Columbus Herbs & Acupuncture
3857 N. High St., Suite 200
Columbus, Ohio 43214
614 804 0614
qiworker@gmail.com
www.clintonvilleacupunctureclinic.com
Anya Syrkin, Dipl., Lac., MS HM, CNS.

New Client Information

Personal Information

Name _____

Address _____

_____

_____

Home phone _____

Work or cell phone _____

Email _____

Birth date _____ Age _____

Number of children _____ Ages _____

Marital status _____

Occupation _____

Referred by _____

Physician name _____

Physician's phone _____

Emergency contact name _____

Relationship _____ Phone _____

Main Concerns

Please tell me about your major health and wellbeing concerns in order of how important they are to you. It will help if you include when and where you first noticed them and to what extent they affect your daily life now.

_____

_____

_____

_____

_____

_____

Have you received a diagnosis for your concerns? If yes, what was the diagnosis? _____

_____

What kinds of treatment(s) have you tried or are currently using related to these concerns? _____

_____

_____

What results have you seen from the above treatments? _____

_____

_____

Please mark the severity of your chief concern today.

No problem _____ Worst imaginable

1 2 3 4 5 6 7 8 9 10

Please mark the greatest degree of severity of your chief concern that you have ever experienced.

No problem _____ Worst imaginable

1 2 3 4 5 6 7 8 9 10

Personal Medical History

Please mark all that apply and explain as necessary.

☐ Allergies _____ ☐ Heart disease _____ ☐ Seizures _____

☐ Asthma _____ ☐ Hepatitis _____ ☐ Stroke _____

☐ Cancer _____ ☐ High blood pressure _____ ☐ Thyroid disease _____

☐ Diabetes _____ ☐ HIV/AIDS _____ ☐ Other _____

Please date and describe all hospitalizations and surgeries _____

_____

Please date and describe significant traumas _____

_____

What do you know about your birth (prolonged labor, forceps, premature, etc.) _____

_____

List all known allergies (food, chemicals, drugs, seasonal, insects, etc.) _____

_____

Have you undergone a course of antibiotics lately? _____

Have you been under the care of a licensed health care professional in the past year? _____

If so, for what reasons? _____

Family Medical History

Please mark which apply, elaborate as appropriate and indicate which family member.

☐ Allergies _____ ☐ Drug/alcohol abuse _____ ☐ Seizures _____

☐ Asthma _____ ☐ Heart disease _____ ☐ Stroke _____

☐ Cancer _____ ☐ High blood pressure _____ ☐ Thyroid disease _____

☐ Diabetes _____ ☐ Mental disorder _____ ☐ Other _____

Review of Symptoms

Past	Current	General
☐	☐	Catch cold easily
☐	☐	Recurrent infections
☐	☐	Night sweats
☐	☐	Bleed or bruise easily
☐	☐	Organ prolapse
☐	☐	Strong thirst (hot or cold)
☐	☐	Fatigue/low energy
☐	☐	Sudden drops of energy Time of day _____
☐	☐	Sudden change in weight

Past	Current	Skin and Hair
☐	☐	Dry skin/scalp/hair
☐	☐	Rashes/hives
☐	☐	Itching
☐	☐	Eczema

- ☐ ☐ Warts
- ☐ ☐ Acne
- ☐ ☐ Change in moles
- ☐ ☐ Hair loss/thinning hair
- ☐ ☐ Graying of hair
- ☐ ☐ Other_____

Past Current

Sleep

- ☐ ☐ Difficulty falling asleep
- ☐ ☐ Wake up easily during the night
  Times per night?_____
  At a particular time?_____
- ☐ ☐ Wake up too early in the am
  What time? _____
- ☐ ☐ Nightmares
- ☐ ☐ Vivid dreams
- ☐ ☐ Grinding teeth
- ☐ ☐ Talking in sleep
- ☐ ☐ Snoring

