Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____(C, H, W)

Email: _____

Gender: _____ Partner Status: _____ Ethnicity: _____

Date of Birth: _____ Age: _____

Employment: _____

In Case of Emergency, Contact _____ Phone _____

How did you hear about this practice? Personal referral: _____

Google Yelp Acufinder Yahoo Citysearch NCCAOM Other:_____

Family & Personal History:

(Please check if yes) M (Mother), F (Father), S (Sibling), (G) Grandparent, (O) Other

	M	F	S	G	O
Allergies (Environmental)	☐	☐	☐	☐	☐
Clotting Disorder	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐
Kidney/UB Disorder	☐	☐	☐	☐	☐
Neurological Disorder	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Stomach/Intestinal Disease	☐	☐	☐	☐	☐
Drug/Alcohol Addiction	☐	☐	☐	☐	☐

Please check if *YOU* have had any of the following:

Allergies (Environmental)	☐
Clotting Disorder	☐
Cancer	☐
Diabetes	☐
Tuberculosis	☐
Hepatitis/HIV	☐
Seizures	☐
High Blood Pressure	☐
High Cholesterol	☐
Thyroid Disorder	☐
Kidney/UB Disorder	☐
Neurological Disorder	☐
Heart Disease	☐
Stomach/Intestinal Disease	☐
Drug/Alcohol Addiction	☐

List any hospitalization(s) & date(s): _____

Please list your **weight:** _____ lbs and **height**: _____ ft____in Date of last physical exam:_____

Name of Physician:_____Phone/Address: _____

Women Only: ***(Please check box if yes)***

Are you pregnant or considering a pregnancy sometime in the future? ☐

Are you breast-feeding? ☐ Do you have pain associated with menstruation? ☐

Have you been diagnosed with fibroids, ovarian cysts or endometriosis? ☐

Number of Pregnancies:_____ Deliveries:_____ Miscarriages:_____ Children's ages:_____

Reason for seeking treatment today: _____

Social History:

Tobacco Use History ☐ Never smoked or used tobacco ☐ Former smoker but quit on _____(approx. date)

Current Smoker → Started _____(approx. date) Amount of cigarettes: _____ per day
Use tobacco in other forms → _____ Amount: _____per day

Alcohol Use History Did you have a drink containing alcohol in the past year? ☐ NO ☐ YES

If Yes: How often? ☐ monthly or less ____ drinks per month ____ drinks per week ____ drinks per day
How often >6 drinks on one occasion in past year? ☐Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐Daily

Recreational Drug Use ☐ Never use recreational drugs ☐ Occasionally use recreational drugs

How often have you used recreational drugs in the past year? ☐Never ☐ Monthly ☐ Weekly ☐Daily

Allergies and Your Allergic Response: ☐ *No Known Allergies*

_____☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:_____
_____☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:_____
_____☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:_____

Current Medications: *Include prescription drugs, Over the Counter drugs, Vitamins, Minerals, Herbs, Dietary (nutritional) supplements* ☐ None

#	Medication Name & Condition Treated	Dose	Frequency	Route
1				☐Oral ☐ Suppository ☐ Injection ☐ IV
2				☐Oral ☐ Suppository ☐ Injection ☐ IV
3				☐Oral ☐ Suppository ☐ Injection ☐ IV
4				☐Oral ☐ Suppository ☐ Injection ☐ IV
5				☐Oral ☐ Suppository ☐ Injection ☐ IV
6				☐Oral ☐ Suppository ☐ Injection ☐ IV
7				☐Oral ☐ Suppository ☐ Injection ☐ IV
8				☐Oral ☐ Suppository ☐ Injection ☐ IV

Provider reviewed with patient:_____ Date: _____

To comply with Article 160, Section 8211.1 (b) of NYS Education Law, we request that you read and sign the following statement:

I/We, the undersigned, do affirm that (patient) _____ has been advised by (L.Ac.) _____ to consult with a physician regarding the condition(s) for which the above named patient seeks acupuncture/herbal medicine treatment.

Patient Signature:_____ Date: _____

Minor under the age of 18 or otherwise lacks capacity to sign:

Name of Parent/Legal Guardian:_____ Relationship to Patient: _____

Signature of Parent/Legal Guardian: _____ Date:_____