New Patient Intake

This is a confidential questionnaire that will help us to determine the optimal treatment plan specific to your needs. If you have any questions or concerns, please do not hesitate to ask us. Thank you.

New York Sports Acupuncture

Patient Name **Date**

General Information

Address City State

Home Phone Occupation Zip

Work Phone Mobile Phone SS# Date of Birth

Email Address

We value your privacy and from time to time we send out email, text and mail communication updates, some may be very important and timely, would you like to receive:

Emails ☐ Yes ☐ No
Texts ☐ Yes ☐ No
Mail ☐ Yes ☐ No

Emergency Contact Relationship Phone

Have you had Acupuncture or Oriental medicine before? ☐ Yes ☐ No

Family Physician Phone

What was your experience? ☐ Very good ☐ Good ☐ No change

☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Single

Are you presently under a doctor's care? ☐ Yes ☐ No Who and what for?

Are there any other therapies which you are involved in? ☐ Yes ☐ No Who and what for?

Insurance Information

Insurance Company Phone Date Called

ID # Co-Pay $ Covered %

Visit # Deductible Amount

Contact Name

Referral ☐ Yes ☐ No

Focus

What is the primary reason for seeking care at our office?

What was the initial cause?

When did it begin?

What makes it worse?

What makes it better?

How does this problem interfere with your daily activities?

☐ Work ☐ Standing ☐ Sexually ☐ Other
☐ Sleep ☐ Emotional ☐ Recreation
☐ Walking ☐ Relationships ☐ Bending
☐ Sitting ☐ Social Life ☐ Stretching

What have you done about this?

Are you interested in:

☐ Pain Relief ☐ Holistic Health ☐ Stress Relief ☐ Other
☐ Preventative Care ☐ Stretching/Yoga ☐ Herbal Therapy
☐ Oriental Nutrition ☐ Maintenance Care

What are your health goals?

List any past or future surgeries:

List any significant trauma & when it occurred
(e.g. auto accident, falls, emotional, sexual, etc.):

List exercise and sport activities you
have been or are currently involved in:

If not, why?_____

(We will ask for insurance card to call and check on Acupuncture coverage)

Diet- Typical foods eaten

Breakfast:

Lunch:

Dinner:

Snack:

Dinner:

HISTORY
Birth to Puberty

1. Did your mother experience any emotional or physical trauma during her pregnancy with you?

2. Were there any complications in her pregnancy with you? For example, did she have preeclampsia, i.e. high blood pressure? Was she placed on bed-rest at any point during the pregnancy? Was she diagnosed with any Western medical conditions during her pregnancy?

3. Were there any difficulties in delivery? Cord wrapped around your neck? Blue baby? Premature delivery?

4. Were you breast fed or formula fed and for what period of time... One month, six months, two years etc.?

5. Were you colicky as a baby? For example, did you cry frequently or have difficulty sleeping?

6. Did you experience any physical or emotional traumas up until the age of six years old? You may or may not remember these situations, but they can still affect your health irregardless.

7. Were there any recurring infections up until the age of six? For example did you get recurring strep infections or ear infections etc.?

8. Also, then from age 6 to age 12, do you or your mom remember any particular emotional or physical traumas?

9. Any broken bones? Or hospitalizations? Any recurring infections?

10. WOMEN ONLY: How old were you when you started your menstrual cycle and were there any symptoms? For example, heavy bleeding, clots, headaches, cramps, etc.?

11. For your first three or four years of menstrual cycle what were your typical symptoms? Also, what were the worst symptoms you experienced around your menstrual cycle? For example, did you experience cramps, clots, headaches or migraines, PMS?

New York Sports Acupuncture

CASE REVIEW QUESTIONNAIRE

Please use blue or black pen

Name:_____

Date:_____

	Onset	Major Complaint(s): list in order of significance to you:	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
1								
2								
3								
4								
5								

For the list below please place an mark in the grey column to the left for all the symptoms that apply to you:

Please indicate the specific frequency of each symptom in terms of how many times per day (D), week (W), month (M), or year (Y)

Note: organs in parenthesis are the Chinese medical system/channel which includes the organ as well as associated tissues.

