PATIENT INFORMATION FORM

GORILLA ACUPUNCTURE
541.231.6558
Sang Ly Montage
Licensed Acupuncturist (L.Ac.)

Name:	Today's Date:	Gender:

Address:	City:	State:	Zip:

Home Phone #:	Alt. Phone #: Work Cell Other	Email: Permission to contact you? ☐Yes ☐No

Age:	Date of Birth:	Time of Birth: AM / PM	Location of Birth:

Height:	Weight:	Relationship status:	# of Children:	# and Ages of Children living at home:

Occupation:	Employer:	How did you hear of Sang Montage?

Physician:	Date last seen:	911 contact info:	Currently have an infectious disease? If so , describe: ☐Yes ☐No

Have you been treated by acupuncture or Oriental Medicine before? ☐Yes ☐No	If so, by whom?	For what condition / how many treatments?	Was it effective? ☐Yes ☐No

REASONS FOR VISIT

Please describe your main concerns in order of importance.

Indicate severity on the scale from 1-10, and circle "better", "worse" or "no change" to indicate the effect of each factor listed.

Main Concern: _____

Known cause? _____

Onset: _____ Diagnosed by a Doctor?
years / months / days ago ☐Yes ☐No When?_____

Severity:
1 — 5 — 10
(1=no symptoms, 10=worst ever)

Factor		Effect	
Massage:	*better*	*worse*	*no change*
Pressure:	*better*	*worse*	*no change*
Heat:	*better*	*worse*	*no change*
Cold:	*better*	*worse*	*no change*
Damp weather:	*better*	*worse*	*no change*
Exercise/Activity:	*better*	*worse*	*no change*
Level of stress:	*low*	*medium*	*high*

Further description: (details of onset or development, impact on life, etc.):

_____
_____
_____
_____

Additional Concern(s):_____

Known cause? _____

Onset: _____ Diagnosed by a Doctor?
years / months / days ago ☐Yes ☐No When?_____

Severity:
1 — 5 — 10

Massage:	*better*	*worse*	*no change*
Pressure:	*better*	*worse*	*no change*
Heat:	*better*	*worse*	*no change*
Cold:	*better*	*worse*	*no change*
Damp weather:	*better*	*worse*	*no change*
Exercise/Activity:	*better*	*worse*	*no change*
Level of stress:	*low*	*high*	*no change*

Further description:

_____
_____
_____
_____

Indicate affected areas of the body:

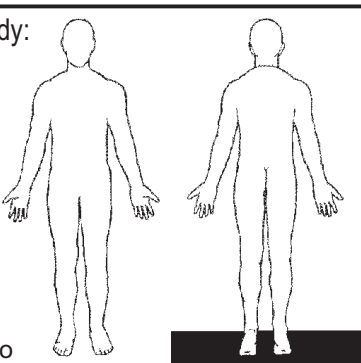
If Pain:

Quality of pain (circle):
Dull *Sharp* *Stabbing*
Sore *Cramping* *Burning*

Duration of pain (circle):
Constant *Intermittent*

Location of pain:
Fixed *Moves Around*

Does the pain radiate? ☐Yes ☐No
Where?



Anything you care to add:

_____
_____
_____
_____
_____
_____

HEALTH HISTORY Name: _____ Date:_____

Mark the scales and boxes of those symptoms you have now or have had in the past:
for current symptoms mark with a "N" for "now", for past symptoms mark with a "P".

TEMPERATURE

Indicate how much you generally feel hot or cold.

COLD [10 5 0 5 10] HOT

- ☐ Cold hands / feet
- ☐ Chills
- ☐ Chill "in the bones"
- ☐ Numbness / Tingling
  Location of sensation:_____
- ☐ Absence of ☐ Excessive thirst
- ☐ Thirst, with desire to drink
- ☐ Thirst, no desire to drink
  Prefers ☐ iced ☐ hot drinks
- ☐ Night sweats
- ☐ Spontaneous sweats
  Circumstances causing sweating:
  _____
- ☐ Hot hands, feet, chest
- ☐ Hot flashes
- ☐ Hot in afternoon
- ☐ Hot at night

MOISTURE

Your overall body moisture (hair, skin, lips, etc.)

