**The Rockledge Building**
**1600 Harrison Ave., Suite 203, Mamaroneck, NY 10543** **914-364-8897**

*The information listed below is **CONFIDENTIAL** and helps us determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. **Please PRINT all information.***

## Personal Information

Name: _____ Today's Date: _____
(first) (middle) (last)

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail: _____

Date of Birth_____/_____/_____ Age _____

If under 18, person responsible for your account_____

Gender: Male _____ Female _____ Occupation: _____

Relationship Status: Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

**Emergency Contact:**

Name_____ Contact Phone:_____

Relationship _____

Primary Physician: _____ Contact Phone: _____

Gynecologist / Obstetrician: _____ Contact Phone: _____

Date of last Physical Exam: _____

Have you traveled outside the United States during the past 12 months? Yes: _____ No: _____

If yes, please indicate which country or region traveled: _____

Whom should we thank for referring you to our office? _____

Have you had acupuncture therapy before? □ Yes □ No Date: _____ With Whom: _____

For what condition were you treated? _____

Results: _____

## Chief Complaint

What health concerns / conditions are you seeking treatment for today? _____

_____

_____

How long have you had this condition? _____

What caused condition? (accident, lifestyle, congenital, drug, etc.): _____

What other forms of treatment have you sought? _____

Are you currently under the care of a medical professional for this condition? _____

Have you been giving a medical diagnosis for this condition? Please indicate; _____

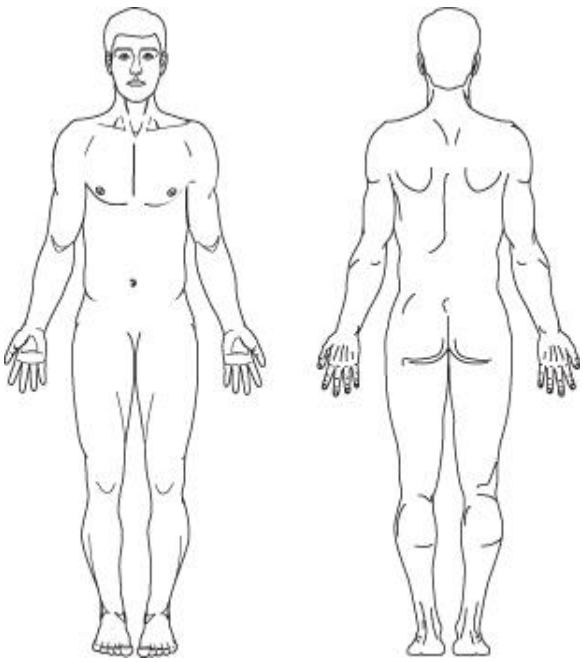
What helps your condition? (i.e. warmth, cold, pressure, activity, rest, etc.)

_____

What aggravates your condition? (i.e. warmth, cold, pressure, activity, rest, etc.)

_____

**PAIN PATIENTS**, please indicate on the figures below the areas of the body where you experience your pain:



How would you characterize your pain: □ dull/achy □ sharp/stabbing □ burning □ tingling □ numbness □ electrical

□ fixed □ moving / radiating

What would you like to achieve with acupuncture treatment? _____

_____

## Health History

**Please indicate if any of the following pertain to you: (marking "yes" does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):**

□ Hepatitis □ HIV □ High Blood Pressure □ Seizures □ Pacemaker □ Blood-Thinning Meds □ Pregnancy