		Overall Temperature (Kidney function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
6		Cold Hands						
7		Cold Feet						
8		Heat in hands						
9		Heat in feet						
10		Heat in chest						
11		Afternoon flushes						
12		Night sweats						
13		Take water to bed						
14		Hot flashes any time of the day…. Average times per day _____						
15		Sweaty feet						
16		Sweaty hands						
17		Thirsty						
18		Perspire easily						
19		Lack of perspiration						
20		Hot body temperature (sensation)						
21		Cold body temperature (sensation)						

		Overall Energy (Lung, Kidney Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
22		Shortness of breath						
23		Difficulty keeping eyes open in the daytime						
24		General weakness						
25		Easily catch colds						
26		Low energy						
27		Feel worse after exercise						

		Overall Blood (Liver, Spleen, Heart Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
29		See floating black spots						
30		Birth marks? If yes: how many:_____ and the location (s):_____						
31		Pale lips or gums						
32		Dry or brittle hair						
33		Dry or brittle nails						
34		Dry scalp						

		(Heart Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
35		Palpitations						
36		Chest pain traveling to shoulder						
37		Anxiety						
38		Frequent dreams						
39		Sores on the tip of the tongue						
40		Restlessness						
41		Easily Startled						
42		Mental sluggishness						

		(Lung Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
43		Nasal Discharge (circle color: white - yellow - green)						
44		Sneezing						
45		Cough						
46		Nose Bleeds						
47		Sinus Congestion						
48		Headache (circle one: forehead - top of head - temple - base of skull)						
49		Overall achy feeling the body						
50		Sadness						
51		Alternating fever and chills						
52		Sore throat						
53		Difficulty breathing						
54		Dry mouth						
55		Dry throat						
56		Dry Nose						
57		Dry Skin						
58		Smoke cigarettes (# of cigarettes per day: _____)						
59		**Allergies:** To what? 1. _____ 2. _____						
		3._____ 4. _____						
60		**Allergies:** Runny Nose						
61		Itchy Eyes						
62		Fatigue						
63		Congestion						
64		Sneezing						
65		Seasonal? What Season(s)? _____						

		(Spleen Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
66		Low appetite						
67		Abrupt weight gain						
68		Abrupt weight loss						
69		Abdominal bloating						
70		Abdominal gas						
71		Gurgling noise in the stomach						
72		Easily bruised						
73		Hemorrhoids						
74		Worry						
75		Fatigue after eating						
76		Prolapsed organs (previously diagnosed which organ? _____)						
77		Circular Thoughts						
78		Athlete's foot						
79		Fungal infection						

		(Spleen, Stomach, Large Intestine, Small Intestine Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
80		Loose stools						
81		Constipated						
82		Incomplete stools						
83		Diarrhea						
84		Blood in stools						
85		Mucous in stools						
86		Mental confusion / fogginess						
87		Undigested food in stools						

		Dampness Trapped in the Body:	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
88		General sensation of heaviness in the body						
89		Swollen joints Location:						
90		Swollen feet						
91		Swollen hands						
92		Snoring						
93		Chest congestion						
94		Nausea						

		(Stomach Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
95		Burning sensation after eating						
96		Heartburn / acid regurgitation						
97		Belching						
98		Stomach pain						
99		Bad breath						
100		Mouth (canker) sores						
101		Bleeding, swollen or painful gums						
102		Vomiting						