DRY [10 5 0 5 10] OILY

- ☐ Dry skin
- ☐ Dry eyes
- ☐ Dry or ☐ thinning hair
- ☐ Dry / brittle nails
- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry throat
- ☐ Dry nose / nosebleeds
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Hesitant urination
- ☐ Painful urination
- ☐ Burning urination
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Dribbling
- ☐ Decreased flow
- ☐ Incontinence
- ☐ Kidney stones ☐ Gallstones
- ☐ Frequent UTI

Input of fluid = output of urine? Y / N
Color of urine_____
Smell of urine_____

- ☐ Dandruff
- ☐ Edema / Swelling _____
- ☐ Rashes _____
- ☐ Itching _____
- ☐ Oily skin
- ☐ Oily hair
- ☐ Acne
- ☐ Weight gain / loss

Location on body:

ENERGY

LOW [10 5 0 5 10] HIGH

- ☐ General fatigue
- ☐ Best time of day _____
- ☐ Worst time of day _____
- ☐ Body / Limbs feel heavy
- ☐ Body / Limbs feel weak
- ☐ Difficllty concentrating
- ☐ Poor memory
- ☐ Vertigo
- ☐ Dizziness
- ☐ Bruises easy
- ☐ Tired after eating
- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ Blood pressure High / Low
- ☐ Headaches _____ x / week
  location on/in head:
  _____

DIGESTION

DIARRHEA [10 5 0 5 10] CONSTIPATION

- ☐ Poor appetite
- ☐ Insatiable hunger
- ☐ Indigestion
- ☐ Heartburn
- ☐ Acid Reflux
- ☐ Strange taste in mouth:_____
- ☐ Nausea / Vomiting
- ☐ Bad breath
- ☐ Gas ☐ after eating
- ☐ Bloating ☐ after eating
- ☐ Belching ☐ Ulcers

Bowel Movements: _____x / every _____days

- ☐ Loose Stool ☐ Formed Stool
- ☐ Alternating diarrhea & constipation (IBS)
- ☐ Complete or ☐ partial elimination
- ☐ Presence of blood, mucus, undigested food
- ☐ Dry Stools
- ☐ Difficult or ☐ painful to pass
- ☐ Fatigued after BM
- ☐ Foul smelling stool

SLEEP

hours per night _____

- ☐ Difficulty falling asleep
- ☐ Wake ___x/ night @_____am / pm
- ☐ Wake to urinate How often?____
- ☐ Disturbing / vivid dreams
- ☐ Restless sleep
- ☐ Rested or ☐ tired upon waking

EMOTIONS

Most commonly felt:

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Joy
- ☐ Fear
- ☐ Timid / shy
- ☐ Indecision

EYES, EARS NOSE THROAT

- ☐ Poor vision ☐ Glasses
- ☐ Night blindness
- ☐ Red or ☐ itchy eyes
- ☐ Spots in front of eyes
- ☐ Sore throat ☐ Mouth sores
- ☐ Cough ☐ Sinus congestion
- ☐ Phlegm: color/consistency_____
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excess earwax
- ☐ Ear infections
- ☐ Teeth Grinding
- ☐ Dental problems

DIET

Have you ever been on a special diet? (vegetarian, vegan, raw, Atkins, etc.)

Describe w/ dates:

Typical Breakfast:

Lunch:

Dinner:

Snacks and Cravings:

HABITS

Amount / Week — If Quit, Year?

Water_____ _____
Coffee / Tea_____ _____
Soda_____ _____
Alcohol_____ _____
Tobacco_____ _____
Recreational Drugs_____ _____
TV/Computer Use_____ _____

EXERCISE

Do you exercise regularly? ☐ Yes ☐ No
If so, what kind and how often?

_____
_____
_____
_____
_____

Known or suspected food, medication or latex allergies? _____

Please add any informationyou feel is important:

NAME: _____

CONDITIONS

Circle the 🧍 if you ever had the condition, note year of onset. Circle the 👪 if there is a family history of the condition.