□ Infectious Disease (please list) _____

**Height** _____ **Weight** _____ **Blood Pressure** ____/_____ when was this reading taken? _____

**CHILDHOOD ILLNESS**: □ Chicken Pox □ Measles □ Rubella □ Diptheria □ Rheumatic Fever □ Pertussis □ Scarlet Fever

**IMMUNIZATIONS:** □ Smallpox □ Polio □ Diptheria □ Pertussis □ Tetanus □ Rubella □ Hepatitis B □ Other _____

**FAMILY HISTORY:**

| | **Self** | **Father** | **Mother** | **Siblings** | **Grandparents** |
|---|---|---|---|---|---|
| Age (if living) | _____ | _____ | _____ | _____ | _____ |
| Health (G=Good, P=Poor) | _____ | _____ | _____ | _____ | _____ |
| **Check those applicable:** | | | | | |
| AIDS / HIV | _____ | _____ | _____ | _____ | _____ |
| Alcoholism | _____ | _____ | _____ | _____ | _____ |
| Anemia | _____ | _____ | _____ | _____ | _____ |
| Anxiety | _____ | _____ | _____ | _____ | _____ |
| Arteriosclerosis | _____ | _____ | _____ | _____ | _____ |
| Arthritis (Osteo / RA) | _____ | _____ | _____ | _____ | _____ |
| Asthma / Allergies | _____ | _____ | _____ | _____ | _____ |
| Cancer | _____ | _____ | _____ | _____ | _____ |
| Colitis | _____ | _____ | _____ | _____ | _____ |
| Depression | _____ | _____ | _____ | _____ | _____ |
| Diabetes | _____ | _____ | _____ | _____ | _____ |
| Epilepsy | _____ | _____ | _____ | _____ | _____ |
| Endocrine Disorders | _____ | _____ | _____ | _____ | _____ |
| Fibromyalgia | _____ | _____ | _____ | _____ | _____ |
| Gall Bladder Disease | _____ | _____ | _____ | _____ | _____ |
| Goiter | _____ | _____ | _____ | _____ | _____ |
| Gout | _____ | _____ | _____ | _____ | _____ |
| Headaches / Migraines | _____ | _____ | _____ | _____ | _____ |
| Heart Disease | _____ | _____ | _____ | _____ | _____ |
| Hepatitis | _____ | _____ | _____ | _____ | _____ |
| High Blood Pressure | _____ | _____ | _____ | _____ | _____ |
| High Cholesterol | _____ | _____ | _____ | _____ | _____ |
| Immune Disorders | _____ | _____ | _____ | _____ | _____ |
| Kidney Disease | _____ | _____ | _____ | _____ | _____ |
| Mental Illness | _____ | _____ | _____ | _____ | _____ |
| Multiple Sclerosis | _____ | _____ | _____ | _____ | _____ |
| Stroke | _____ | _____ | _____ | _____ | _____ |
| Suicide | _____ | _____ | _____ | _____ | _____ |
| Thyroid Disease | _____ | _____ | _____ | _____ | _____ |
| Other Conditions: | _____ | _____ | _____ | _____ | _____ |

## Health History

**Please list any prescription, over-the-counter medications or nutritional supplements you are presently taking, even if only occasionally. Remember to list inhalers, eye drops, nose sprays and food supplements if applicable:**
**(if you need more space, use the back of this page)**

| **Prescription Drugs / Dosage / Frequency** | **For What Purpose / Condition** |
|---|---|
| | |
| | |
| | |
| | |
| | |

| **Vitamins / Supplements / Dosage / Frequency** | **For What Purpose / Condition** |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Hospitalizations and Surgeries:**

| Reason | When | Reason | When |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

| Reason | When | Reason | When |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Systems Review

**Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings  Nervousness  Mental Tension

**Energy and Immunity** (please circle any that you experience now and underline any you have experienced in the past):

Fatigue  Slow Wound Healing  Chronic Infections  Chronic Fatigue Syndrome

## Systems Review (continued)

**Head, Eye, Ear, Nose, & Throat** (please circle any you experience now and underline any you have experienced in the past):

| | | | | |
|---|---|---|---|---|
| Impaired Vision | Eye Pain/Strain | Glaucoma | Glasses/Contacts | Tearing/Dryness |
| Impaired Hearing | Ear Ringing | Earaches | Headaches | Sinus Problems |
| Nose Bleeds | Frequent Sore Throats | Teeth Grinding | TMJ/Jaw Problems | Hay Fever |

