EMPIRICAL
POINT
• EST. 2001 •

Hello

Welcome to Empirical Point! Congratulations on taking this step toward better health. I bring to the table a passion for Chinese Medicine, ongoing study, and since 2001, a successful clinical practice. I uphold the highest standards of care in my practice, ensuring skillful diagnosis and treatment, pharmaceutical grade Chinese herbs and a cooperative, supportive approach. My commitment is to assist and advocate, encouraging you to participate in and own your healing process.

At the onset of our work together, I will ask a lot of questions about your health history, lifestyle and current complaint. Symptoms are signs that point to the real issues; my job is to gather information and follow those signs to the underlying causes. This means you receive more than the temporary relief that symptom-focused therapy offers. I will draw from a variety of healing modalities to help restore comfort and balance.

Attached are several forms. Please read them through carefully, fill them out to the best of your ability, and bring them with you to our scheduled appointment. Your thoughtful answers will help me establish a picture of who you are, where you would like to be, and where disharmony disrupts health. Your attention to detail will help me identify existing imbalances and create a comprehensive treatment plan especially for you.

If you have any questions, please don't hesitate to call or email. It is a pleasure to welcome you to my office, and I look forward to our meeting.

Sincerely,
Sharon Sherman

Information provided on this form is confidential

PATIENT INFORMATION

Today's Date _____

Name _____

Male ◯ Female ◯ Date of Birth _____ Age _____ Height/Weight _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Mobile Phone _____

e-Mail Address _____ Occupation _____ Marital Status _____

Emergency Contact Name/Phone _____ Referred By _____

Primary Physician's Name / Address / Phone _____

_____

Condition(s) your physician is currently treating you for _____

Prior experience with acupuncture _____

MEDICAL HISTORY

Illness, hospitalization, surgery or accidents? Please list in chronological order and indicate length of injury or illness

Age: _____ Event: _____ Outcome: _____

Age: _____ Event: _____ Outcome: _____

Age: _____ Event: _____ Outcome: _____

Age: _____ Event: _____ Outcome: _____

Age: _____ Event: _____ Outcome: _____

Age: _____ Event: _____ Outcome: _____

Age: _____ Event: _____ Outcome: _____

Age: _____ Event: _____ Outcome: _____

Age: _____ Event: _____ Outcome: _____

Please list all medications including prescriptions, vitamins, herbs, and supplements you have taken within the past six months, frequency with which you take them, and the condition/symptoms you take them for

_____ Frequency _____ Condition _____

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LIFESTYLE

What is your definition of health? _____

_____

What are your health goals and how would you like Oriental medicine help you realize your goals? _____

_____

How do you rate your general health? _____

Do you follow a regular exercise program? What activities are involved? _____

How many days a week do you exercise? _____

What is the length of a workout? _____

What is your occupation? How many hours is a typical workday? _____

Average length of sleep per night? _____

What is the quality of your sleep? _____

Is there difficulty falling asleep or staying asleep? _____

Do you typically feel well rested upon waking? _____

What time of day do you have the most energy? _____

What time of day do you have the least energy? _____

Do you smoke? If so, how much do you smoke? _____

Do you use recreational drugs? _____

If so, what do you use and what is the frequency? _____

Do you experience allergies? _____

Please list all known allergens _____

What is a typical reaction in response to a known allergen? _____

Stress, Emotions and Trauma

What provokes stress in your life? _____

Describe the level of stress in your life? _____

How does stress impact you and how do you deal with it? _____

_____

Which emotions seem to be predominating in your life? _____

_____

Please describe any traumatic experiences you have had:

Age:_____ Event:_____

Age:_____ Event:_____

Age:_____ Event:_____

Age:_____ Event:_____

What type of acute illness are you prone to getting? How often have you experienced them in the last two years? _____

_____

Name _____ Date _____

Describe your daily menu over a two day period, please be as detailed as possible, including all foods and beverages.

AM Meal Time _____

Midday Meal Time _____

PM Meal Time _____

Snacks Time _____

Snacks Time _____

Snacks Time _____

Medication and Supplements Time _____

Medication and Supplements Time _____

Medication and Supplements Time _____

Typically on a daily basis, how many portions of each category do you include in your diet?