	YOU	Year	FAMILY
Arthritis - - - - - - -	🧍	_____	👪
Diabetes I / II - - -	🧍	_____	👪
Osteoporosis - - -	🧍	_____	👪
Ulcers - - - - - - - -	🧍	_____	👪
Heart Disease - -	🧍	_____	👪
Hemorroids - - - -	🧍	_____	👪
Stroke - - - - - - -	🧍	_____	👪
Paralysis - - - - -	🧍	_____	👪
Dyxlexia - - - - - -	🧍	_____	👪
Pacemaker - - - -	🧍	_____	👪
Fibromyalgia - - -	🧍	_____	👪
TB / Pleurisy - - -	🧍	_____	👪
Anemia - - - - - - -	🧍	_____	👪
Hemophilia - - - -	🧍	_____	👪
Rheumatic Fever	🧍	_____	👪
Cancer - - - - - - -	🧍	_____	👪
type(s):			

	YOU	Year	FAMILY
Asthma / Emphysema - - - -	🧍	_____	👪
Abdominal Pain - - - - - - - -	🧍	_____	👪
Leaky Gut Syndrome - - - -	🧍	_____	👪
Low / High Blood Pressure	🧍	_____	👪
Hyper / Hypo Thyroid - - - -	🧍	_____	👪
Gallbladder Disease - - - - -	🧍	_____	👪
Slow wound healing - - - - -	🧍	_____	👪
Hepatitis A / B / C - - - - - -	🧍	_____	👪
Chronic Infections - - - - - -	🧍	_____	👪
Alcoholism / Drug Abuse - -	🧍	_____	👪
Chronic Fatigue Syndrome	🧍	_____	👪
Vericose Veins - - - - - - - - -	🧍	_____	👪
Mental Illness - - - - - - - - -	🧍	_____	👪
Seizure / Epilepsy - - - - - - -	🧍	_____	👪
Kidney Disease - - - - - - - -	🧍	_____	👪
Allergies - - - - - - - - - - - - -	🧍	_____	👪
type(s):			

Overall Health as a child (circle one): *good / fair / poor*

Describe any conditionnot listed above:

REPRODUCTIVE HISTORY

Sexually active? ☐ Y ☐ N ☐ Painful Intercourse ☐ Change of sexual drive: ⇧ ⇩ ☐ Hemorrhoids ☐ Hernia

♀ FEMALE

Age at first menses: _____
Length of full cycle: _____ days
Length of menses: ____ days
Last menses start date: ____ / ___
☐ Hysterectomy Date: _____
☐ Irregular periods ☐ Clots
☐ PMS Blood color:
☐ Painful periods _____
☐ Endometriosis ☐ Fibroids ☐ Ovarian Cysts ☐ Abnormal Pap Smear ☐ Nipple Discharge

☐ Heavy flow
☐ Scanty flow
☐ Cramps
☐ Before bleeding
☐ First few days
☐ Throughout period

☐ Breast tenderness/lumps
☐ Fatigue w/ menses
☐ Midcycle spotting
☐ Vaginal discharge
☐ Yeast infections
☐ Birth control (type:_____used since:_____)

# of pregnancies: ____
# of births: ____ premature ____
# of abortions / miscarriages: ____
☐ Trying to get pregnant since when?_____
☐ Possibly pregnant now?

MENOPAUSE

Age at last menses : _____ ☐ Hot flashes _____x / day ☐ Vaginal dryness
Year menopause began: ____ ☐ Night sweats _____x / week ☐ Low libido

♂ MALE

☐ Erectile dysfunction DX date: _____
☐ Impotence ☐ Premature ejaculation

☐ Genital / testicular Pain
☐ Genital / testicular Itch
☐ Redness / swelling / sores on genitals
☐ Discharge color/consistency/odor:_____

☐ Prostate disease
Last PSA test date:_____
☐ Vasectomy date: _____

Please feel free to add any comments you feel are important:

MEDICATONS & SUPPLEMENTS

Please list any vitamins, herbs, supplements, or medications you are currently taking.
Please include dosages, time(s) of administration, and the benefit or side effects you associate with their use.
Careful completion of this form allows for more compatible herbal therapy and nutritional counseling.
If you need more space to write please use the back of this page. Thank you.

