Montage Oriental Medicine

PATIENT INFORMATION FORM

541.708.3953

Name:		Today's Date:	
Address:	City:	State:	Zip:
Best Contact Number	Best Way To Reach You	Email: Permission to contact you? ☐Yes ☐No	
Age: Date of Birth:			
Height: Weight:	Relationship status: # of Children:	Names and ages of Children:	
Occupation:	Employer:	How did you hear of Sang Montage?	
Physician: Date last seen:	911 contact info:		
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:

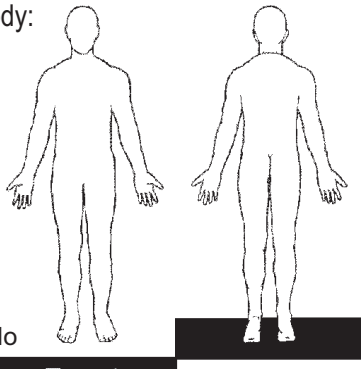
If Pain:

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?



Front **Back**

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 *Location on body:*
- ☐ Edema / Swelling _____
- ☐ Rashes _____
- ☐ Itching _____
- ☐ Oily skin
- ☐ Oily hair
- ☐ Acne
- ☐ Weight gain / loss

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 condition not 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)

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

☐Continued on Back-->

☐ 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 enjoy:

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 Montage Oriental Medicine'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.

Cancellation Policy: I understand and accept that I must notify Montage Oriental Medicine at least 36 hours prior to any scheduling changes to avoid a charge of $95.00. If under ordinary circumstances you miss appointments without advance notification it may result in termination of your continued treatment contract. Initial:_____

X Signed: _____ Date: _____

Parent / Guardian (if applicable) _____

Print Name: _____

Montage Oriental Medicine

845 NE 7th St.
Grants Pass, OR 97526

541.708.3953

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

PATIENT NAME:

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)