		(Liver, Gall Bladder Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
103		Alternating diarrhea and constipation						
104		Chest pain						
105		Tight sensation in the chest						
106		Skin rashes						
107		Tingling sensation Location:_____						
108		Numbness Location:_____						
109		Muscle spasms/cramping Location:_____						
110		Muscle twitching Location:_____						
111		Bitter taste in the mouth						
112		Seizures						
113		Convulsions						
114		Neck tension						
115		Shoulder tension						
116		Limited Range-of-Motion, Neck						
117		Limited Range-of-Motion, Shoulder						
118		High-pitched ringing in the ears						
119		Gall stones (history or current)						
120		Anger easily						
121		Lump in the throat						
122		Frustration						
123		Sexually transmitted disease (Which? _____)						
124		Recreational drugs (Which? _____, How much per week? _____)						
125		Depression						
126		Difficulty falling asleep						
127		Wake in the night between 12-3am						
128		Skin Tags (small growths on the skin)						
129		Frequently unable to adapt to stress (What causes the stress? _____						

		Eyes (Liver Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
130		Itchy						
131		Bloodshot						
132		Hot						
133		Dry						
134		Watery						
135		Gritty						
136		Blurry vision						
137		Near-sighted						
138		Far-sighted						

		Sleep (Kidney, Bladder Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
139		Average number of hours of sleep per night?_____						
140		Wakes in middle of night (times? _____)						
141		Wake in middle of night sweaty						
142		Wakes in middle of night hot						
143		Wake unrefreshed						
144		Light sleeper / wakes easily						

		(Kidney, Urinary, Bladder Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
145		Frequent cavities						
146		Past/ Present Concussions If yes, how many?_____						
147		Easily broken bones						
148		Sore knees						
149		Weak knees						
150		Cold sensation in the knees						
151		Low back pain						
152		Excessive hair loss						
153		Low-pitched ringing in the ears						
154		Kidney stones						
155		Bladder infections						
156		Wake during the night to urinate						
157		Lack of bladder control						
158		Fear						
159		Memory problems						

		Urination (Kidney, Bladder Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
160		Dark yellow						
161		Clear						
162		Strong odor						
163		Reddish color						
164		Difficult						
165		Frequent						
166		Burning						
167		Discharge						
168		Cloudy						

		Libido (Kidney Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
169		High						
170		Low						

		Women Only: Menses	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
171		Irregular menstrual cycle						
172		Bleeding between periods						
173		vaginal discharge						
174		Number of children? _____						
175		Number of pregnancies? _____						
176		How many days to date has it been since your 1st day of bleeding with your last cycle?						
177		Average number of days of flow? _____						
178		Age of first menstruation? _____						
179		Are you currently pregnant? _____						

		Pre-menstrual symptoms (Liver Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
180		Nausea						
181		Food cravings						
182		Depression						
183		Vomiting						
184		Headaches						
185		Irritability						
186		Water retention						
187		Migraines						
188		Anxiety						
189		Breast swelling						
190		Breast tenderness						
191		Dull pain (where?_____)						
182		Sharp pain (where?_____)						
193		Other emotions (Which? _____)						

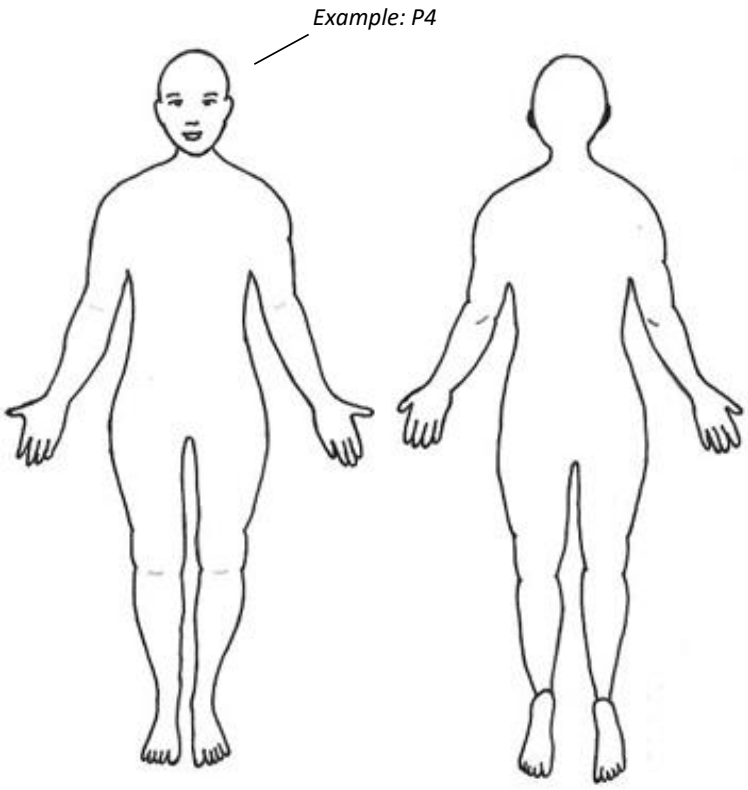
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Date Resolved (Office Use Only)
Color (normal, bright red, pale, brown, rust, dark, purple, other)								
Amount of flow (normal, heavy, light)								
Pain/cramps (location, dull, sharp, other)								
Clots (large, small, black, purple, red, other)								
Vomiting (check if yes)								
Nausea (check if yes)								