Medication / Supplement	Reason for taking	Since when?	Dosage	Actual Benefit(s) / Side Effect(s)

☐Continued on Back-->

***Important**: Indicate any blood-thinning medication:*

☐ Coumadin / Warfarin ☐Heparin

☐Other (specify)_____

INJURIES & SURGERIES

Please indicate the type and exact location of the trauma, and when it occurred.
Please include all dental work (wisdom teeth, crowns), tonsillectomy, appendectomy, etc.

Type	Year	Recovery Time	Residual Effect(s) / Other Notes
Please list at least 3 things you are good at:			

I certify that the information provided on these forms is true to the best of my knowledge. I also understand that the information provided is confidential as outlined in the Privacy Policy notice.

I do not expect Sang Montage or Gorilla Acupuncture's staff to be able to explain or predict all the possible risks and complications of treatment. I understand it is my responsibility to ask for a more detailed explanation of anything regarding my treatment. I freely give my permission and consent for treatment, and by signing this form I confirm that I am aware and responsible for my actions

I UNDERSTAND THAT GORILLA ACUPUNCTURE IS OPERATING ON A CUTTING EDGE BUSINESS MODEL THAT HAS HIGH EXPECTATIONS FOR ME TO PARTICPATE WITH AND WITHIN MY COMMUNITY. I UNDERSTAND THAT HEALING ISN'T ALWAYS COMFORTABLE AND PLEASANT. I UNDERSTAND THAT IT WILL TAKE TIME, PATIENCE, AND UNDERSTANDING. I UNDERSTAND THAT EVERYONE HAS NEEDS, INCLUDING MYSELF AND BY MY RETURNING FOR TREATMENT I AM AGREEING THAT I AM WORTHY, READY TO PARTICIPATE AND BE ACCOUNTABLE TO THIS HEALING PROCESS. I LOVE MYSELF. I LOVE MY COMMUNITY. I AM WORTHY AND READY TO HEAL MYSELF AND MY COMMUNITY FOR THE GREATER GOOD.

Cancellation Policy: I understand and accept that I must notify Gorilla Acupuncture at least 24 hours prior to any scheduling changes. If under ordinary circumstances you miss appointments without advance notification it may result in termination of your continued treatment contract.

X Signed: _____ Date: _____

Parent / Guardian (if applicable) _____

Print Name: _____

GORILLA ACUPUNCTURE
PO Box 3225
Applegate OR 97530
541-231-6558

Sang Ly Montage
Licensed Acupuncturist (L.Ac.)

PRIVACY POLICY: Acknowledgement of Receipt

This form must be signed to indicate you have read and understood the NOTICE OF PRIVACY POLICY. This document includes a summary of the policy, including how your personal health information may be used & shared, and how you can obtain access to this information.

IMPORTANT NOTE: This summary does not include all details of the privacy policy. Please refer to the NOTICE OF PRIVACY POLICY for a complete understanding regarding the use of your personal health information.

I. Ways your health information may be used and shared:

a) In Treatment - To provide you with treatment and/or other health services.
b) In Payment - To bill you or a responsible third party for services provided to you.
c) For Health Care Operations - Including quality control, compliance monitoring, audit, etc.

II. Situations requiring no consent for disclosure:

a) All interactions with you as patient
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (to prevent and control the spread of infectious disease)
e) Lawsuits and disputes (only in response to a court or administrative order)
f) Law enforcement (as required by law)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities (if you are an organ donor)

III. Disclosures requiring your consent:

a) Patient directories: you may determine what health data, if any, you want listed in patient directories.
b) Persons involved in your care, or the payment for your care: you may choose to share your health information with a family member, friend, or any other person at your discretion.

IV. Other disclosures of your health information not covered by the NOTICE OF PRIVACY POLICY or the laws that apply will be made *only with your written consent.*

V. You have the following rights relating to the health information kept about you:

a) You may inspect your health records and receive a copy of your health records upon written request
b) You may know to whom your health information has been disclosed upon written request
d) You may request limits to be placed on the health information disclosed about you
e) You may request a copy of the complete NOTICE OF PRIVACY POLICY document at any time

I acknowledge that I have received & read the NOTICE OF PRIVACY POLICY, and that I understand its terms.

_____ _____
Signature of patient or patient representative Date

_____ _____
Printed name of patient Date