Red Meat _____	Vegetables (cooked) _____	Fried Food _____	Fruit _____
Poultry _____	Vegetables (raw) _____	Beans/Nuts _____	Alcohol _____
Fish _____	Coffee/Tea/Cola _____	Soy Products _____	Water _____
Sweets _____	Bread/Potato/Rice _____	Whole Grains _____	Dairy _____

What foods do you have an aversion toward? _____

What foods do you crave? _____

Name _____

Information provided on this form is confidential

HEALTH CONCERNS

Please use this form to list complaints in order of importance to you

1. Problem you would like to address _____

How long have you had this condition? _____

Have you seen a physician or any other healthcare provider for this complaint? If yes, please supply provider's name/address/phone

_____

What diagnosis has a physician given for this complaint? _____

What treatments and/or medications were given? _____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.) _____

_____

What makes it better? _____

What makes it worse? _____

Do you have a personal opinion on what may have caused your complaint?

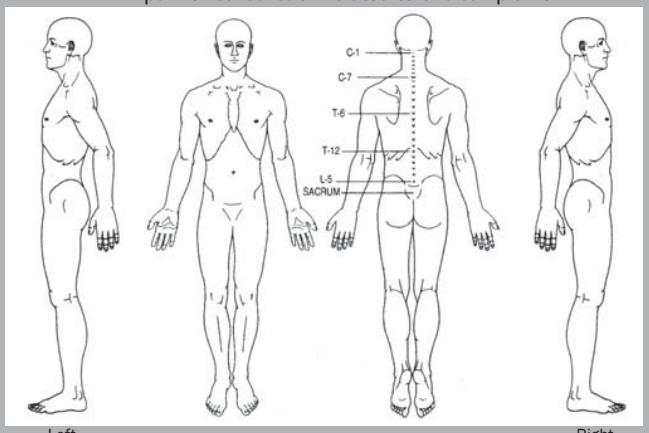
_____

_____

_____

_____

Please mark on the diagram below any areas of discomfort, pain or constriction related to this complaint



2. Problem you would like to address _____

How long have you had this condition? _____

Have you seen a physician or any other healthcare provider for this complaint? If yes, please supply provider's name/address/phone

_____

What diagnosis has a physician given for this complaint? _____

What treatments and/or medications were given? _____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.) _____

_____

What makes it better? _____

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Do you have a personal opinion on what may have caused your complaint?

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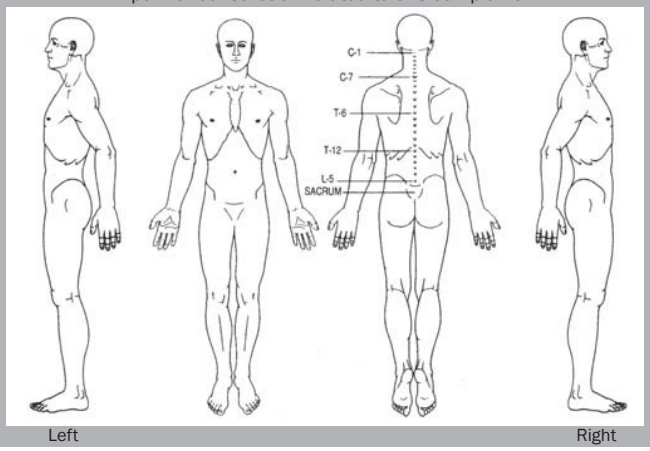
_____

_____

Please mark on the diagram below any areas of discomfort, pain or constriction related to this complaint



Name _____

Information provided on this form is confidential

HEALTH HISTORY

Personal History

Please check any conditions or symptoms that you have experienced

- ☐ Arthritis
- ☐ High/Low Blood Pressure
- ☐ Cancer
- ☐ Ulcer
- ☐ Chronic Fatigue
- ☐ Alcoholism
- ☐ Gastritis / Pancreatitis
- ☐ Liver / Gall Bladder Disease
- ☐ Hypo / Hyperglycemia
- ☐ Diabetes
- ☐ Seizures
- ☐ Anemia
- ☐ Lyme Disease
- ☐ Asthma
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Food Allergies / Intolerance
- ☐ Hepatitis
- ☐ Thyroid Imbalance
- ☐ Chronic Pain Condition
- ☐ Infertility
- ☐ Heart Disease
- ☐ Elevated Blood Cholesterol
- ☐ Diverticulitis / IBS
- ☐ Raynaud's Disease
- ☐ Respiratory Allergies
- ☐ Impotence
- ☐ Emphysema

Family Medical History

Please check any condition that applies to your immediate family

Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to selection

- ☐ Diabetes _____
- ☐ High Blood Pressure _____
- ☐ Other_____
- ☐ Seizures _____
- ☐ Allergies _____
- ☐ Heart Disease _____
- ☐ Cancer _____
- ☐ Other_____
- ☐ Stroke _____
- ☐ Asthma _____

Please check if you have experienced any of the symptoms listed below in the last 3 months