**Respiratory** (please circle any you experience now and underline any you have experienced in the past):

| | | | |
|---|---|---|---|
| Pneumonia | Frequent Common Colds | Difficulty Breathing | Emphysema |
| Persistent Cough | Pleurisy | Asthma | Tuberculosis |
| Shortness of Breath | Other Respiratory Problems: _____ | | |

**Cardiovascular** (please circle any you experience now and underline any you have experienced in the past):

| | | | | |
|---|---|---|---|---|
| Heart Disease | Chest Pain | Swelling of Ankles | High Blood Pressure | |
| Palpitations/Fluttering | Stroke | Heart Murmurs | Rheumatic Fever | Varicose Veins |

**Gastrointestinal** (please circle any you experience now and underline any you have experienced in the past):

| | | | | | |
|---|---|---|---|---|---|
| Ulcers | Changes in Appetite | Nausea/Vomiting | Epigastric Pain | Passing Gas | Heartburn |
| Belching | Gall Bladder Disease | Liver Disease | Hepatitis B or C | Hemorrhoids | Abdominal Pain |

**Genito-Urinary Tract** (please circle any you experience now and underline any you have experienced in the past):

| | | | | |
|---|---|---|---|---|
| Kidney Disease | Painful Urination | Frequent UTI | Frequent Urination | Heavy Flow |
| Kidney Stones | Impaired Urination | Blood in Urine | Frequent Urination at Night | |

**Female Reproductive/Breasts** (please circle any you experience now and underline any you have experienced in the past):

| | | | |
|---|---|---|---|
| Irregular Cycles | Breast Lumps/Tenderness | Nipple Discharge | Heavy Flow |
| Vaginal Discharge | Premenstrual Problems | Clotting | Bleeding Between Cycles |
| Menopausal Symptoms | Difficulty Conceiving | Painful Periods | Low Libido |

**Male Reproductive** (please circle any you experience now and underline any you have experienced in the past):

| | | | |
|---|---|---|---|
| Prostate Problems | Testicular Pain/Swelling | Penile Discharge | Low Libido |

**Musculoskeletal** (please circle any you experience now and underline any you have experienced in the past):

| | | | | |
|---|---|---|---|---|
| Neck/Shoulder Pain | Muscle Spasms/Cramps | Arm Pain | Upper Back Pain | Mid Back Pain |
| Low Back Pain | Leg Pain | Joint Pain (if so, where?): _____ | | |

## Systems Review (continued)

**Neurologic** (please circle any you experience now and underline any you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

**Endocrine** (please circle any you experience now and underline any you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

**Other** (please circle any you experience now and underline any you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

## Lifestyle

Do you typically eat at least three meals per day? Yes No If no, how many? _____

How many hours per night do you sleep? _____ Do you wake rested? Yes No

How much water do you drink per day? _____

Do you drink caffeinated beverages? Yes No If yes, how many per day? _____

Do you drink alcoholic beverages? Yes No If yes, how many per week? _____

Are you a vegetarian? Yes Yes, not strict No

Do you exercise regularly? Yes No

Please describe your exercise program: _____

Do you have a spiritual practice, or participate in a spiritual community? Yes No

Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y N Why/Why not? _____

Do you smoke? _____ What? _____ How much per day? _____ Since when? _____

Please describe any use of drugs for non-medical purposes: _____

Have you experienced any major traumas? Y N Explain: _____

_____

Level of education completed: High School Bachelors Masters Doctorate Other

Television habits: _____ Reading habits: _____

Interests and hobbies: _____

## Symptom Survey

**Please rate the severity of symptoms you experience <u>frequently</u> from 1-5 (5 being the worst!)**
**LEAVE BLANK IF NOT APPLICABLE.**

