

**Present Health Concerns:**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_ Approx. Date of Onset: \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine

Other therapies tried  Medications  Surgery  Chiropractic  Phys. Therapy  Other \_\_\_\_\_

Other Complaint: \_\_\_\_\_ Approx. Date of Onset: \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine

Other therapies used  Medications  Surgery  Chiropractic  Phys. Therapy  Other \_\_\_\_\_

**Past Medical History**

If you are a **new** patient to New York Spine & Wellness or if your current medical information has changed, please provide a list including the following:

- List all **medications** that you are currently taking (or have used in the past 2 months), with dosages.
- List any **vitamins, minerals, herbs, or homeopathic remedies** that you are presently taking
- List of **allergies** that you have to any drugs, foods or other items e.g. adhesive tape, latex, etc.
- List past injuries, broken bones, surgeries and hospitalizations, with approx dates.

**General**

<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Fever/Chills	<input type="checkbox"/> Tremors
<input type="checkbox"/> Heavy Appetite	<input type="checkbox"/> Sweat easily	<input type="checkbox"/> Poor sleeping
<input type="checkbox"/> Changes in appetite	<input type="checkbox"/> Localized weakness	<input type="checkbox"/> Heavy sleeping
<input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Bleed/bruise easily	<input type="checkbox"/> Dream disturbed sleep
<input type="checkbox"/> Cravings	<input type="checkbox"/> Sudden energy drop? Is it at a specific time of day? _____	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Peculiar tastes		<input type="checkbox"/> Dizziness
<input type="checkbox"/> Strong thirst	<input type="checkbox"/> Fatigue	

**Skin & Hair**

<input type="checkbox"/> Rashes/Hives	<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Fungal infections
<input type="checkbox"/> Itching	<input type="checkbox"/> Eczema/Psoriasis	<input type="checkbox"/> Recent moles
<input type="checkbox"/> Dry skin	<input type="checkbox"/> Loss of hair	<input type="checkbox"/> Change in hair/skin texture
<input type="checkbox"/> Dandruff	<input type="checkbox"/> Pimples/Acne	<input type="checkbox"/>
<input type="checkbox"/> Other Hair or skin concerns:		

**Head, Eyes, Ears, Nose & Throat**

<input type="checkbox"/> Concussions	<input type="checkbox"/> Spots in front of eyes	<input type="checkbox"/> Swollen glands
<input type="checkbox"/> Glasses/contacts	<input type="checkbox"/> Earaches/Infections	<input type="checkbox"/> Sores on lips/tongue
<input type="checkbox"/> Eye strain/pain	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Dry mouth
<input type="checkbox"/> Red eyes	<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Excessive saliva
<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Teeth problems
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Post nasal drip	<input type="checkbox"/> Gum problems
<input type="checkbox"/> Excessive tearing	<input type="checkbox"/> Excessive phlegm/Color _____	<input type="checkbox"/> TMJ disorder
<input type="checkbox"/> Poor/blurry vision	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Grinding teeth
<input type="checkbox"/> Night blindness	<input type="checkbox"/> Recurrent sore throats	
<input type="checkbox"/> Cataracts/Glaucoma	<input type="checkbox"/> Headaches	
Other head & neck concerns:		

**Cardiovascular**

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Swelling of feet
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Fainting	<input type="checkbox"/> Blood clots
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Swelling of hands	
<input type="checkbox"/> Other heart or blood vessel concerns:		

**Respiratory**

<input type="checkbox"/> Cough	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pain with deep breath
<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Production of Phlegm	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tight Chest
<input type="checkbox"/> Thick <input type="checkbox"/> Thin Color _____	<input type="checkbox"/> Wheezing	
<input type="checkbox"/> Other lung related concerns:		

**Gastrointestinal**

<input type="checkbox"/> Nausea	<input type="checkbox"/> Belching	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Itchy anus
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Burning anus
<input type="checkbox"/> Constipation	<input type="checkbox"/> Black stools	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Gas/bloating	<input type="checkbox"/> Mucus in stools	<input type="checkbox"/> Fissures
<input type="checkbox"/> Hiccups	<input type="checkbox"/> Acid regurgitation	<input type="checkbox"/> Gum problems
<input type="checkbox"/> Excessive tearing	<input type="checkbox"/> Excessive phlegm/Color _____	<input type="checkbox"/> Chronic laxative use?
<input type="checkbox"/> Poor/blurry vision	<input type="checkbox"/> Nose bleeds	
Other concerns with your general digestion:		