Past Current

Circulation

- ☐ ☐ Cold hands or feet
- ☐ ☐ Swelling of hands/feet
- ☐ ☐ Blood clots
- ☐ ☐ Varicose veins
- ☐ ☐ Edema/swollen ankles
- ☐ ☐ Puffy eyes

Past Current

Head, Ears, Eyes, Nose, Throat

- ☐ ☐ Headaches
  Where _____
  When _____
- ☐ ☐ Migraines
- ☐ ☐ Dizziness/vertigo
- ☐ ☐ Fainting spells
- ☐ ☐ Earache
- ☐ ☐ Change in hearing
- ☐ ☐ Ringing in the ears
- ☐ ☐ Blurry vision
- ☐ ☐ Night blindness
- ☐ ☐ Color blindness
- ☐ ☐ Spots before eyes
- ☐ ☐ Dry eyes
- ☐ ☐ Eye pain/sore eyes
- ☐ ☐ Excessive tearing
- ☐ ☐ Glasses/contacts
- ☐ ☐ Facial pain
- ☐ ☐ Facial paralysis
- ☐ ☐ Nosebleeds
- ☐ ☐ Blocked nose/sinuses
- ☐ ☐ Sinus infections
- ☐ ☐ Jaw pain
- ☐ ☐ Teeth/gum problems
- ☐ ☐ Recurrent sore throat
- ☐ ☐ Hoarseness/loss of voice
- ☐ ☐ Tonsillitis/swollen glands
- ☐ ☐ Sores on lips/mouth/gums
- ☐ ☐ Strange taste in mouth
- ☐ ☐ Swollen glands/lumps
- ☐ ☐ Oral ulcers
- ☐ ☐ Other _____

Past Current

Nervous System

- ☐ ☐ Loss of taste/smell/touch
- ☐ ☐ Tingling sensations/numbness
- ☐ ☐ Tremors
  Where? _____
- ☐ ☐ Lack of coordination/balance
- ☐ ☐ Paralysis or seizures
- ☐ ☐ Stroke
- ☐ ☐ Concussion
- ☐ ☐ Other _____

Past Current

Chest

- ☐ ☐ Pain in chest
- ☐ ☐ Tightness or pressure in chest
- ☐ ☐ Pain with breathing
- ☐ ☐ Difficulty breathing
- ☐ ☐ Shallow breathing
- ☐ ☐ Shortness of breath
- ☐ ☐ Recurrent/chronic cough
- ☐ ☐ Coughing up blood
- ☐ ☐ Coughing up phlegm
- ☐ ☐ Asthma/wheezing
- ☐ ☐ Production of phlegm
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Heart palpitations or rapid heartbeat
- ☐ ☐ Irregular heartbeat
- ☐ ☐ Other _____

Past Current

Digestion

- ☐ ☐ Little appetite
- ☐ ☐ Strong appetite
- ☐ ☐ Hunger but no desire to eat
- ☐ ☐ Food cravings
- ☐ ☐ Belching
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Heartburn
- ☐ ☐ Indigestion
- ☐ ☐ Abdominal pain
- ☐ ☐ Regurgitation
- ☐ ☐ Weight loss
- ☐ ☐ Weight gain
- ☐ ☐ Loose stools/diarrhea
- ☐ ☐ Dysentery
- ☐ ☐ Strong smelling stools
- ☐ ☐ Blood in stools
- ☐ ☐ Constipation (< 1 b.m./day)
- ☐ ☐ and dry stools
- ☐ ☐ not daily
- ☐ ☐ with difficulty
- ☐ ☐ Alternating constipation and diarrhea
- ☐ ☐ Gas/flatulence
- ☐ ☐ Hernia
- ☐ ☐ Rectal pain/prolapse
- ☐ ☐ Hemorrhoids
- ☐ ☐ Anorexia nervosa
- ☐ ☐ Bulimia
- ☐ ☐ Bad breath
- ☐ ☐ Other _____