___ Heaviness in the body
____Fatigue/Worse after eating
___ Hard to get up in morning
___ Edema (swelling)
___ Muscles Feel tired often
___ Easy bruising & bleeding
___ Bad Breath
___ Increased Appetite
___ Decreased Appetite
___ Crave Sweets
___ Hypoglycemia
___ Nausea / Vomiting
___ Gas / Belching / Burping
___ Insulin Sensitivity
___ Hemorrhoids
___ Constipation
___ Diarrhea
___ Abdominal pain
___ Indigestion
___ Heartburn / Reflux
___ Stomach Bloating
___ Over-Thinking / Worry
___ Obsession Thinking
___ Tendency to Gain Weight
___ Brain Foggy

___ Heart Palpitations
___ Chest Pain
___ Insomnia
___ Sleep Problems
___ Easily Startled
___ Restlessness / Agitation
___ Vivid Dreams
___ Nightmares
___ Lack of Joy in Life
___ Poor Memory
___ Laugh for no reason

___ Dry Cough
___ Cough with Sputum
___ Nasal Discharge
___ Post Nasal Drip
___ Sinus Infection
___ Sinus Congestion
___ Itchy, Red, Painful Throat
___ Dry Mouth/Throat/Nose
___ Skin Rashes/Hives
___ Snoring
___ Grief / Sadness
___ Shortness of Breath
___ Allergies / Asthma
___ Low Resistance to Colds
___ Sneezing
___ Mild Fever Comes & Goes
___ Smokes Cigarettes
___ Constipation
___ Colitis/Diverticulitis
___ Skin Problems
___ Claustrophobia

___ Urinary Problems
___ Bladder Infection
___ Lack of Bladder Control
___ Weakness/Pain Low Back
___ Decrease Bone Density
___ Feel Cold Easily
___ Low Sex Drive
___ Excess Sexual Desire
___ Poor Memory
___ Loss of Hair
___ Hearing Problems
___ Cavities
___ Crave/Avoid Salty Food
___ Fear
___ Hot Flush/Night Sweats
___ Ear Ringing
___ Hearing Impairment
___ Knee Problems
___ Kidney Stones

___ Irritability / Anger
___ Depression / Stress
___ Headaches / Migraines
___ Visual Problems
___ Red / Dry/ Itchy Eyes
___ Eye Problems
___ Gall Stones
___ Dizziness
___ Blurred Vision
___ Feeling of Lump in Throat
___ Clenching Teeth at Night
___ Muscle Cramping/Twitch
___ Tension
___ Joints/Neck/Shoulder Pain
___ Poor Circulation
___ Soft / Brittle Nails
___ Emotional Eater
___ Light colored Stool
___ Difficulty Making Decisions
___ Jaundice
___ Difficulty Digesting Oily

## ♀For Women

Age of first period _____ Date of last period _____ Number of children (live births) _____

Number of days between periods (your cycle) _____Number of days of flow_____

| **Color of flow:** | **Amount of flow:** | **# of pads you use per day:** | **Pain and cramping:** |
|---|---|---|---|
| □ pale/light red | □ spotting | 1st day ___ | □ No |
| □ red | □ light | 2ND day ___ | □ Yes |
| □ bright red | □ even throughout | 3RD day ___ | □ before flow □ mild |
| □ dark red | □ heavy | 4th day ___ | □ during flow □ moderate |
| □ dark red/brown □ clots | | +days ___ | □ after flow □ severe |

**Other symptoms related to menses:** □ Discharge □ PMS □ Headache □ Nausea

□ Constipation □ Diarrhea □ Swollen Breasts □ Mood Swings □ Increased Appetite

□ Decreased Appetite □ Insomnia **Type of Contraception used**: _____

**Have you ever been diagnosed with**: □ fibroids □ fibrocystic breasts □ endometriosis □ ovarian cysts □ PID

□ polycystic ovary syndrome □ STD _____

**Please indicate if the following pertain to you:**

□ Do you have lower back weakness, soreness or pain?
□ Do you have ringing in your ears?
□ Is your hair prematurely gray?
□ Do you have vaginal dryness?
□ Is your mid-cycle cervical mucus scanty or missing?
□ Do you have dark circles under your eyes?
□ Do you have night sweats?
□ Are you prone to hot flashes?
□ Would you describe yourself as “afraid” frequently?
□ Do you have dizziness?
□ Do you have knee problems?

