
- Feel better after exercise
- Tight feeling in chest
- Bitter taste in mouth
- Blood shot eyes
- Angered easily
- Skin rashes
- Headache at top of head
- Hot flashes
- Dry eyes
- Numbness of hands or feet
- Muscle spasms, twitching, cramping
- Seizures
- Tremors
- Convulsions
- Irritability; easily susceptible to stress
 - Shingles (ever had?) _____

Are there any other conditions which you have had, or have right now, that we should be aware of?

What is the most important thing for me to know about you? _____

Put a check mark by the symptoms that pertain over the **LAST TWO WEEKS**.

- Sore, cold or weak knees
- Low back pain
- Frequent urination
- Do you get up more than one time at night to urinate? Number of times_____
- Lack of bladder control
- Memory problems
- Hair loss
- Ringing in the ears
- Cold hands and/or feet
- Genital sores/herpes
- Kidney stones

Musculoskeletal:

- General aches
- Muscular atrophy/loss
- Muscular weakness
- Arthritis
- Joint instability
- Muscle cramps
- Spasms
- Recent sprains
- Injuries or falls
- Joint pain

Urine is:

- Normal color
- Cloudy
- Difficult
- Scanty
- Urgent
- Has odor
- Clear
- Dark yellow
- Reddish
- Burning
- Painful

Libido (sexual drive) is:

- Normal
- Low
- High

- Depression
- Mania
- Weight loss/gain
- High blood pressure
- Low blood pressure
- Phlebitis
- Blood clots
- Parasites
- Poor hearing
- Concussion

- Itching
- Eczema
- Hives
- Pimples
- Dandruff
- Loss of hair
- Dry skin
- Rash
- Recent moles

WOMEN

- ◆ Are you/or could you be pregnant now?
Yes No
- ◆ Number of children _____
- ◆ Number of pregnancies _____
- ◆ Your age at first period _____

- ◆ Are your menses cycles regular? Yes No

- ◆ Number of days between periods? _____

- ◆ Average days of flow? _____
The flow is: Normal Heavy Light
Color is: Normal Dark Pale
 Bright red Brown

- ◆ Are there blood clots: Yes No

- ◆ Do you have pain/cramps? Yes No
 Before During After period

- ◆ Do you have nausea or vomiting?
 Yes No Before During period

- Birth control method: _____

- ◆ Do you experience any of the following before your period each month?
 Water retention Breast tenderness
 Breast swelling mental depression
 Irritability Food cravings
 Migraines Low back pain

- ◆ Do you bleed between periods?
 Yes No

- ◆ Do you have unusual vaginal discharge between periods? Yes No

- ◆ If yes, describe consistency, color, odor

Sexually transmitted disease:

OVERALL, TODAY I FEEL:

| _____ |
Great OK Not Too Good

MEN

- Feeling of coldness or numbness in the external genitalia?

- Pain or swelling of testicles?

- Premature ejaculation?

- Impotence?

- Number of children? _____

- Prostate problems

Sexually transmitted disease:

OVERALL, TODAY I FEEL:

