New York Spine & Wellness Center

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

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

Skin & Hair

❑ Rashes/Hives	❑ Ulcerations	❑ Fungal infections
❑ Itching	❑ Eczema/Psoriasis	❑ Recent moles
❑ Dry skin	❑ Loss of hair	❑ Change in hair/skin texture
❑ Dandruff	❑ Pimples/Acne	❑
❑ Other Hair or skin concerns:		

Head, Eyes, Ears, Nose & Throat

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

Cardiovascular

❑ High blood pressure	❑ Palpitations	❑ Swelling of feet
❑ Low blood pressure	❑ Fainting	❑ Blood clots
❑ Chest pain	❑ Cold hands/feet	❑ Phlebitis
❑ Irregular heartbeat	❑ Swelling of hands	
❑ Other heart or blood vessel concerns:		

Respiratory

❑ Cough	❑ Asthma	❑ Pain with deep breath
❑ Coughing blood	❑ Bronchitis	❑ Shortness of breath
❑ Production of Phlegm	❑ Pneumonia	❑ Tight Chest
❑ Thick ❑ Thin Color ____________	❑ Wheezing	
❑ Other lung related concerns:		

Gastrointestinal

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

Genito-Urinary

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

Musculoskeletal

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

Neuropsychological

❑ Seizures	❑ Memory loss	❑ Easily susceptible to stress
❑ Loss of balance	❑ Concussion	❑ History of emotional/physical abuse
❑ Areas of numbness	❑ Depression	❑ Have you ever been treated for emotional problems? ❑Yes ❑ No
❑ Tics	❑ Anxiety	❑ Have you ever considered or attempted suicide? ❑Yes ❑ No
❑ Lack of coordination	❑ Irritability	❑
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

❑ Heavy or ❑ Light flow	❑ Clots in flow	❑ Vaginal dryness
❑ Painful periods	❑ Vaginal discharge ó color?	❑ Vaginal sores
❑ Irregular periods	❑ Vaginal odor	❑ Hot flashes
❑ Breast lumps/soreness	Date of last PAP:	Results were ❑ normal ❑ abnormal

Number of pregnancies _______ Births ______ Miscarriages _____ Abortions ______
Were your births relatively normal? Explain:

5496 East Taft Road
North Syracuse, NY 13212
Phone: 315-552-6700

5719 Widewaters Parkway
Dewitt, NY 13214
Phone: 315-703-3480

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

The Acupuncturists at New York Spine and Wellness Center (NYSW) are committed to your health and well being. All of us affiliated with NYSW 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. Acupuncturist are not physicians therefore, we recommend that you consult a Medical Doctor/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:

I DO AFFIRM THAT THE UNDERSIGNED LICENSED ACUPUNCTURIST

HAS ADVISED ME

TO CONSULT A PHYSICIAN REGARDING THE CONDITION(S) FOR WHICH I SEEK ACUPUNCTURE TREATMENT.
____________ (Patient or Representative Initials)

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 NYSW 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, or 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
Patient declines copy: _____________________ (patient initials)

Initial Physical Modality Improvement Questionnaire

NAME:		DOB:
DATE:		Date of injury:
Body part(s) covered under this injury:		
Circle visit type	Acupuncture/ Chiropractic/ Massage	
Please answer the following questions.		
1	Please list any difficulties you have walking:	
2	Please list any assistive devices you use to walk, e.g. cane, walker, ect.:	
3	Please list any difficulties you have with bathing/washing yourself:	
4	Please list any difficulties you have while dressing yourself:	
5	Please list house work that is difficult for you to do:	
6	Please list any issues you have with falling asleep or staying asleep:	
7	Please list any areas of your body that do not have full range of motion:	
8	Do you take any medication for pain? If so please list name and does and how many times a day you take it:	
9	Are you currently participating in any strength or aerobic exercise programs?	