

Longmont Institute of Integrative Medicine
1304 North Vivian Street Longmont, Colorado 80501

LIIM Patient Documents

Naomi Rabinowitz, MD
Natural Medicine and Acupuncture



Contents

Information & Consent Form
Patient Profile
Questionnaire

www.liim.org
www.longmontacupuncture.net

Longmont Institute of Integrative Medicine

1304 North Vivian Street Longmont, Colorado 80501

Patient Profile

Please Print

Name (Last, First):

Street Address:

City, State, Zip:

Email Address:

This information will permit your acupuncturist to communicate with you by email.
You will also receive our informative quarterly newsletter.

Home Phone :

Work Phone:

Cell Phone:

Current age: _____

Birth date:

Place of Birth (City, State, Country):

Time (include AM or PM):

Social Security Number:

Emergency Contact (Name and Phone Number):

Please tell us how you heard about Acupuncture here so we can acknowledge them:

_____ Google

_____ Other Internet Resource (specify)

_____ Referred by an Organization (specify)

_____ Referred by a Person

Referrer's Name and (if known), Address: _____

Longmont Institute of Integrative Medicine

1304 North Vivian Street Longmont, Colorado 80501

ACUPUNCTURE CONSENT FORM

About the Treatment

Only sterile, disposable needles are used in our practice. Chinese herbs and other supplements will be prescribed when appropriate.

Acupuncture has been practiced for thousands of years and is a very safe procedure. If you've never experienced acupuncture you should be aware that you may experience some of the following: Minor, transient discomfort can occur as the needles penetrate the skin. Numbness, tingling or a sensation of heat or pulling may occur during the treatment.

All of these sensations are normal.

It is extremely rare for a serious medical incident to result from acupuncture.

The most common untoward effects of the treatment include, but are not limited to, these:

Occasionally, the acupoint will bleed slightly when the needle is withdrawn. "Black and blue" marks from minor bleeding under the skin are infrequent, but do happen.

Transient lightheadedness can occur as the body's energy (Qi) changes, but passes rapidly.

With regard to treatment outcome, usually the person's symptoms are ameliorated after the treatment. If they are unchanged, more or different treatment is needed. Uncommonly, a symptom will get worse after the treatment as energy moves through an area of blockage. Thereafter, once the energy moves freely, the relief is usually significant.

Please let the practitioner know if you are pregnant, or trying to get pregnant, as this will influence the placement of the needles.

Signed consent for treatment

I have read the above information, agree to the terms therein and agree to treatment.

Name: _____ **Date:** _____

Longmont Institute of Integrative Medicine

1304 North Vivian Street Longmont, Colorado 80501

This questionnaire is an essential component for successful diagnosis and treatment. Please answer all questions carefully.

Name _____ Date _____ Age _____ Gender _____

List your five main complaints below, in order of importance:

Number of Years

- | | |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |

Check if you have taken frequent:

- ____ Antibiotics
- ____ Antihistamines
- ____ Sedatives
- ____ Hormones
- ____ Birth Control Pills
- ____ Bronchial Inhalers
- ____ Cortisone
- ____ Nose Drops or Sprays
- ____ Skin Ointments
- ____ Vitamins
- ____ Antidepressants

List any drugs, vitamins, herbs or homeopathics you are currently taking: (use back of sheet if necessary)

Check if your mother, father, brothers or sisters have had any of the following:

	Diabetes	Cardio-Vascular Disease	Allergies	Asthma	Cancer	Rheumatic Disease
Father	_____	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____	_____
Brother (s)	_____	_____	_____	_____	_____	_____
Sister (s)	_____	_____	_____	_____	_____	_____

Have you ever been hospitalized for a:

- | | | |
|--------------------|----------|-----------|
| Medical problem | no _____ | yes _____ |
| Surgical procedure | no _____ | yes _____ |
| Psychiatric reason | no _____ | yes _____ |

If yes, list reasons for hospitalization, treatment & date of stay: (use back of sheet if necessary)

Name _____

Body Systems Review (please check all that apply):

