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
1702 East Prince Road. #130
Tucson, AZ 85719
(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/MAINCOMPLAINT_____
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

_____

_____

_____

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

.

☐ Cancer	☐ Asthma	☐ High Blood Pressure
☐ Diabetes	☐ Allergies	☐ Thyroid Disorders
☐ Heart Disease	☐ HIV	☐ Rheumatic Fever
☐ Seizures	☐ Herpes	☐ Addictive Disorders
☐ Stroke	☐ Hepatitis	☐ 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
- ❑ Constipations
- ❑ 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

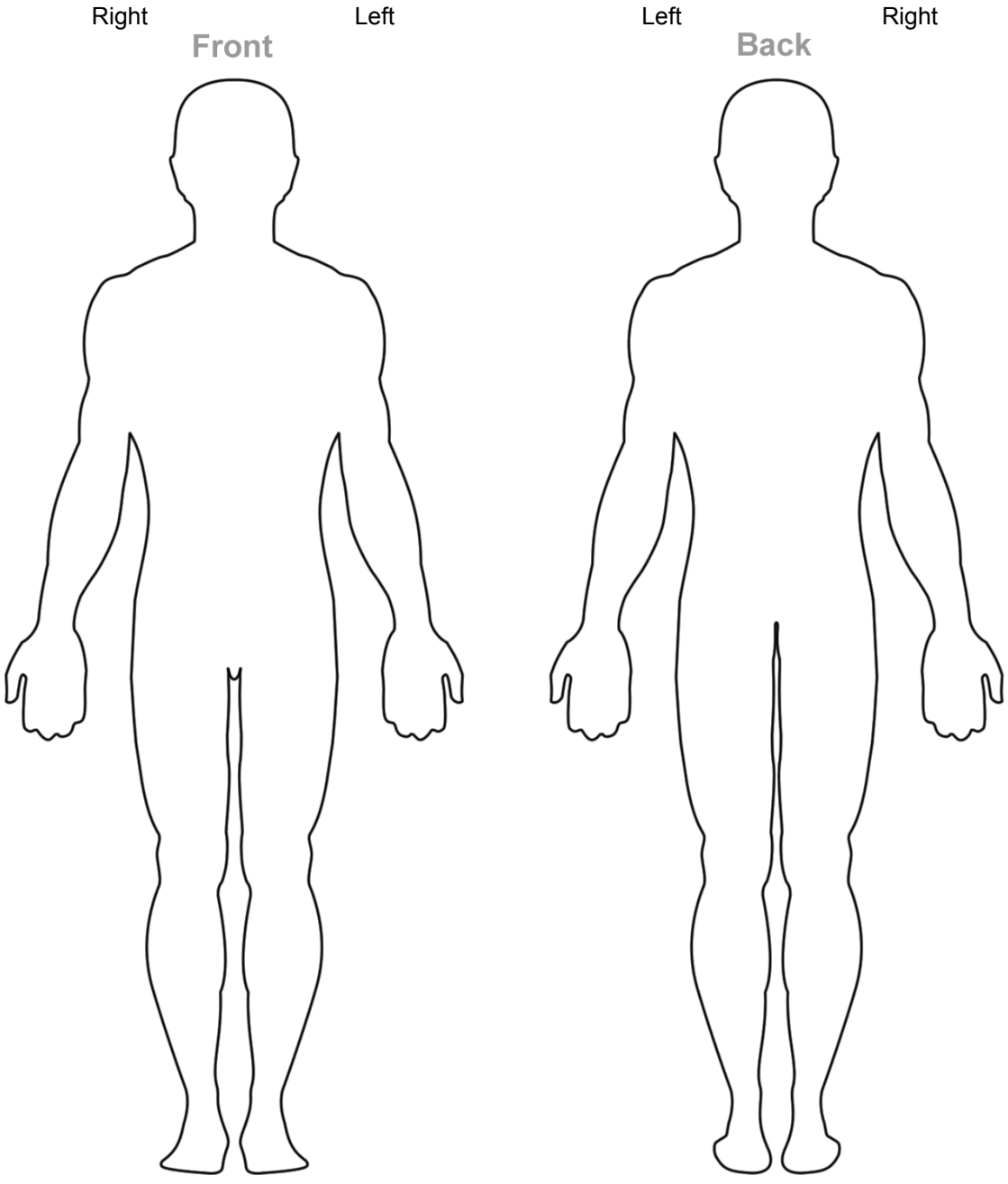
Patient Name_____ **Date:** _____

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.