Acupuncture NYC **303 Fifth Ave, Suite 1501 NY, NY 10016; (646) 369-0160**

Name:_____ Date:_____

Date of birth_____ Male Female Other

Married Single Other

Address

Street_____Apt_____

City_____ State _____ Zip_____

Phone_____ Email_____

Occupation_____

Emergency contact

Name: _____

Phone:_____

Medical history

Height:_____ Weight _____

Are your currently under the care of a physician? Yes No

Physician's name:_____

Other care providers:_____

Are you currently receiving care for any health problems? Yes No

Diagnosis_____ Date_____

Chief Complaint

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What are the main health problems for which you are seeking treatment?

What do you think caused these health problems?

What symptoms are you experiencing?

Do you have any other problems you want us to address?

Please list any allergies, food sensitivities, or food cravings that you have:

Please list any accidents, surgeries or hospitalizations (include dates).
If there are no significant past medical events, please state so.
All information relevant to the chief complaint must be included.

Please list any medications you are currently taking and why

Please list any vitamins, supplements, and herbs you are currently taking and why

Substance	Never	Infrequently	A few times a week	Once a week	Once a day	Twice a day	More than twice a day
Tobacco							
Coffee							
Soda							
Alcohol							

Recreational drugs							

How do you feel about the following areas of your life? Please check the appropriate box and indicate any problems you may be experiencing.

Do you exercise? Yes No

What type of exercise?

How often?

Select the applicable exposures:
Loud noises
Chemicals
Heat
Smoke
Physical hazards
Vibration
Repetitive stress
Radiation
Animals
Did you serve in the armed forces? Yes No

Please circle any symptoms you are currently experiencing:

Respiratory

Fever/chills
Sore throat
Post-nasal drip
Swollen lymph nodes
Snivel
Swollen lymph nodes
Cough
Seasonal allergies
Sinusitis
Sputum
Difficulty breathing
Chest pain
Loss of smell
Loss of taste
Asthma
Chronic respiratory issues
Frequent colds
Flu

Digestive

No appetite
Excessive appetite
Bloating
Belching
Gas
Abdominal pain
Food allergies
Nausea
Vomiting
Acid reflux
Heartburn
Stomach ulcer
Intestinal ulcers
Intestinal parasites
Loose stool
Urgent bowel movement
Constipation
Hemmorhoids
Rectal bleeding
Unusual stool color
Gum disease
Liver disease
Gallbladder disease
Jaundice

Neurological

Fatigue/weakness
Insomnia
Anxiety
Depression
Obsessive thoughts
Irritability
Anger
Fear
Desire to sleep a lot
Apathy
Difficulty focusing attention
Night sweating
Spontaneous sweating

Urinary

Frequent urination
Difficult urination
Urination at night
Inability to hold urine
Dribbling urination
Burning urination
Blood in urine
Pus
Genital sores/irritation
Pain in the genitals
Venereal diseases

Musculo-skeletal

Headache/Migraine
Neck pain
Shoulder pain
Upper back pain
Mid-back pain
Low back pain
Sciatica
Joint pain
Joint swelling
Muscle tension
TMJ/TMD
Dental cavities

Cardiovascular

High blood pressure
Low blood pressure
Seazures
Arrhythmia
Blood issues
Lymph nodes swelling
Varicose veins
Deep leg pain
Varicose veins
Thrombophlebitis
Leg cramps
Extremity swelling
Extremity numbness

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Women	Men	Dermatology
Menstrual pain	Erectile dysfunction	Itching
Short menstrual period	Premature ejaculation	Rashes
Long menstrual period	Low libido	Skin ulcers
Irregular period	Low sperm count	Eczema
Mid-cycle bleeding	Enlarged prostate	Psoriasis
Miscarriage	Pain in the penis	Acne
Infertility	Varicocele	Boils
PSOS	Sowllen testicles	Color change
Endometriosis	Painful testicles	Change in mole
Fybroma	Prostatitis	Skin cancer
Amenorrhea	Oncology	
Breast tenderness		
Breast lumps		
Vaginal discharge		
Vaginal dryness		
Painful intercourse		
Lack of sexual desire		
Sexual frustration		
Menopausal symptoms		
Oncology		

Endocrene
Diabetes
High blood sugar
Low blood sugar
Liver enzymes
Hypo-thyroidism
Hyper-thyroidism

PATIENT ADVISORY TO CONSULT A PHYSICIAN

To comply with Article 160, Section 8211.1(b) of NYS Education law, we request that you read and sign the following statement:
We, the undresigned, do affirm that (Patient/ or Guardian name)_____ Has been advised by Andre Yershov, Licensed Acupuncturist,
To consult a physician regarding the conditions for which such patient seeks acupuncture treatment.

_____ _____

I consent to acupuncture treatments and other procedures associated with Traditional Oriental Medicine by the Licensed Acupuncturist named below. I have discussed the nature and purpose of my treatment with this person.
I understand that methods of treatment may include but are not limited to acupuncture, moxabustion, cupping, guasha, electrical stimulation and Tui Na (Chinese Massage).
I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near to needling sites that may last a few days and dizziness or fainting. Bruising is a common side effect of cupping or guasha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this clinic uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are potential risks of moxabustion. I understand that while this document describes the major risks of treatment, other side effects may occur.
The herbs and nutritional supplements (which are from plant, animal and mineral sources), which may be recommended are traditionally considered safe, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives and tingling of the tongue. I will notify my practitioner of any unanticipated or unpleasant effects associated with the consumption of herbs.
I will notify my practitioner if I become pregnant.
I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on my practitioner to exercise judgment during the course of treatment which the practitioner thinks at the time, based upon the facts known to him, is in my best interests.
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 intended 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.

Print name of Patient/Guardian_____

Signature of Patient Guardian_____Date_____