□ Do you have low back pain pre-menstrually?
□ Is your back sore or weak?
□ Are your feet cold, especially at night?
□ Are you typically colder than those around you?
□ Is your libido low?
□ Are you often fearful?
□ Do you wake up at night or early in the morning because you have to urinate?
□ Do you urinate frequently, and is the urine diluted and/or profuse?
□ Do you have early morning loose, urgent stools?
□ Do you have profuse vaginal discharge?
□ Do you feel cold cramps during your period that respond to a heating pad?

- □ Are you often fatigued?
- □ Do you have poor appetite?
- □ Is your energy low after a meal?
- □ Do you feel bloated after eating?
- □ Do you crave sweets?
- □ Do you have loose stools, abdominal pain, or digestive problems?
- □ Are your hands and feet cold?
- □ Are you prone to feeling sluggish?
- □ Are you prone to heaviness or grogginess in the head?
- □ Do you have varicose veins?
- □ Are you prone to worry?
- □ Have you been diagnosed with low blood pressure?
- □ Do you sweat a lot without exerting yourself?
- □ Do you feel dizzy or light-headed, or have visual changes when you stand up fast?
- □ Is your menstruation thin, watery, profuse, or pinkish in color?
- □ Are you more tired around ovulation or menstruation?
- □ Do you ever spot a few days or more before your period comes?
- □ Have you ever been diagnosed with uterine prolapse?
- □ Are your menstrual cramps accompanied by a bearing down sensation in your uterus?
- □ Are you often sick, or do you have allergies?
- □ Have you ever been diagnosed with hypothyroid or anemia?
- □ Do you have hemorrhoids or polyps?

- □ Are your menses scant or late?
- □ Do you have dry, flaky skin?
- □ Are you prone to getting chapped lips?
- □ Are your fingernails or toenails brittle?
- □ Are you losing hair on your head?
- □ Is your hair brittle or dry?
- □ Do you have diminished nighttime vision?
- □ Do you get dizzy or light-headed around your period?
- □ Are your lips, the inner side of your lower eyelids, or tongue pale in color?

- □ Is your menstrual flow ever brown or black in color?
- □ Do you feel mid-cycle pain around your ovaries?
- □ Do you have painful, unmovable breast lumps?
- □ Do you experience periodic numbness of your hands and feet, especially at night?
- □ Do you have varicose or spider veins?
- □ Do you have red cherry spots (hemangiomas) on your skin?
- □ Do you have chronic hemorrhoids?
- □ Does your menstrual blood contain clots?
- □ Have you been diagnosed with endometriosis or uterine fibroids?
- □ Do you have piercing or stabbing menstrual cramps?
- □ Do you have dark spots in your eyes?
- □ Have you been diagnosed with any vascular abnormality or blood clotting disorder?

□ Are you prone to emotional depression?
□ Are you prone to anger and/or rage?
□ Do you become irritable pre-menstrually?
□ Do you feel bloated or irritable around ovulation?
□ Does it feel as if your ovulation lasts longer than it should?
□ Are your breasts sensitive/sore at ovulation?
□ Do you experience nipple pain or discharge from your nipples?
□ Do you have a lot of pre-menstrual breast distension or pain?
□ Do you become bloated pre-menstrually?
□ Are your pupils usually dilated and large?
□ Do you have difficulty falling asleep at night?
□ Do you experience heartburn or wake up with a bitter taste in your mouth
□ Are your menses painful?
□ Do you feel your menstrual cramps in the external genital area?
□ Is your menstrual blood thick and dark, or purplish in color?