**Genito-Urinary**

<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Premature ejaculation
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Nocturnal emissions
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Impotency	<input type="checkbox"/> Sores on genitals
<input type="checkbox"/> Urgency to urinate	<input type="checkbox"/> Increased libido	<input type="checkbox"/> Frequent urinary tract infections
<input type="checkbox"/> Unable to hold urine	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Chronic yeast infection
<input type="checkbox"/> Decrease in flow		<input type="checkbox"/> If you wake to urinate, how often?
Other concerns with genitals or urinary system:		

**Musculoskeletal**

<input type="checkbox"/> Neck pain	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Knee pain
<input type="checkbox"/> Upper back pain	<input type="checkbox"/> Cramps/spasms	<input type="checkbox"/> Foot/ankle pain
<input type="checkbox"/> Lower back pain	<input type="checkbox"/> General joint pain/stiffness	<input type="checkbox"/> Hip pain
<input type="checkbox"/> Hand/wrist pains	<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Muscle pains
<input type="checkbox"/> Joint(s) with limited range of motion:		
Other muscle, joint or bone concerns:		

**Neuropsychological**

<input type="checkbox"/> Seizures	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Easily susceptible to stress
<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Concussion	<input type="checkbox"/> History of emotional/physical abuse
<input type="checkbox"/> Areas of numbness	<input type="checkbox"/> Depression	<input type="checkbox"/> Have you ever been treated for emotional problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Tics	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Have you ever considered or attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lack of coordination	<input type="checkbox"/> Irritability	<input type="checkbox"/>
Other neurological or psychological concerns:		

**OB/Gynecology**

Age of first menses _____ If no longer menstruating, approx date menses ended: _____		
First day of last period _____ Length between periods: ____ days Duration of period ____ days		
<input type="checkbox"/> Heavy or <input type="checkbox"/> Light flow	<input type="checkbox"/> Clots in flow	<input type="checkbox"/> Vaginal dryness
<input type="checkbox"/> Painful periods	<input type="checkbox"/> Vaginal discharge – color?	<input type="checkbox"/> Vaginal sores
<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Vaginal odor	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Breast lumps/soreness	Date of last PAP: _____	Results were <input type="checkbox"/> normal <input type="checkbox"/> abnormal
Number of pregnancies _____ Births _____ Miscarriages _____ Abortions _____		
Were your births relatively normal? Explain:		



## I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

CNY Acupuncture is committed to your health and well being. All of us affiliated with CNY Acupuncture believe that while Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Therefore, we recommend that you consult a physician regarding any condition(s) for which you are seeking acupuncture and/or other Oriental Medicine modality treatment(s).

To comply with Article 160, Section 821 1.1 (b) of NYS Education Law, we request that you read and sign the following statement:

**WE, THE UNDERSIGNED, DO AFFIRM THAT \_\_\_\_\_ (Patient)**

**HAS BEEN ADVISED BY \_\_\_\_\_ (Licensed Acupuncturist/Clinician)**

**TO CONSULT A PHYSICIAN REGARDING THE CONDITION(S) FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Licensed Acupuncturist

\_\_\_\_\_  
Date

## II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

- I consent to acupuncture treatments and other procedures associated with the practice of Traditional Oriental Medicine provided by members of CNY Acupuncture staff. I have discussed the nature and purpose of my treatment with the member of the clinical staff named below. I understand that I can refuse treatment at any time.
- I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, and bodywork therapies such as Tui Na/Chinese Massage and Shiatsu.
- I have been informed that acupuncture is a safe method of treatment but that it may have side effects including: bruising, numbness, tingling (that may last a few days), dizziness, fainting, infection. Common side effects of cupping are bruises. Potential risks of moxibustion are burns and scarring. Rare and unusual risks of acupuncture include: spontaneous miscarriage, nerve damage, organ puncture (which includes lung puncture/pneumothorax.) I understand that while this document describes the major risks of treatment, other side effects and risks may occur.
- I will notify the clinical staff member who is caring for me prior to treatment if I am pregnant.
- I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment
- I understand the clinical staff may review my medical records and lab reports and that portions of my records may be used for continuing quality improvement, teaching or research purposes, however my name and identifying information will not be disclosed. Otherwise all of my records will be kept confidential and will not be released to any party without my written consent.

**By voluntarily signing below I show that I have read, or have had read to me, this 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.**

### *Patient*

Print Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### *Patient's Representative*

Print Name: \_\_\_\_\_ Representative Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Reason Patient Unable to Sign: \_\_\_\_\_ Date: \_\_\_\_\_

### *Acupuncturist/Clinical Staff*

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**When form is complete: original to patient file, copy to patient**