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Confidential New Patient Intake Form

Please complete this document as thoroughly as possible. All information is confidential.

Patient Information

Name:____ Date:______________

Date of Birth:_________ Age:________ Height:_______ Weight:_______ ☐M ☐F Marital Status:________________

Occupation:______________________ Employer: ______________Years:__________

Contact Information

Street Address:________________________City:__________ State: ________ Zipcode: _________

Home Phone: ( )________________ Cell:( )______________ Work: ( )______________ Email:________________

Emergency Contact Name:____________________ Phone:__________ Relationship:__________

Name of Primary Care Physician: ______________Phone:__________ Last Time Seen:__________

How did you hear about us? ____

Have you ever received acupuncture or herbal therapy before? Yes No

For what conditions?______________ With Whom?______________ Did you have a positive experience?_________

Health History

Are you Currently Pregnant? ___________ Are you presently trying to become pregnant?____________

Check ✓the box if any of the following are true:

☐ I have a pacemaker
☐I am taking Coumadin/Warfarin or similar medication
☐I have known allergies
☐I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)
☐Lymph nodes removed If so, where?__________ Can you have injections on that side?____________

Major Reason(s) for today's visit, **in order of importance to you:**	Severe	Moderate	Slight
1. ______________________________	☐	☐	☐
2. ______________________________	☐	☐	☐
3. ______________________________	☐	☐	☐
4. ______________________________	☐	☐	☐
5. ______________________________	☐	☐	☐

How long have you had this condition?______________ Have you had this condition before?______________

How did this condition occur? ____

____

What makes it better (heat, cold, activity, rest, food, etc)?

____

What makes it worse (heat, cold, activity, rest, stress, particular foods, etc)?

____

How do these conditions impair your daily activities? ______________________________

____

Treatments you have received for these conditions? ______________________________

Which treatments helped the most?______________________________

Have you seen an MD for these conditions? Y/N

If so, what diagnoses have you received, if any? ______________________________

List all practitioners involved in your care (including specialty)

Name	Specialty	Name	Specialty

Current & Past Medical History

Major Hospitalizations- Please list all hospitalizations for any serious illness or operation

Date	Illness/Operation

Trauma- Please describe any major traumas you have experienced

____

____

Medications/Supplements- Please list all medications, supplements, vitamins and herbs you use.

Name	Reason	Duration	Dose	Physician

Allergies & Sensitivities- Please list seasonal, environmental, food or drug allergies & sensitivities

____

____

Please Check ✔ if you have or have had any of the following medical conditions:

	You	Family Member (please specify)
AIDS/HIV		
Alcoholism		
Allergies		
Asthma		
Bipolar		
Schizophrenia		
Diabetes		
Epilepsy/Seizure Disorder		
Cancer (specify type)		
Hepatitis (specify type)		
Heart Disease		
High Blood Pressure		
Stroke		
Hemophilia		
Other Bleeding Disorder		
Multiple Sclerosis		
Immune Disorder		
Liver Disease		
Kidney Disease		
Lyme Disease		

	You	Family Member (please specify)
Hyperthyroid		
Hypothyroid		
Tuberculosis		
Other (specify)		

Occuptional Concerns

Please check ✓ if your work exposes you to any of the following:

☐Physical Stress ☐Emotional Stress ☐Heavy Lifting ☐Chemicals/Environmental Pollution

☐Other_______________________________________

What is your job satisfaction on a scale from 1-10 (1=least, 10=most)? __________________________

Health Habits

Lifestyle

Check or circle all that apply.

☐Cigarettes _____packs per day/week ☐Alcohol ______drink per day/week wine /beer /liquor

☐Recreational Drugs frequency__________

☐Soda _____cups per day ☐Artificial Sweeteners

☐Coffee or other caffeinated beverage _____cups per day

Exercise & Energy

What kind of exercise do you do?____

How often?______________________ Do you have more or less energy after exercising?_____________________________________

Do you fatigue easily?_______________________ Do you have more energy after eating?_______________________

What time of day is your energy highest?_________ Lowest?_______________

Do you feel weak or have lack of strength?________

Diet

Please check ✓all that apply and specify how long.

