ny chi acupuncture

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New York, NY 10016
917.575.0293

Please note that all information is strictly confidential.

First Name | Middle Initial

Last Name

Address | City/State/Zip

Email | Cell Phone

Home Phone | Work Phone

Occupation

In Case of Emergency Contact

Relationship and Phone

Height | Weight | Age

OBGYN Name | Phone

Other relevant physicians/specialists

May I discuss your treatment with your physicians? ◯ Yes ◯ No

How did you hear about the clinic?

Would you like to receive our monthly email newsletter? ◯ Yes ◯ No

Note: We never share your email.

Reason for today's visit

How, when, and where did this condition begin?

What types of treatment have you tried?

Please list the main health concerns you would like to address in order of importance:

1.

2.

3.

What are your goals with acupuncture treatment?

How much time and energy do you currently have to devote to lifestyle changes such as exercise, meditation and cooking? **There is no wrong answer- this information will help me in making realistic, appropriate recommendations for you.* Please circle one answer.

a. High: I'm ready for a total overhaul if needed
b. Moderate: I'm able to make some changes
c. Low: My plate is full and I'm not able to make changes at this time or I need someone to do it for me

Medical History:

Surgeries, Major Illnesses, Hospitalizations, and Major Accidents:

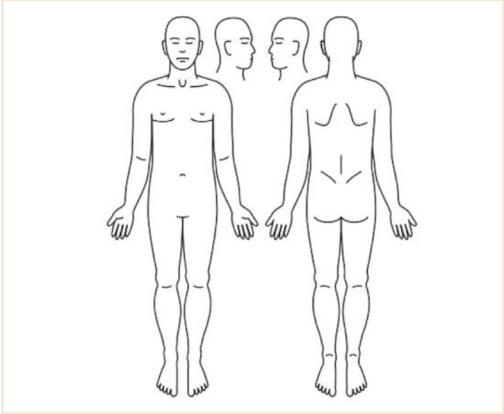
Current medications, supplements, and vitamins (including what they are for):

Do you have, or have you had any of the following illnesses? Please circle any that apply.

◯ Mental Illness	◯ Diabetes	◯ Hepatitis	◯ HIV+	◯ Seizures
◯ Cancer	◯ Heart Disease	◯ Asthma	◯ Allergies	◯ Stroke
◯ Arthritis	◯ Ulcers	◯ High Blood Pressure	◯ Herpes	◯ Tuberculosis
◯ Osteoporosis	◯ Kidney Stones	◯ Rheumatic Fever	◯ Thyroid Problems	◯ Mononucleosis
◯ Gallstones	◯ Chronic Fatigue	◯ STDs_____		

◯ Other_____

Pain:
Please place an "X" by any areas of pain:



Lifestyle:

Please describe what you typically eat:

Do you cook at home? ◯ Yes ◯ No If yes, how many meals per day are home cooked?

Any food intolerances/sensitivities or dietary special needs? ◯ Yes ◯ No

If yes, please describe:

Exercise? ◯ Yes ◯ No How often?

Type?

Sleep: Hours per night | Time to Bed | Time to Rise

Feel Rested in AM? | Trouble Falling Asleep? ◯ Yes ◯ No ◯ Sometimes

Wake during the night? ◯ Yes ◯ No | Wake up feeling rested ◯ Yes ◯ No

Work: Enjoy work? ◯ Yes ◯ No | Hours per week working

Body Systems Review (please check all that apply):

0 Never | **1** In the past but not now | **2** Occasionally | **3** Frequently | **4** Almost Always

0 1 2 3 4	low appetite	0 1 2 3 4	heavy limbs
0 1 2 3 4	loose stools	0 1 2 3 4	fatigue
0 1 2 3 4	abdominal gas/bloating after food	0 1 2 3 4	hemorrhoids
0 1 2 3 4	fatigue after eating	0 1 2 3 4	belching
0 1 2 3 4	organ prolapse	0 1 2 3 4	nausea
0 1 2 3 4	bruise easily	0 1 2 3 4	diarrhea
0 1 2 3 4	obsessive thoughts/worrying	0 1 2 3 4	craving for sweets

0 1 2 3 4	spontaneous sweat	0 1 2 3 4	feeling of sadness
0 1 2 3 4	allergies	0 1 2 3 4	catch colds easily
0 1 2 3 4	asthma	0 1 2 3 4	feel tired after exercise
0 1 2 3 4	shortness of breath	0 1 2 3 4	general weakness
0 1 2 3 4	cough	0 1 2 3 4	nasal discharge
0 1 2 3 4	dry nose/mouth/throat	0 1 2 3 4	sinus congestion

0 1 2 3 4	sore, cold or weak knees	0 1 2 3 4	hair loss
0 1 2 3 4	low back pain	0 1 2 3 4	memory loss
0 1 2 3 4	frequent urination	0 1 2 3 4	hot flashes
0 1 2 3 4	urinary incontinence	0 1 2 3 4	nightsweats
0 1 2 3 4	ear problems	0 1 2 3 4	feeling cold
0 1 2 3 4	early morning diarrhea	0 1 2 3 4	edema (swollen extremities)
0 1 2 3 4	craving salt	high low normal	libido