Past Current

Urinary

- ☐ ☐ Pain on urination
- ☐ ☐ Urgent urination
- ☐ ☐ Frequent urination
- ☐ ☐ Blood in urine
- ☐ ☐ Cloudy urine
- ☐ ☐ Dribbling urination
- ☐ ☐ Urinary incontinence/retention
- ☐ ☐ Incontinence at night
- ☐ ☐ Do you wake to urinate?
  How many times? _____
- ☐ ☐ Bladder/kidney infections
- ☐ ☐ Recurrent yeast infections
- ☐ ☐ Kidney stones

Past Current

Male System

- ☐ ☐ Prostate problems
- ☐ ☐ Change in sexual drive
- ☐ ☐ Rashes/itching
- ☐ ☐ Genital discharge
- ☐ ☐ Erection difficulty
- ☐ ☐ Low sperm count/motility

Past Current

Muscles and Joints

- ☐ ☐ Neck pain
- ☐ ☐ Shoulder pain
- ☐ ☐ Back pain
  Where _____
- ☐ ☐ Hand/wrist pain
- ☐ ☐ Knee pain
- ☐ ☐ Foot/ankle pain
- ☐ ☐ Joint/bone problems
- ☐ ☐ Muscle pain/weakness
- ☐ ☐ Tremors/tics in muscles
- ☐ ☐ Osteoporosis
- ☐ ☐ Herniated disc
- ☐ ☐ Sciatica
- ☐ ☐ Other _____

Mind and Emotions

Past Current

- ☐ ☐ Poor memory
- ☐ ☐ Difficulty concentrating
- ☐ ☐ Depression
- ☐ ☐ Often stressed
- ☐ ☐ Lose control of emotions
- ☐ ☐ Substance abuse
- ☐ ☐ Anxiety/nervousness
- ☐ ☐ Manic behavior
- ☐ ☐ Panic attacks
- ☐ ☐ Easily angered
- ☐ ☐ Aggressive behavior
- ☐ ☐ Other _____

Female System

Past Current

- ☐ ☐ Premenstrual irritability
- ☐ ☐ Clots in menstrual blood
  Color of blood _____
- ☐ ☐ Irregular menses
- ☐ ☐ Painful menses
- ☐ ☐ Heavy/prolonged bleeding
- ☐ ☐ Missed menses
- ☐ ☐ Spotting/abnormal bleeding
- ☐ ☐ Vaginal discharge
- ☐ ☐ Vaginal dryness
- ☐ ☐ Genital sores
- ☐ ☐ Ovarian cysts
- ☐ ☐ Fibroids
- ☐ ☐ Endometriosis
- ☐ ☐ Breast lumps
- ☐ ☐ Breast swelling or redness
- ☐ ☐ Nipple discharge
- ☐ ☐ Abnormal Pap smear
- ☐ ☐ Infertility
- ☐ ☐ Other _____

Are you pregnant now? _____

Is it possible you're pregnant now?
_____

Are you trying to get pregnant?
_____

Do you practice birth control?
_____

What type and for how long?
_____

Number of pregnancies _____
Number of births _____
Num. of premature births _____
Number of abortions _____
Age of first menses _____
Duration of menses _____
First day of last menses _____
Number of days in cycle _____
Age of menopause _____
Date of last Pap _____

Comments _____

_____

Daily Routines

Please describe your daily activities from when you awake until you go to sleep. Include types of food you eat, exercise, work and other activities.

	Time	Activities, Foods, Routine	Variation
Morning			
Awaken	_____	_____	_____
Breakfast	_____	_____	_____
Activities after breakfast	_____	_____	_____
Midday			
Lunch	_____	_____	_____
Activities after lunch	_____	_____	_____
Evening			
Dinner	_____	_____	_____
Activities after dinner	_____	_____	_____
Night			
Activities	_____	_____	_____
Bed time	_____	_____	_____

List other regular activities not included above. These could be exercise, meditation, spiritual practices, etc. _____

_____

Are you sexually active? Yes_____ No_____ Frequency_____

How many hours per week do you work?_____ Do you enjoy what you do? _____

How far is your commute? _____

How many hours a day do you spend sitting or driving? _____

Other comments about your daily routine _____

General Health Habits

Are you a vegetarian or vegan? Yes_____ No_____ If yes, how long _____

What are the major stressors in your life? _____

How much water do you drink per day? Number of cups _____

Do you exercise regularly? Yes_____ No_____ Length of time_____ Times per week_____

Types(s) of exercise _____

Please mark any of the following that apply.