		Men Only:	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
194		Swollen testes						
195		Testicular pain						
196		Impotence						
197		Premature ejaculation						
198		Feeling of coldness or numbness in external genitalia						
199		Enlarged prostate						
Other :_____								

Indicate the area of pain/discomfort on the body image below by selecting the quality of the pain and the appropriate number.

(Example See Below: P4 indicating Pressure at a level 4 of pain)

Aching
Burning
Cramping
Dull
Fixed
Moving
Numbness
Pressure
Tingling
Sharp
Tight
Weak
Tremors



0	No pain or discomfort
2	Mild, annoying
4	Nagging, troublesome
6	Miserable, distressing
8	Intense, horrible
10	Worst, unbearable

Do the following reduce pain?

☐ Pressure ☐ Cold ☐ Heat ☐ Exercise ☐ Other_____

Do the following worsen pain?

☐ Pressure ☐ Cold ☐ Heat ☐ Exercise ☐ Other_____

Other comments :_____

_____

_____

_____

PATIENT SIGNATURE: _____ Date:_____

II. Patient Medical History

Hospital visits/stay:

Date	Reason	Outcome

Western Medical Diagnosis:

Current Medications:

Name of Medication	Dosage	Reason

Physician / Health Care Providers:

Type	Name	Phone #
Primary Physician:		
Cardiologist:		
Oncologist:		
Chiropractor:		
Naturopath:		
Physical Therapist:		
Other:		

FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge

Check Family Members that Apply	Father	Mother	Aunt(s)	Uncle(s)	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still living)											
Age at death (if deceased)											
Heart Attack											
Stroke											
Uterine Cancer											
Colon Cancer											
Breast Cancer											
Ovarian Cancer											
Prostate Cancer											
Cancer Other:_____											
Skin Cancer											
ADD/ADHD											
ALS or other Motor Neuron Diseases											
Alzheimer's											
Anemia											
Anxiety											
Arthritis											
Asthma											
Autism											
Autoimmune Diseases (such as Lupus)											
Bipolar Disease											
Bladder disease											
Blood clotting problems											
Celiac disease											

	Father	Mother	Aunt(s)	Uncle(s)	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Dementia											
Depression											
Diabetes											
Eczema											
Emphysema											
Environmental Sensitivities											

Epilepsy											
Flu											
Genetic Disorders											
Glaucoma											
Headache											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)											
Inflammatory Bowel Disease											
Insomnia											
Irritable Bowel Syndrome											
Kidney disease											
Multiple Sclerosis											
Nervous breakdown											
Obesity											
Osteoporosis											

	Father	Mother	Aunt(s)	Uncle(s)	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Other											
Parkinson's											
Pneumonia/Bronchitis											
Psoriasis											
Psychiatric disorders											
Schizophrenia											
Sleep Apnea											
Smoking addiction											
Stroke											
Substance abuse (such as alcoholism)											
Ulcers											