touchstone
ACUPUNCTURE

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; _____

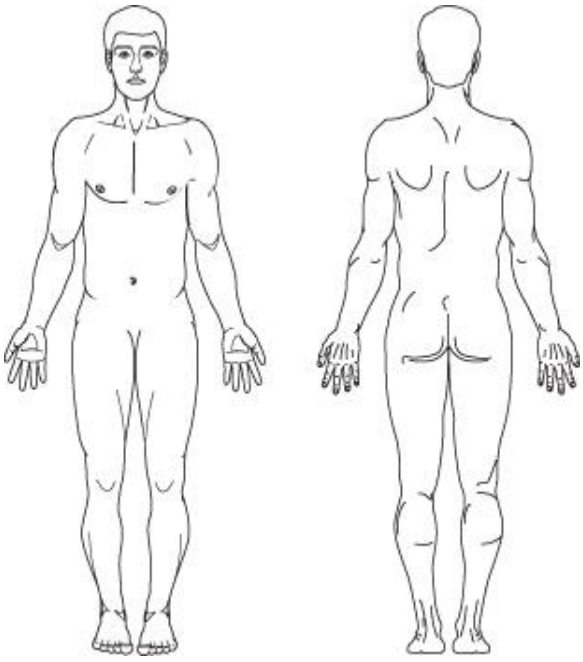
What helps your condition? (i.e. warmth, cold, pressure, activity, rest, etc.)

_____

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

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:_____