0 = never 1 = rarely 2 = occasionally 3 = frequently 4 = always

0	1	2	3	4	low appetite	0	1	2	3	4	ravenous appetite
0	1	2	3	4	loose stools	0	1	2	3	4	heartburn/acid reflux
0	1	2	3	4	mouth sores	0	1	2	3	4	fatigue after eating
0	1	2	3	4	abdominal gas/bloating after food	0	1	2	3	4	bruise easily
0	1	2	3	4	gums (bleeding/swollen)	0	1	2	3	4	thirst
0	1	2	3	4	organ prolapsed (diagnosed)	0	1	2	3	4	belching or vomiting

0	1	2	3	4	spontaneous sweat	0	1	2	3	4	fatigue
0	1	2	3	4	allergies	0	1	2	3	4	catch colds easily
0	1	2	3	4	asthma	0	1	2	3	4	shortness of breath
0	1	2	3	4	general weakness	0	1	2	3	4	cough
0	1	2	3	4	dry nose/mouth/skin/throat	0	1	2	3	4	nasal discharge
0	1	2	3	4	feel worse after exercise	0	1	2	3	4	sinus congestion

0	1	2	3	4	sore, cold or weak knees	0	1	2	3	4	feel cold
0	1	2	3	4	low back pain	0	1	2	3	4	edema
0	1	2	3	4	frequent urination	0	1	2	3	4	urinary incontinence
0	1	2	3	4	early morning diarrhea	0	1	2	3	4	ear problems

yes	no	impaired memory	yes	no	hair loss
yes	no	infertility	high	normal	low

0	1	2	3	4	muscle spasms/twitches	0	1	2	3	4	irritable
0	1	2	3	4	feel better after exercise	0	1	2	3	4	numb extremities
0	1	2	3	4	tight feeling in chest	0	1	2	3	4	dry eyes
0	1	2	3	4	alternating diarrhea/constipation	0	1	2	3	4	ear ringing
0	1	2	3	4	symptoms worse with stress	0	1	2	3	4	anger easily
0	1	2	3	4	neck/shoulder tension	0	1	2	3	4	red eyes

0	1	2	3	4	feel heart beating	0	1	2	3	4	chest pain
0	1	2	3	4	insomnia	0	1	2	3	4	disturbing dreams
0	1	2	3	4	sores on tip of tongue	0	1	2	3	4	headaches
0	1	2	3	4	anxiety	0	1	2	3	4	restlessness
0	1	2	3	4	chest pain traveling to shoulder						

high	normal	low	overall body temperature
high	normal	low	overall energy level

0	1	2	3	4	see floaters in eyes	0	1	2	3	4	foggy thinking
0	1	2	3	4	heat in palms or soles	0	1	2	3	4	dizzy upon standing
0	1	2	3	4	feeling of heaviness	0	1	2	3	4	nausea
0	1	2	3	4	afternoon fever	0	1	2	3	4	night sweats
0	1	2	3	4	enlarged lymph nodes	0	1	2	3	4	cloudy urine
0	1	2	3	4	face flushes						

Name _____

Urination: Please circle any of the following symptoms you are currently experiencing:

Burning Urgent Retention Scanty
Profuse Dribbling Greater than 1x a night

Bowel Movements: Frequency: _____ When? _____ Feels complete? Yes No

Please circle any of the following symptoms you are currently experiencing:

Stools: Undigested food Blood Mucus
Consistency: Well-formed Hard Loose Alternates

Men Only:

Have you been diagnosed with prostate problems? Yes No
Do you experience premature ejaculation? Yes No
Do you have problems with Impotence? Yes No
Have you been diagnosed with Infertility? Yes No

Diseases/ Disorders:

Women Only:

Fertility History

Are you pregnant now? Yes No
Have you been pregnant in the past? Yes No
Number of live births _____ Miscarriage ____ Abortion _____
Infertility work-up (if pertinent)