☐Vegetarian ☐Kosher ☐Low Carb ☐Other________________________

☐Vegan ☐Low Fat ☐Raw Food

How many meals do you eat per day? _______________________

Describe typical meals:

Breakfast____

Lunch____

Dinner____

Snacks____

Any food cravings? ____

Rate taste preferences from 1-5(1=like most, 5=like least) ____Sour ____Bitter ___Sweet ____Spicy ____Salty

Any Food intolerance?____

Are you always thirsty?_________ Never thirsty?_________ Thirsty with no desire to drink?______________

Do you prefer hot or cold drinks? __________________

Emotions & Sleep

How do you feel emotionally? ____

Do you have (check all that apply)? ☐depression ☐anxiety ☐panic attacks ☐irritable or short tempered

☐considered or attempted suicide ☐other_______

Are you currently in therapy?____________

Are you currently taking antidepressants or anti-anxiety medications ?___________

What is your stress level on a scale of 1-10 (1=lowest, 10=highest)?_________

Where in your body do you hold your stress?______________________________

How do you relax? ____

How many hours do you generally sleep per night? ______ Do you wake up feeling well rested? ______

Do you have: ☐trouble falling asleep ☐trouble staying asleep ☐dream disturbed sleep

☐night sweats ☐other_________________________

Do you take sleeping pills or anything to help you sleep?______ If so, what?_________________

Review of Systems

Please check ✓ all that apply.

General

___Prefer Cold Weather
___Prefer Hot Weather
___Sweat Easily
___Lack of Sweat
___ Body Heaviness
___Significant Weight Loss or Gain
___History of Dieting

Skin/Hair

___Dry Skin
___Moist Skin
___Eczema
___Hives
___Rashes
___Psorasis
___Warts
___Acne
___Itching
___Fungal Infection
___Change in Pigmentation
___Hair Loss/Balding
___Dry Hair
___Oily Hair
___Premature Graying
___Dandruff
___Brittle Nails
___Nail Ridges

Head/Eyes/Ears/Nose/Throat

___Dizziness
___Vertigo
___Foggy Headed
___Head Feels "Heavy"
___Headache
Type________
Location__________
___Migraine
___Poor Balance
___Dark Circles Around Eyes
___Eye Pain
___Glasses/Poor Vision
___Red Eyes
___Itchy Eyes
__Spots in Eyes
___Watery Eyes
___Cataracts
___Glaucoma
___Night Blindness
___Color Blindness
___Sensitivity to Light
___Poor Hearing
___Ear Pain
___Ear Discharge
___Ringing in Ears
___Sinus Pain
___Loss of Smell
___Excessive Phelgm
color____________
___Nosebleeds
___Sinus Problems/Congestion
___Frequent Runny Nose
___Dry Mouth
___Excessive Saliva
___Lump in Throat
___Frequent Sore Throat
___Sores on Tongue or Mouth (circle)
___Bleeding Gums
___TMJ or Grind Teeth
___Soft Teeth
___Cavities

Respiratory

___Tightness of Chest
___Coughing up Blood
____Pneumonia
____Difficulty Breathing While Lying Down
___Difficulty Inhaling
___Cough
-wet or dry
-color of phlegm_______
___Difficulty Exhaling
___Asthma
___Wheezing
___Bronchitis
___Emphysema
___Seasonal Allergies (when_____________)
___Shortness of Breath
___Frequent Colds
___Snoring

Cardiovascular/Hematology

___High Blood Pressure
___Low Blood Pressure
___Blood Clots
___Fainting

___Chest Pain
___Irregular Heartbeat
___ Palpitations
___ Bleed or Bruise Easily

___Poor Circulation
___Varicose Veins
___Raynauds
___Poor or Slow Healing

___Cold Hands/Feet
___Swollen Hands/Feet
___Edema
___Anemia

Gastrointestinal

___Nausea
___Vomiting
___Belching
___Acid Reflux
___Bad Breath
___Ulcers
___Laxative Use

___Bloating
___Flatulence
___Diarrhea
___Constipation
___Loose Stools
___Foul-Smelling Stool
Stool Frequency____________

___Poor Appetite
___ Heavy Appetite
___Mucus in Stool
___Undigested Food in Stool
____Stool are Difficult to Pass
___Black Stools
Stool Color____________

___Gall Stones
___Anal Pain
___Anal Itching
___Hemorrhoids

Genito-Urinary

___Frequent Urination
___Urgent Urination
___Pain on Urination
___Dribbling Urination

____Wake to Urinate
____Incontinence
____Blood in Urine
____Bedwetting

___Increased Libido
___Decreased Libido
___Kidney or Bladder Infections
___Kidney Stones

Men Only

___Impotence
___Premature Ejaculation
___Nocturnal Emission

___Enlarged Prostate
___Difficulty starting stream of urine
___Testicular Pain or Swelling

___Discharge from Penis
___Have had a PSA
Results of last PSA_______

Women Only

Age Menses Began______ Duration of Flow______ Length of Cycle______ Date of last Menses______ Quality of Blood______

___Irregular Menses
___Painful Menses
___Amenorrhea
___Menopause
age______________
___Taking Birth Control
___Ectopic Pregnancy

