



Dr. Arkadiy Sarkisov, D.Ac, LAc, LMT
3700 52nd St SE Grand Rapids, MI 49512
Phone: (616) 656-3700 or (616) 250-4414
www.say-acupuncture.com

Patient Information Sheet

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____) _____
Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female Marital Status: _____
Occupation: _____ Employer: _____

Emergency Information

Emergency Contact: _____ Relationship: _____
Emergency Phone Number: (____) _____

Medical Information

Primary Care Doctor: _____ Last seen: _____ Referred by: _____
Chief Complaint(s): _____
Has this condition been diagnosed by a DO/MD? ☐ Yes ☐ No If Yes, Diagnosis: _____
Have you been treated for this condition by anyone else? ☐ Yes ☐ No If Yes, who? _____
How long have you had this condition? _____ Have you had acupuncture before? ☐ Yes ☐ No
Name of Acupuncturist: _____ Have these treatments helped? ☐ Yes ☐ No ☐ Somewhat
Known or suspected allergies: _____
Do you have any current or past infectious disease(s)? ☐ Yes ☐ No ☐ Possibly **If Yes, please identify:**
☐ HIV + ☐ Hepatitis B ☐ Hepatitis C ☐ Streptococcus ☐ Mononucleosis ☐ Tuberculosis ☐ Flu / Cold
☐ Other: _____
Are you pregnant right now? ☐ Yes ☐ No ☐ Trying ☐ Maybe
Are you taking Coumadin / Warfarin or other anticoagulant medication? ☐ Yes ☐ No
Do you have a pacemaker? ☐ Yes ☐ No
Do you have Implants? ☐ Yes ☐ No If Yes, please specify: _____ (Breast, Buttocks, etc.)
Dominant hand: ☐ Left ☐ Right Height _____ Weight _____

Initial _____ Date _____

Medical Information (Continued, page 2 and 3)

Cardiovascular Conditions:

Past / Present

- | | | |
|--------------------------|--------------------------|--------------------------|
| ☐ | ☐ | Myocardial Infarction |
| ☐ | ☐ | Myocarditis |
| ☐ | ☐ | Angina |
| ☐ | ☐ | Congestive Heart Failure |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Low Blood Pressure |
| ☐ | ☐ | Chest Pain |
| ☐ | ☐ | Palpitations |
| ☐ | ☐ | Tachycardia (H/R > 100) |
| ☐ | ☐ | Bradycardia (H/R < 60) |
| ☐ | ☐ | CVA (stroke) |
| ☐ | ☐ | Varicose Veins |
| ☐ | ☐ | Edema |
| ☐ | ☐ | Other: _____ |

Gastrointestinal:

Past / Present

- | | | |
|--------------------------|--------------------------|------------------------|
| ☐ | ☐ | Stomach Ulcers |
| ☐ | ☐ | Colitis |
| ☐ | ☐ | Crohn's Disease |
| ☐ | ☐ | Nausea |
| ☐ | ☐ | Vomiting |
| ☐ | ☐ | Abdominal Pain |
| ☐ | ☐ | Bloating |
| ☐ | ☐ | Heart Burn |
| ☐ | ☐ | Belching |
| ☐ | ☐ | Gall Bladder Disease |
| ☐ | ☐ | Gall Bladder Stones |
| ☐ | ☐ | Hemorrhoids |
| ☐ | ☐ | Constipation |
| ☐ | ☐ | Diarrhea |
| ☐ | ☐ | Irritable Bowel Syndr. |
| ☐ | ☐ | Leakey Gut Syndrome |
| ☐ | ☐ | Other: _____ |

Eye, Ear, Nose & Throat:

Past / Present

- | | | |
|--------------------------|--------------------------|------------------|
| ☐ | ☐ | Impaired Vision |
| ☐ | ☐ | Blurred Vision |
| ☐ | ☐ | Eye Pain/Strain |
| ☐ | ☐ | Glaucoma |
| ☐ | ☐ | Dryness |
| ☐ | ☐ | Tearing |
| ☐ | ☐ | Impaired Hearing |
| ☐ | ☐ | Ear Ringing |
| ☐ | ☐ | Earaches |
| ☐ | ☐ | Ear Infections |
| ☐ | ☐ | Sinus Problems |
| ☐ | ☐ | Nose Bleeds |
| ☐ | ☐ | Teeth Grinding |
| ☐ | ☐ | Hay Fever |
| ☐ | ☐ | Other: _____ |