□ Do you wake up early in the morning and have trouble getting back to sleep?
□ Do you have heart palpitations, especially when anxious?
□ Do you have nightmares?
□ Do you seem low in spirit or lacking vitality?
□ Are you prone to agitation or extreme restlessness?
□ Do you fidget?
□ Do you sweat excessively, especially on your chest?

□ Are your mouth and throat usually dry?
□ Are you often thirsty for cold drinks?
□ Do you often feel warmer than those around you?
□ Do you wake up sweating or have hot flashes?
□ Do you breakout with red acne, especially pre-menstrually?
□ Do you have a short menstrual cycle?
□ Do you have vaginal irritation?

□ Do you feel tired and sluggish after a meal?
□ Do you have fibrocytic breasts?
□ Do you have cystic or pustular acne?
□ Do you have urgent, bright, or foul-smelling stools?
□ Does your menstrual blood contain stringy tissue or mucus?
□ Are you prone to yeast infections and vaginal itching?
□ Are you overweight?
□ Do you have a wet, slimy tongue?
□ Does your body feel like a barometer? Can you sense when it will rain?

**Fertility Information**

# of IVF procedures_____ # of IUI procedures_____

Has a physician diagnosed a difficulty with fertility due to: □ Female Factor □ Male Factor □ Unexplained

□ Other _____

## Conclusion

Are you interested in additional health services besides acupuncture? □ No □ Yes

Please check which services you would be interested in: □ Chinese herbal medicine □ Therapeutic massage

□ Tai chi □ Qi gong health exercises □ Relaxation techniques □ Nutritional consultation

## Patient Advisory to Consult a Physician

Touchstone Acupuncture and Kathy Casey, L.Ac., Dipl. OM., are committed to your health and well-being. While we believe that Traditional Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any conditions for which you are seeking acupuncture treatment.

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 undersigned, do affirm that _____**
**PRINT PATIENT NAME**

**has been advised by _____ to consult a physician**
**LICENSED ACUPUNCTURIST**

**regarding the condition or conditions for which such patient seeks acupuncture treatment.**

_____ _____
**Patient / Patient Representative Signature** **Date**

## NOTICE OF PRIVACY PRACTICES

This Notice together with our Practices Regarding Disclosure of Health Information, describe how health information about you may be used and disclosed. They also describe how you can gain access to your health information. **PLEASE REVIEW THIS INFORMATION CAREFULLY**.

**Understanding Your Health Record:**
A record is made each time you visit our office for treatment. This record includes symptoms, clinician observations, diagnosis and treatment. The record may also contain other pertinent information provided yb you or another of your health care practitioners with whom we may have spoken.

**Your Health Information Rights:**
Your health record is owned by Touchstone Acupuncture, however, the content is always available to you for your review. You have the right to request a review of your file and to obtain copies of documents contained in your file. You also have the right to request that amendments be made to your record. In addition, you may request that the use of your information be restricted from certain uses and disclosures and to request a list of individuals or entities to whom your information has been disclosed. You may revoke any authorizations you have given regarding disclosure of your health information at any time. This revocation must be provided to us, in writing.

**Our Responsibilities:**
We are required to maintain the privacy of your health information and to provide you with a copy of this notice of our privacy practices. We will follow the terms of this notice and advise you if we are unable to comply with a request you may make regarding the use of your health information. We reserve the right to amend our privacy policies and we use our best efforts to notify you of any such amendments. Other than for reasons stated in this notice, we will not use or disclose your health information without your consent.

I, _____, have received a copy of this notice of
Patient /Guardian Name

Privacy Practices and a copy of the Practices Regarding Disclosure of Patient Health Information. I understand my health information will be used and disclosed consistent with these notices.

Patient name:_____ (please print)

Patient / Guardian signature:_____

Date:_____