Aspirin	currently_____	occasionally_____	Diet pills	currently_____	occasionally_____
Tranquilizers	currently_____	occasionally_____	Vitamins	currently_____	occasionally_____
Antacids	currently_____	occasionally_____	Sleeping pills	currently_____	occasionally_____
Laxatives	currently_____	occasionally_____	Herbs	currently_____	occasionally_____
Cold tablets	currently_____	occasionally_____	Antihistamines	currently_____	occasionally_____
Ibuprofen	currently_____	occasionally_____	Oral contraceptives	currently __	occasionally_____

List any medications you are currently taking _____

Please mark your current use levels of the following:

Tobacco frequently_____ occasionally_____ never_____ Number of cigarettes per day_____Age started _____

Alcohol frequently_____ occasionally_____ never_____ Number of drinks per week_____ Type of drinks _____

Caffeine frequently_____ occasionally_____ never_____ Number of cups per day_____ Type of drinks_____

Other frequently_____ occasionally_____ never_____ Describe _____

Do you have any current or past problems with addiction or substance abuse? Yes____ No_____

Substance_____ Amount_____ When did you quit? _____

Signature_____ **Date** _____

DISCLOSURE STATEMENT

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Anya Syrkin, Dipl., Lac., MS HM, CNS.

EDUCATION AND EXPERIENCE

Anya Syrkin graduated from American Institute of Alternative Medicine (AIAM) in June 2013. AIAM is a three year program with a curriculum strongly emphasizing Traditional Chinese Medicine as well as Acupuncture. Prior to graduation, Anya did an intensive study in Beijing, China. The program took place in Beijing Hospital for Traditional Chinese Medicine and Western Integrative Medicine in 2012. In August 2013, Anya gained her certification of a Diplomate in Acupuncture (Dipl. Lac) as issued by the National Council of Colleges for Acupuncture and Oriental Medicine (NCCAOM). Ohio State Acupuncture License was awarded October 2013. Included in this certification is a course in Clean Needle Technique, and First Aid/CPR. Anya's education also included adjunct therapies such as moxibustion, cupping, gua'sha, tuina, auriculotherapy, electro-acupuncture, and lifestyle and Traditional Chinese Medical (TCM) nutritional counseling. Anya Syrkin holds a Masters Degree in Herbal Medicine from Maryland University of Integrative Health (former Tai Sophia Institute) in Laurel, MD, and Certified Nutritional Specialist (CNS) from American College of Nutrition. She has been a part of Columbus State Community College Nursing Department faculty since 2007. The course she teaches there are: Herbology, Homeopathy and Holistic Healing Methods.
Other information and recipes available during a session will be based on Anya's extensive training in wellness, nourishment, Western herbs, Aromatherapy and Flower Essences.

This clinic uses only single-use, disposable, factory-sterilized needles, and complies with the rules and regulations promulgated by the Ohio Department of Public Health and Environment concerning proper cleaning and sanitation measures.
Anya

FEE SCHEDULE:

Initial Acupuncture Consultation and Treatment	$ 90.00
Fertility Acupuncture/Wellness Consultation and Treatment	$100.00
Follow up Acupuncture Treatment	$ 65.00
Cupping Treatment	$ 65.00
Cupping Treatment adjunct to Acupuncture Treatment	$ 15.00
Nutrition Information Consultation	$135.00

I understand that if I need to reschedule an appointment for any reason, I will give at least 24 hours notice or be responsible for half the session fee. If I don't call or show up, I will be responsible for the full session fee.