Doctor or clinic _____ When? _____

What tests (HSG? Blood work, etc.) and findings _____

Current medications (Clomid, Lupron etc.) _____

Name _____

Menstrual History

At what age did you get your first period: _____ Date of last menstrual cycle? _____

Are you currently on the Pill? Yes No

Number of days from the start of one period to the start of the next: _____

Are your menstrual cycles spaced regularly? Yes No

Average number of days of flow: _____

Maximum Flow Day: Use of tampon or pad is Light = use one for longer than 4 hours

Normal = change every 3 hours Heavy = change every hour or less Heavy with clots

Maximum Flow Day: Color is Pink Red Dark Bright Red Brown

Does your period cause you pain or cramping? No Yes: Before During After Period

Do you get nausea or vomiting with your period? No Yes: Before During After Period

Do you experience any of the following before your period each month?

Water retention Breast tenderness or swelling Mental depression Irritability

Food cravings Migraines Other _____

Do you ever bleed or spot between periods? Yes No

Do your bowel movements become loose at the beginning of your period? Yes No

Do you have any vaginal discharge between periods? Yes No

Gynecological Problems

Date of last pap smear? _____ Have you ever had an abnormal pap smear? Yes No

Any gynecological surgery? No Yes: _____

Have you ever had a venereal disease or PID? No Yes: _____

Do you get yeast infections regularly? Yes No

Have you ever been diagnosed with uterine fibroids or polyps? Yes No

Have you ever been diagnosed with ovarian cyst or PCOS? Yes No

Have you ever been diagnosed with endometriosis? Yes No

Have you been diagnosed pelvic adhesions abnormalities? Yes No

Menopause

Have you experienced menopause? Yes No When? _____

Are you on HRT or herbal aids now? Yes No What? _____

If you are experiencing menopausal symptoms, please describe: _____

Name _____

Lifestyle/habits

List what you typically eat for the following meals:

Breakfast:

Lunch:

Dinner:

Snacks:

Do you skip meals? Breakfast _____ Lunch _____ Dinner _____

Do you drink caffeinated beverages?

No _____

Yes _____ Coffee _____ (cups/day) Tea _____ Soda _____

Do you drink alcohol? No _____

Yes _____ What? _____ How often? _____

Do you eat fish _____ chicken _____ meat _____ eggs _____ dairy products _____

Do you eat fruit? _____

Which? _____

How often? _____

Do you eat vegetables? _____

Which? _____

How often? _____

How much water do you drink? _____

Do you eat sweets (cake candy, ice cream, cookies, etc.)? No _____

Yes _____ What? _____ How often? _____

Do you have or have you had an eating disorder? No _____

Yes _____ Anorexia _____ Bulimia _____

Do you exercise? No _____ Yes _____

How often? _____ What type of exercise? _____

How many hours do you typically sleep? _____

What time do you typically go to bed? _____ Arise? _____

Do you have trouble falling asleep? _____

staying asleep? _____

Do you have nightmares? _____

Do you use sleep medication? No _____

Yes _____ What kind _____

How often _____

Name _____

Do you _____ smoke marijuana?
_____ use cocaine?
_____ heroin?
_____ other drugs? What kind?

Do you smoke cigarettes? No _____
Yes _____ How much? _____ For how long? _____
Have you ever tried to quit before? _____
What means? _____
Longest time cigarette free _____

What kind of work do you do?

Is the work stressful for you? _____
Is there stress in other areas of your life (home, family, relationships)?

Medical/Psych Care

Who is your personal physician?

Name:

Address:

Phone:

Do you regularly see any specialists? (Gyn, GI, ENT, GU, etc.)

Name:

Name:

Address:

Address:

Phone:

Phone:

Do you get chiropractic, osteopathic, physical therapy or massage treatment? If so, which one(s)?

Are you now or have you been in

_____ psychotherapy?

_____ group therapy?

_____ 12 step program?

Do you regularly meditate or participate in spiritual practice?

Have you ever had acupuncture before? No _____
Yes _____ When and with whom?

Do you have experience with western or Chinese herbal treatment?

Please shade area of pain