0 1 2 3 4	irritable	0 1 2 3 4	muscle spasms/twitches
0 1 2 3 4	feel better after exercise	0 1 2 3 4	heartburn/acid reflux
0 1 2 3 4	tight feeling in chest	0 1 2 3 4	dry eyes/red eyes
0 1 2 3 4	alternating diarrhea/constipation	0 1 2 3 4	ear ringing
0 1 2 3 4	symptoms worse with stress	0 1 2 3 4	anger easily
0 1 2 3 4	neck/shoulder tension	0 1 2 3 4	frequent headaches
0 1 2 3 4	floaters in vision	0 1 2 3 4	blurry vision
0 1 2 3 4	feeling of heat rushing to head	0 1 2 3 4	brittle or weak nails

0 1 2 3 4	feel heart beating	0 1 2 3 4	chest pain
0 1 2 3 4	insomnia	0 1 2 3 4	disturbing dreams
0 1 2 3 4	sores on tip of tongue	0 1 2 3 4	excessive laughter
0 1 2 3 4	anxiety	0 1 2 3 4	palpitations
0 1 2 3 4	restlessness	0 1 2 3 4	excessive sweat
0 1 2 3 4	red cheeks		

Urination (circle all that apply):

◯ Burning ◯ Urgent ◯ Retention ◯ Frequent
◯ Scanty ◯ Profuse ◯ Dribbling
◯ Cloudy ◯ Dark ◯ Pale

Wake to urinate more than once nightly? ◯ Yes ◯ No

Bowel Movements: Frequency When?

Feels Complete? ◯ Yes ◯ No

Consistency: ◯ Well-Formed ◯ Hard ◯ Loose ◯ Alternates

In Stools? ◯ Undigested Food ◯ Blood ◯ Mucus

How thirsty are you? ◯ High ◯ Average ◯ Low

Do you crave warm or cold drinks?

Do you find that you "run" particularly hot or cold?

How is your energy in general?

Do you often get headaches or migraines? ◯ Yes ◯ No

How do you feel emotionally right now?

Skin: ◯ Eczema ◯ Dry ◯ Sensitive Skin
◯ Acne ◯ Oily
◯ Psoriasis ◯ Combination

Other skin issues: _____

Women Only:

No. of pregnancies: No. of children Age of first period

Infertility ◯ Yes ◯ No ◯ Maybe On the Pill? ◯ Yes ◯ No Abortions? ◯ Yes ◯ No

Have you experienced menopause? ◯ Yes ◯ No When?

If you are experiencing menopausal symptoms, please describe

Date of last menstrual period? Are you pregnant now? ◯ Yes ◯ No

Is your period regular? ◯ Yes ◯ No Number of days from one period to next

Flow is: ◯ Light ◯ Normal ◯ Heavy

Color is: ◯ Pale Red ◯ Dark Red ◯ Red ◯ Brown ◯ Purple

Blood Clots? ◯ Yes ◯ No How big/color?

Do you get pain or cramps? ◯ Yes ◯ No Severe? ◯ Yes ◯ No

Do you experience any of the following before or during your period each month?

◯ Water retention ◯ Breast Tenderness or swelling ◯ Emotional Upset
◯ Irritability ◯ Food Cravings ◯ Migraines
◯ Other _____

Do you ever bleed between periods? ◯ Yes ◯ No

Do you have any unusual vaginal discharge? ◯ Yes ◯ No

Have you ever had any of the following:

◯ Abdominal Surgery ◯ LEEP Procedure ◯ Fibroids ◯ Polyps

◯ Endometriosis ◯ Chlamydia ◯ Ectopic Pregnancy ◯ IUD

Do you know your FSH level? _____

Have you recently had your estrogen/progesterone levels taken? If so, what are they?

Please describe any reproductive procedures you have been through or are going through currently that you have not listed above. Please include procedures that involve both sexes:

I am committed to your health and well-being. While Chinese Medicine is a very thorough health care system, it is not a replacement for western treatment including regular checkups with your primary care physician and OBGYN. New York State law requires me to recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

We, the undersigned, do affirm that _____(print patient name), has been advised by Susan Wallmeyer, L.Ac. to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

Patient Signature **Date**

Print Practitioner Name

Practitioner Signature

I consent to acupuncture treatments and other procedures associated with Traditional Oriental Medicine, and I have discussed the nature of my treatment with Susan Wallmeyer, L.Ac.

I understand that methods of treatment may include but are not limited to: Acupuncture, moxibustion, cupping, gua sha, electrical stimulation, tui na (Chinese massage), Chinese herbal medicine, other supplements.

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 the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and guasha. Unusual risks of acupuncture include pneumothorax and organ puncture. Slight superficial burns are a possible side effect of moxibustion.

I acknowledge that if I don't give 24 hours' notice for cancellation of an appointment, I will automatically be charged a $75 fee for the missed appointment.

Patient Signature

Date