Respiratory:

Past / Present

- | | | |
|--------------------------|--------------------------|--------------------------|
| ☐ | ☐ | Pneumonia |
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Bronchitis |
| ☐ | ☐ | Persistent/Chronic Cough |
| ☐ | ☐ | Difficulty Breathing |
| ☐ | ☐ | Shortness of Breath |
| ☐ | ☐ | Emphysema |
| ☐ | ☐ | Pleurisy |
| ☐ | ☐ | Frequent Common Colds |
| ☐ | ☐ | Other: _____ |

Neurological:

Past / Present

- | | | |
|--------------------------|--------------------------|---------------------|
| ☐ | ☐ | Migraine |
| ☐ | ☐ | Headaches |
| ☐ | ☐ | Vertigo / Dizziness |
| ☐ | ☐ | Paralysis |
| ☐ | ☐ | Numbness / Tingling |
| ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Loss of Balance |
| ☐ | ☐ | Seizures |
| ☐ | ☐ | Dyslexia |
| ☐ | ☐ | Other: _____ |

Emotional / Mental:

Past / Present

- | | | |
|--------------------------|--------------------------|---------------------|
| ☐ | ☐ | Clinical Depression |
| ☐ | ☐ | Mild Depression |
| ☐ | ☐ | Mood Swings |
| ☐ | ☐ | Panic Attacks |
| ☐ | ☐ | Excessive dreams |
| ☐ | ☐ | Nightmares |
| ☐ | ☐ | Nervousness |
| ☐ | ☐ | Anxiety |
| ☐ | ☐ | Autism |
| ☐ | ☐ | ADD or ADHD |
| ☐ | ☐ | Other: _____ |

Energy & Immunity:

Past / Present

- | | | |
|--------------------------|--------------------------|--------------------------|
| ☐ | ☐ | Chronic Fatigue Syndrome |
| ☐ | ☐ | General Fatigue |
| ☐ | ☐ | Morning Fatigue |
| ☐ | ☐ | Fatigue after Exercise |
| ☐ | ☐ | Slow Wound Healing |
| ☐ | ☐ | Easy Bruising |
| ☐ | ☐ | Frequent Sore Throat |
| ☐ | ☐ | Frequent Flu or Cold |
| ☐ | ☐ | Chronic Infections |
| ☐ | ☐ | Autoimmune Disease |
| ☐ | ☐ | Other: _____ |

Urinary Tract:

Past / Present

- | | | |
|--------------------------|--------------------------|---------------------|
| ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | Kidney Stones |
| ☐ | ☐ | Painful Urination |
| ☐ | ☐ | Dribbling Urination |
| ☐ | ☐ | Frequent UTI |
| ☐ | ☐ | Frequent Urination |
| ☐ | ☐ | Blood in Urine |
| ☐ | ☐ | Discharge |
| ☐ | ☐ | Incontinence |
| ☐ | ☐ | Other: _____ |

Muscle-Skeletal:

Past / Present

- | | | |
|--------------------------|--------------------------|-----------------------------|
| ☐ | ☐ | Muscle Spasms / Cramps |
| ☐ | ☐ | Fibromyalgia |
| ☐ | ☐ | Osteoporosis |
| ☐ | ☐ | Osteochondritis |
| ☐ | ☐ | Tennis Elbow |
| ☐ | ☐ | Carpal-Tunnel Syndrome |
| ☐ | ☐ | TMJ / Jaw Problems |
| ☐ | ☐ | Arthritis Joint Pain: _____ |
| ☐ | ☐ | Other: _____ |