General

- ☐ Poor Appetite
- ☐ Chills
- ☐ Cravings
- ☐ Bleed / Bruise easily
- ☐ Muscle Weakness / Fatigue
- ☐ Poor Sleeping
- ☐ Night Sweats
- ☐ Localized Weakness
- ☐ Weight loss / gain
- ☐ Sudden energy drop
- ☐ Fatigue
- ☐ Sweats Easily
- ☐ Poor Balance
- ☐ Peculiar tastes / smells
- ☐ Strong thirst (hot or cold drinks)
- ☐ Fevers
- ☐ Tremors
- ☐ Change in appetite
- ☐ Dental / gum problems

Skin and Hair

- ☐ Rashes
- ☐ Eczema / Psoriasis
- ☐ Skin discoloration
- ☐ Dermatitis
- ☐ Ulcerations
- ☐ Dandruff
- ☐ Acne
- ☐ Warts
- ☐ Hives / Allergic Dermatitis
- ☐ Loss of hair
- ☐ Change in skin / hair texture
- ☐ Fungal Infection
- ☐ Itching
- ☐ Recent moles
- ☐ Face flushing

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Eye Strain
- ☐ Color Blindness
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Sores on lips / tongue
- ☐ Difficulty swallowing
- ☐ Eye pain
- ☐ Cataracts
- ☐ Poor hearing
- ☐ Recurrent sore throats / colds
- ☐ Dental problems
- ☐ Migraines
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Spots in front of eyes
- ☐ Grinding teeth
- ☐ Jaw clicks / locks
- ☐ Glasses
- ☐ Night Blindness
- ☐ Earaches
- ☐ Sinus problems
- ☐ Facial pain
- ☐ Headaches

Cardiovascular

- ☐ Chest pain or pressure
- ☐ Cold hands / feet
- ☐ Shortness of breath
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Swelling of hands / feet
- ☐ Varicose / spider veins
- ☐ Spontaneous sweating
- ☐ Palpitations at rest
- ☐ Blood clots
- ☐ Pressure in chest
- ☐ Dizziness
- ☐ Fainting
- ☐ Phlebitis
- ☐ High blood pressure

Respiratory

- ☐ Cough / Wheezing
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Coughing blood
- ☐ Pain with deep inhalation
- ☐ Asthma
- ☐ Tight sensation in chest
- ☐ Production of phlegm, what color? _____
- ☐ Bronchitis
- ☐ Difficult inhale / exhale

Please check if you have experienced any of the symptoms listed below in the last 3 months

Gastrointestinal

- ☐ Nausea
- ☐ Gas
- ☐ Indigestion
- ☐ Bloating / Edema
- ☐ Changes in appetite
- ☐ Excessive appetite
- ☐ Vomiting
- ☐ Belching
- ☐ Bad breath
- ☐ Chronic laxative use
- ☐ Acid reflux / GERD
- ☐ Significant thirst
- ☐ Diarrhea
- ☐ Black stools
- ☐ Rectal pain
- ☐ Loose stools (>2 per day)
- ☐ Hernia
- ☐ IBS / Crohn's Disease
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Abdominal pain/cramps
- ☐ Poor appetite

Genito-Urinary

- ☐ Pain on urination
- ☐ Unable to hold urine
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Decreased libido
- ☐ Pain in testicles
- ☐ Blood in urine
- ☐ Scanty flow
- ☐ Urinary tract infection
- ☐ Prostatitis
- ☐ Herpes
- ☐ Urgent urination
- ☐ Copious flow
- ☐ Burning urination
- ☐ Dribbling after urination
- ☐ Infections
- ☐ Night urination... What time?_____ How often?_____

Gynecological / Reproductive

Age of first menses _____

Date of last menses _____

Date of last PAP / Pelvic _____

Number of pregnancies _____

Number of ectopic pregnancies _____

Number of live births _____

Number of miscarriages _____

Number of abortions _____

Do you practice birth control? _____

What type? _____

How long? _____

- ☐ Difficult / Painful intercourse
- ☐ Vaginal dryness
- ☐ Vaginal sores
- ☐ Vaginal discharge
- ☐ Infertility
- ☐ Irregular menstruation
- ☐ Painful menstruation
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Fibrocystic breast tissue
- ☐ Polycystic Ovarian Disease
- ☐ PMS

Musculoskeletal

- ☐ Neck pain
- ☐ Knee pain
- ☐ Hip pain
- ☐ Back pain Low_____ Middle_____ Upper_____
- ☐ Shoulder pain
- ☐ Sprains / Strains
- ☐ Muscle pain
- ☐ Hand / wrist pain
- ☐ Sciatica
- ☐ Muscle weakness
- ☐ Bursitis
- ☐ Carpal Tunnel pain
- ☐ Foot / ankle pain
- ☐ Tendonitis
- ☐ Rotator cuff pain