___Clots
___PMS
___Vaginal Discharge
color___________
___Vaginal Odor
___Pelvic Pain

___Breast Lumps
___Breast Pain/Swelling
___Endometriosis
___Uterine Fibroids
___Hysterectomy
___PCOS

___Nipple Discharge
___Abnormal PAP
___Hot Flashes
___Menopausal Bleeding
___Infertility

# of Pregnancies______ # of Miscarriages______ # of Abortions____ # of Births____ # of Premature Births______

Neuropsychological

___Poor Memory
___Tics
___Tremors
___ADD/ADHD

___Poor Concentration
___Concussion
___Lack of Coordination

Musculoskeletal

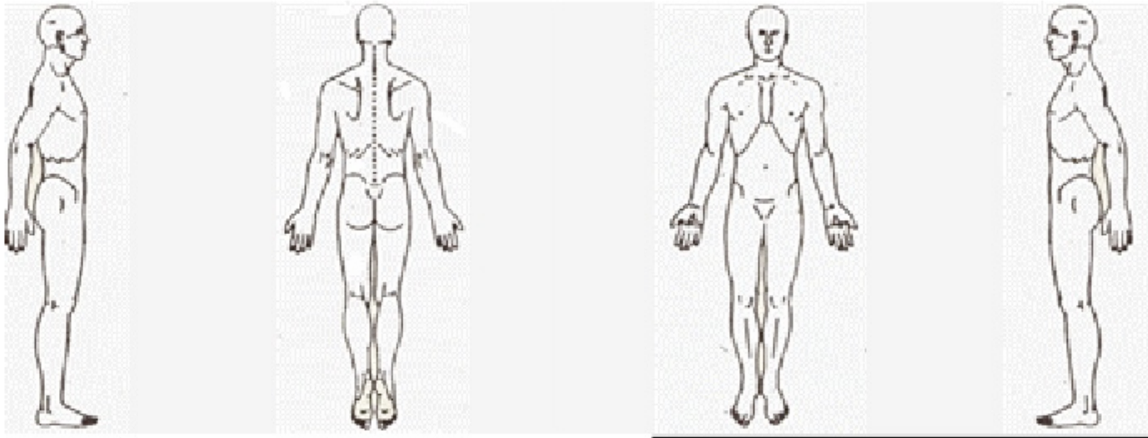
___Painful Bones
___Joint Pain
___Joint Swelling
___Morning Stiffness

___Osteoporosis
___Arthritis
___Sciatica
___Broken Bones

___Muscle Cramps/Spasms
___Muscle Tightness
___Muscle Weakness
___Tendinitis (where__________)

____Burning Pain
___Chronic Pain

Please mark areas of pain or distress on the diagram below with an X:



Location	Type of Pain					
___________________	Sharp	Fixed	Burning	Aching	Constant	Intermittent
___________________	Sharp	Fixed	Burning	Aching	Constant	Intermittent
___________________	Sharp	Fixed	Burning	Aching	Constant	Intermittent
___________________	Sharp	Fixed	Burning	Aching	Constant	Intermittent

What are your health goals?

____

____

Are there any other health issues you would like to discuss?

____

____

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Practice Policies

Fees: Payment for services is collected at the time services are rendered, unless other arrangements are made in advance. Payment may be made in cash, check or credit card.

Insurance: I do not bill insurance directly. However, if your insurance covers acupuncture, I can issue you a 'superbill,' which you can submit to your insurance company. The insurance company will then reimburse you directly if it is covered. It is the patient's responsibility to determine whether or not acupuncture is a covered service.

Since policies vary, I cannot guarantee that any services will be covered, but I will do my best to support you in getting reimbursement.

Missed Appointment and Cancellation: There is a 24hour cancellation policy. If you do not cancel at least 24 hours prior to your scheduled appointment, you will be billed for the full price for that visit. This is done as a courtesy to other people who are waiting to be scheduled. This fee will be waived for emergency situations only.

*****By signing below you indicate that you have read (or have been read) and understand the above financial policy and agree to the terms of the policy:**

Signature______________________________
Print Name____________________________
Date: ________________

Contact Authorization

I do/do not (circle one) give my permission for Elisa Hirsch-Cotter, M.S., L.Ac. to contact me by telephone regarding my appointments.

List preferred contact number:
1.______________________________________
OK to leave message on machine? _____YES _______NO
OK to leave message with another person answering telephone? _____YES _____no

I do/do not (circle one) give permission for Elisa Hirsch-Cotter, M.S., L.Ac to contact me by email for matters related to my care.

Patient Name____
Patient Signature:_____________________________________
Date: __________________

NYS Law to Seek Medical Services

By signing below, I acknowledge that I have been advised to seek medical services from an M.D. for the condition(s) for which I am seek treatment. I understand that under NYS law, the practitioner is required to advise me to consult a physician.

Signature______________________________
Print Name____________________________
Date: ________________