| _____ |
Great OK Not Too Good

Body Chart

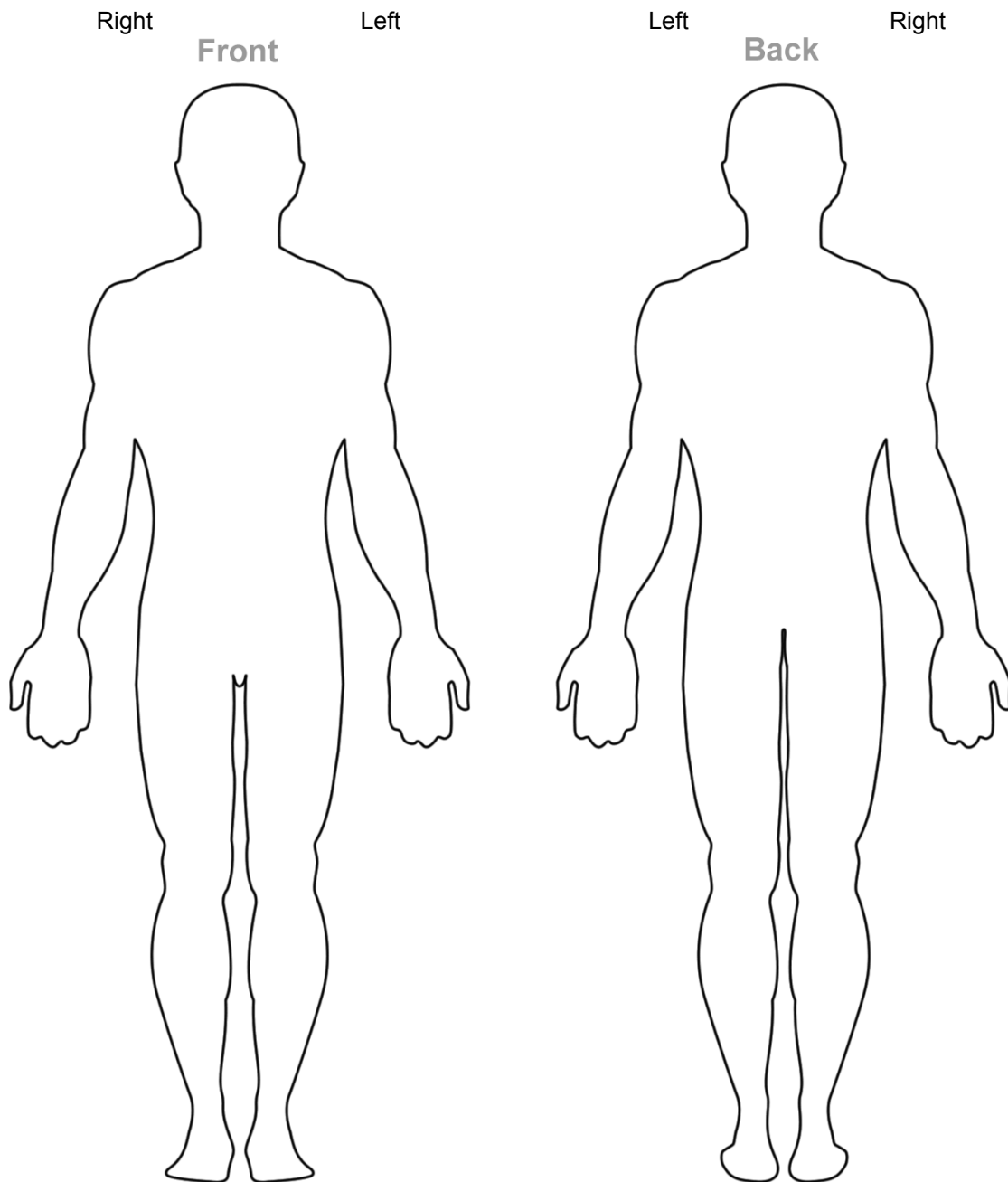
Patient Name _____ Date: _____

Acupuncturist _____ Date of Injury : _____

Patient Date of Birth _____ Age: _____

Signature _____

Please use a pen to indicate the areas where you are experiencing pain or discomfort currently.
Indicate/circle where you experience pain that is sharp, dull, achy, pins/needles, areas without feeling, areas of stiffness.
On a scale of 0 – 10, 10 being highest, how much pain/discomfort are you experiencing today?_



GENERAL INSTRUCTIONS FOR PRE-MADE CHINESE HERBAL FORMULAS

- Stop taking TONIFYING/SUPPORTING herb formulas (pills or cooked tea formulas) when you are coming down with a cold or flu. Call the office about this if you have question. You may have the cold/flu treated with the appropriate formula. Taking your regular formula(s) could make your cold/flu worse.
- Female patients taking Xiao Yao Wan: Please DO NOT take it during your period. Please stop this formula when your period starts unless otherwise instructed.
- The formula you are given is specific to you. Please do not let another person “try it out”. A particular formula is chosen for you according to your pattern imbalance. An example: if a formula is for a person whose main symptom is headache, they could be given one of 10 different formulas. Your generosity could make someone else worse instead of better.
- While it is unlikely, if you notice any unusual reactions, for example a rash, please call the Clinic and discontinue the formula immediately until further instructed.