Quality of the Pain

- ☐ Achy
- ☐ Dull
- ☐ Sharp
- ☐ Pain is worse after rest
- ☐ Tender
- ☐ Throbbing
- ☐ Heavy
- ☐ Pain is worse after exertion
- ☐ Hot / Burning
- ☐ Cramping
- ☐ Stabbing
- ☐ Heat makes pain feel better
- ☐ Numb / Tingling
- ☐ Spreading / Radiating
- ☐ Gnawing
- ☐ Ice / Cold makes pain feel better

How many hours of the day are you in pain?_____

How many days of the week are you in pain?_____

Neuropsychological

- ☐ Seizures
- ☐ Lack of coordination
- ☐ Anxiety / Panic attacks
- ☐ Nervousness
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Bad temper / Irritable
- ☐ ADD / ADHD
- ☐ Vertigo / Dizziness
- ☐ Concussion
- ☐ Easily susceptible to stress
- ☐ Manic Depression
- ☐ Areas of numbness
- ☐ Depression
- ☐ Seasonal Affective Disorder
- ☐ Substance Abuse

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www.philadelphia-acupuncture.com

Informed Consent for Acupuncture and Chinese Medicine Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including, but are not limited to, acupuncture, acupressure, electrical stimulation, pricking, moxibustion, cupping, gua sha, qi gong, herbal therapy, nutritional counseling, and various modes of physiotherapy, on me by Sharon Sherman, L.OM., who is a Licensed Practitioner of Oriental Medicine.

I understand that all needles utilized for acupuncture treatments are prepackaged sterile single use needles that have never been used before and will be disposed of after treatment.

I understand that herbs and nutritional supplements are traditionally considered an important and safe part of the practice of Oriental Medicine. I understand that Sharon Sherman, L.OM., may recommend that I take a Chinese herbal formula(s) and/or nutritional supplementation. I will immediately inform Sharon Sherman, L.OM. if I experience any adverse reaction to the herbs and/or nutritional supplements.

I will notify Sharon Sherman, L.OM. if I am or become pregnant, have a seizure disorder, have a pacemaker, have had lymph nodes removed, have a bleeding disorder or am taking anti-coagulants or have a blood-borne infectious disease. (e.g. Hepatitis B or C, HIV)

Oriental medicine can treat a variety of disorders, but ***is not a substitute for conventional medical treatment and diagnoses.*** I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about the content of the consent, and by signing below I agree to receive the above-named treatments and procedures from Sharon Sherman, L.OM. I also understand there is always a possibility of an unexpected complication, and I understand that no guarantee can be made concerning the results of the treatments on me by Sharon Sherman, L.OM.

I intend this informed consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from Sharon Sherman, L.OM.

I understand that it may be necessary for Sharon Sherman, L.OM. to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives Sharon Sherman, L.OM., permission to release any medical records for the reasons set forth in this paragraph.

Patient Name (print) _____ Patient Representative Name (print) _____

Patient Signature _____ Date _____

Patient's Representative Signature (if applicable) _____ Date _____

CANCELLATION POLICY

Please respect your scheduled time and other patients by arriving for your appointment punctually.

In today's hectic world unplanned issues (or events) come up for all of us. If you need to cancel or reschedule an appointment, please do so ***a minimum of 24 hours in advance*** so that others needing treatment can take advantage of an open time slot.

If you do not cancel at least 24 hours in advance, you will be charged a ***$100.00*** missed appointment fee that will be collected at the time of your next treatment. Overlooked and disregarded appointments create a financial burden to this practice as well as a missed opportunity for someone wanting treatment.

My intention is not to collect missed appointment fees but to provide timely treatments for all my clients.

Your cooperation and consideration are greatly appreciated.

Patient Name (print) _____

Patient Representative Name (print) _____

Patient Signature _____ Date _____

Patient's Representative Signature (if applicable) _____ Date _____

NOTICE OF PRIVACY POLICIES

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations.

You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters and appointment reminder, by calls, post cards or letters.

Disclosure

This office may use or disclose your Pr otected Health Info rmation when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we ammend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

If you have questions, complaints or want more information contact this office.

Contact Sharon Sherman - Empirical Point Acupun cture
Telephone (215) 247-7100
Address 40 W. Evergreen Ave, Suite 112, Philadelphia, PA 19118
Send a written complaint to the U.S. Department of Health and Human Services.
DHHS (Office of Civil Rights)
200 Independence Ave S.W. Room 509F HHH Building
Washington, DC 20201

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I, _____ have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office.

This practice has attempted to provide each patient with a statement of Privacy Policies.

Patient's Signature _____ Date _____