Initial _____ Date _____

Women Only Check all that apply:Hysterectomy: ☐ Yes ☐ No Date: _____

Have your ovaries been removed: _____

☐ Yes ☐ No

Age at first period: _____

Date of last menses: _____

Typical length of menses (days): _____

Typical length of cycle (from 1st day

to 1st day of menses): _____

Number of: Pregnancies: __ Births: __

Abortions: _____ Miscarriages: _____

Method of Birth Control: _____

Menopause: ☐ Yes ☐ No Age: _____Menopausal Symptoms: ☐ Yes ☐ No

Explain: _____

Past / Present

☐ ☐ Premenstrual Problems☐ ☐ Irregular Cycles**Women Only (Cont.):**

Past / Present

☐ ☐ Heavy Flow☐ ☐ Scanty Flow☐ ☐ Painful Periods☐ ☐ Blood Clots☐ ☐ Bleeding Between Cycles☐ ☐ Fibroids☐ ☐ Painful Intercourse☐ ☐ Infertility☐ ☐ Endometriosis☐ ☐ Vaginal Discharge☐ ☐ Breast Lumps☐ ☐ Breast Tenderness☐ ☐ Nipple Discharge☐ ☐ Fibrocystic Breasts☐ ☐ Ovarian Cysts☐ ☐ Abnormal Pap Smear☐ ☐ Low libido☐ ☐ Excessive libido**Endocrine/Other Conditions:**

Past / Present

☐ ☐ Hypothyroidism☐ ☐ Hyperthyroidism☐ ☐ Hypoglycemia☐ ☐ Diabetes Type I☐ ☐ Diabetes Type II☐ ☐ Night Sweats☐ ☐ Unusual Sweating☐ ☐ Feeling Hot or Cold☐ ☐ Cold Hand / Feet☐ ☐ Thin / Graying hair☐ ☐ Loss of hair☐ ☐ High Cholesterol☐ ☐ Cancer, Type: _____☐ ☐ Candida☐ ☐ Hemophilia☐ ☐ Bleeding Problems☐ ☐ Anemia☐ ☐ Rashes☐ ☐ Eczema / Hives☐ ☐ Other: _____**Men Only:**

Past / Present

☐ ☐ Impotence☐ ☐ Vasectomy☐ ☐ Prostate problems☐ ☐ Testicular Pain/Inflammation☐ ☐ Low libido☐ ☐ Excessive libido☐ ☐ Seminal emissions**Surgeries and hospitalizations:**

Reason and Date.

Medications and supplements:

Reason, Dose, How Long.

Social Life

Daily amount:

Tobacco: ☐ Yes ☐ No Amount: _____Alcohol: ☐ Yes ☐ No Amount: _____Coffee: ☐ Yes ☐ No Amount: _____Recreational Drugs: ☐ Yes ☐ No Amount: _____

Daily Water intake: _____

Daily Soda intake: _____

Are you vegetarian or vegan? ☐ Yes ☐ NoPhysical exercise? ☐ Yes ☐ No Regularly ☐ Yes ☐ NoHow would you rate your current stress level? ☐ Extreme ☐ Very High ☐ High ☐ Moderate ☐ Low ☐ None

How would you rate your health in the past month:

Energy: ☐ Great ☐ Good ☐ Fair ☐ PoorDigestion: ☐ Great ☐ Good ☐ Fair ☐ PoorUrination: ☐ Great ☐ Good ☐ Fair ☐ PoorAppetite: ☐ Great ☐ Good ☐ Fair ☐ PoorSleep: ☐ Great ☐ Good ☐ Fair ☐ Poor

Hours of sleep / night: _____

Initial _____ Date _____

Pain Chart

Quality of pain: ☐Fixed ☐Constant ☐Sharp ☐Cramping

☐Burning ☐Migrating ☐Stabbing ☐Sore ☐Dull

On a scale of 1 – 10 (10 being worst) how strong is your pain?