PATIENT'S RIGHTS

-The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known
-The patient may seek a second opinion from another health care professional or may terminate therapy at any time.

The practice of Acupuncture is regulated by the Ohio State Medical Board.
I have read and understand this document.

_____ _____
Patient's or Guardian's signature Date

STATEMENT OF INFORMED CONSENT

I hereby request and consent to the performance of acupuncture and other treatments within the scope of practice of an acupuncturist to be performed by Anya Syrkin, L. Ac., representing Columbus Herbs & Acupuncture, on me (or, if the patient is a minor, on the patient named below, for whom I am legally responsible).

I understand that there are minor risks associated with acupuncture treatment, including, but not limited to, slight bleeding and/or bruising of the skin. I understand that the risk of infection is negligible when using single use, disposable needles.

I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture. I understand that results are not guaranteed.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications. I wish to rely on the acupuncturist to exercise good judgment during the course of the procedure, based on the facts then know, and act in my best interest.

I have read the above consent, or have had it read to me. I have had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend for this consent form to cover the entire course of treatment for my present condition, as well as any future conditions for which I may seek treatment.

Following your treatment:

Occasionally, a person may feel light headed after an acupuncture treatment. If this happens to you, please sit for a while in the designated area. You'll feel fine in a few minutes.

PAYMENT WILL BE REQUESTED FOR CHANGES OR CANCELLATIONS OF LESS THAN 24 HOURS
Please sign and date below to indicate that you have read and understand this form.

_____ _____
Patient Signature (or Guardian, if minor) Date

_____
Printed Name

_____
Address City, State, Zip

_____Phone (Daytime)
(Evening)

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What to Expect from your first treatment

Welcome to my office! You are in for what I hope will be a relaxing and enjoyable experience.

Your comfort and safety are my greatest concern. Please let me know at any time if I can make you more comfortable. You are welcome to ask questions at any time, and let me know if you don't understand the answer! Chinese Medicine is a different way of looking at the body. If the explanations are not clear, the fault is mine, not yours.

Please wear comfortable clothes. You will probably remain dressed, depending on the issue that we are addressing, but you may be required to remove some articles of clothing. Loose clothes are best.

Do not come in overly full or very hungry or after an intense workout. If you are coming in for a pain condition, please do not take pain medication prior to your treatment- IF YOU CAN STAND IT. Having said this please do not force yourself to be miserable. Again, when experiencing pain do not make yourself suffer needlessly, this is only a suggestion.

Please be prepared to disclose any medications or supplements you are taking. Usually herbs can be used in conjunction with pharmaceuticals, but they can interact. It is imperative that you give me the information to prevent this. Your safety is my priority.

Occasionally, a person may feel lightheaded after a treatment. This is a result of your body's energies readjusting it self, you will return to normal within a few minutes. You can wait for this to pass in the treatment or waiting room.

Most people find their acupuncture treatments very relaxing and enjoyable. It's not uncommon to fall asleep during a session. I look forward to working with you soon.

The following is a partial list of conditions Acupuncture was found to be helpful with:
Abdominal pain, Addiction (smoking cessation, alcohol, drugs), Allergic rhinitis (including hay fever), Anxiety, Back Pain, Bell's palsy, Cramps(menstrual), constipation, Cycle regulation, Cold and Flu, Depression, Dermatological disorders, Diarrhea, Dizziness, Ear aches, Facial pain, Headache, Hypertension(high blood pressure)Hypotension(low), IBS, Insomnia, Infertility men or women, Joint pain, Induction of labor, Knee pain, Low back pain, Malposition of fetus, Morning sickness, Nausea and vomiting, Neck pain, Pain, Pain of the shoulder, Postoperative pain, Respiratory disorders, Rheumatoid Arthritis, Sciatica, Shingles, Sore throat, Tendonitis, Weight control and weight issues, and much more.

Anya