Now _____ Best Day _____ Worst Day _____

Does the pain radiate? ☐Yes ☐No Where? _____

What helps the pain? ☐Ice ☐Heat ☐Rest ☐Movement

☐Pressure ☐Moisture ☐Massage ☐Nothing

What aggravates the pain? ☐Ice ☐Heat ☐Movement

☐Rest ☐Pressure ☐Moisture ☐Massage ☐Nothing

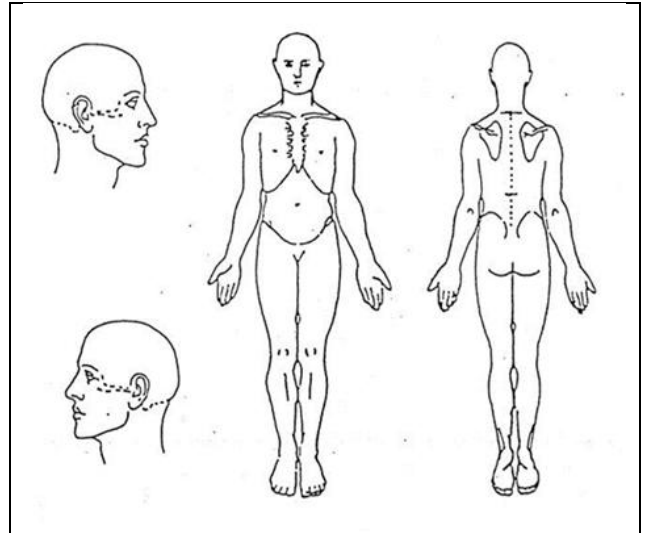
Do any medications help your pain? ☐Yes ☐No

If Yes, name of medication: _____

Other treatments you have had for your pain? _____

Describe the onset of your pain: _____

HIGHLIGHT AREAS OF PAIN BELOW:



Family History

Please check all that apply to family medical history (if checked, please specify which relative):

☐ Alzheimer's/Depression: _____	☐ High Blood Pressure: _____
☐ Anxiety/Depression: _____	☐ High Cholesterol: _____
☐ Arthritis: _____	☐ Kidney Disease: _____
☐ Asthma: _____	☐ Liver Disease: _____
☐ Bleeding Disorder: _____	☐ Lung Disease: _____
☐ Cancer, Type: _____	☐ Osteoporosis: _____
☐ Diabetes: _____	☐ Stroke/TIA: _____
☐ Heart Disease: _____	☐ Thyroid Disease: _____
☐ Other: _____	

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Born Clinic 24 hours prior to any cancellations or changes to my appointment times and that if I do not, I may be charged for the appointment.

X Signature: _____ Date: _____

Parent / Guardian (if applicable): _____

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with medical and Traditional Chinese acupuncture, moxibustion, electro-acupuncture, cupping, and Chinese massage and Medical Massage by a National Board-Certified and State of Michigan Licensed Acupuncturist, **Dr. Arkadiy Sarkisov, D.Ac, LAc, LMT**. I understand that acupuncturists practicing in the State of Michigan are not primary care providers.

Initial here _____ Pregnancy: I understand that it is my responsibility to notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant, so that my practitioner can avoid points and certain techniques that could induce a miscarriage. Otherwise, acupuncture can be very beneficial in the pregnancy and birthing process.

Initial here _____ Acupuncture / Moxibustion: I understand that acupuncture is a technique of inserting and manipulating filiform, sterile, disposable needles into acupuncture points on the body to restore health and well-being. Moxibustion is the application of heat to the skin at certain points on the body to restore health and well-being. Acupuncture and moxibustion are typically safe methods of treatment; however, certain adverse side effects may result. These could include but are not limited to, local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment.

Initial here _____ Acupressure / Tui-Na Massage and other Massage Modalities: I understand that I may also be given acupressure / Tui-na massage or other massage modalities as part of my treatment to improve or prevent symptoms and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include but are not limited to, bruising, sore muscles or aches, and the possible aggravation of symptoms existing before treatment.

Initial here _____ Cupping: I understand that I may also be given cupping (the application of glass cups with a vacuum to the skin) as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. ***I am aware that these treatments are intended to cause minor bruising and though unsightly, are not normally painful.*** However, certain adverse side effects may result from this treatment. These could include but are not limited to, bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment.

Initial here _____ Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include but are not limited to, electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment.

Initial here _____ Treatment Acknowledgment: I understand that results are individual, and there are no guarantees. I understand that I may decline or discontinue the treatment at any time for any reason.

Initial here _____ Payment and Insurance: I understand that services provided by **Dr. Arkadiy Sarkisov, D.Ac, LAc, LMT** are self-pay and that full payment is due at the time of service. I understand that insurance will not be billed on my behalf. I may submit an itemized receipt to my insurance plan for consideration of reimbursement; however, coverage and reimbursement are not guaranteed. I understand that it is my responsibility to verify my insurance benefits and that I am responsible for all charges, regardless of whether my insurance reimburses me.

I do not expect **Dr. Arkadiy Sarkisov, D.Ac, LAc, LMT** and/or **Born Clinic** staff to be able to anticipate and explain all the possible risks and complications of treatment. I have carefully read and understood all of the above information, and I am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment. I give my permission and consent to treatment.

Patient Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

Parent / Guardian (if applicable): _____