CNY COMMUNITY ACUPUNCTURE

Registration Information and Health Intake Form

Traditional Chinese Medicine is based on the principal of balancing an individual's body, mind, emotions and spirit. The following confidential questionnaire is a detailed and invaluable source of information about you. It provides the practitioner with a complete sense of you as a unique individual as opposed to a collection of symptoms.

At CNYCA we appreciate the diversity of human beings and do not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or gender identity, height, weight, nationality, language, level of education, level of income or HIV status. Our goal is to make this a safe, peaceful and healing place for all members of our community.

Patient Information

Name: _____

Address:_____

_____

Home#: _____ Cell#: _____Work#: _____

e-mail: _____

Preferred Contact Method: _____ email _____ home phone _____ cell phone

Date of Birth: _____ Sex: _____ Relationship Status: _____

Occupation: _____ Employer: _____

Referred by/How did you hear about us?: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Healthcare Information:

What do you wish to address with acupuncture? _____

_____

Date of Last Physical: _____ Last Blood Work: _____

List all Healthcare Practitioners whose care you are under: _____

_____

Medications/Drugs (Prescription and over the counter):

Name	Dosage	How Long?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Supplements:

Name	Dosage	How Long?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalizations/Surgeries/Accidents (give date and reason):

_____

_____

Family Information:
Spouse/Partner name:_____ Child name/age:_____

Child name/age: _____ Child name/age: _____

Family History	**Allergies**
Has anyone in your family suffered from any of the following? Disease — Relation □ Diabetes _____ □ High Blood Pressure _____ □ Stroke _____ □ Cancer (type) _____ _____ □ Heart Disease _____ □ Kidney Disease _____ □ Mental Illness _____	Medications: _____ Environmental (type, onset, what makes them better or worse): _____ _____ _____ _____ Foods (include age at onset): _____ _____ _____

Health History

Height: _____ Weight (now): _____ (1 year ago): _____ (max): _____

List types of exercises you do, including frequency and duration:

_____

_____

Do you follow any special diet? ___ Veg ___ Vegan ___ GF ___ LF ___ Kosher Other _____

List a typical day of meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks (what and when): _____

Food Cravings (what types of food do you crave and at what time of day?):

_____

Smoking	___ Y ___ N	How much in a day?			
Alcohol	___ Y ___ N	How much in a week?		Type?	
Coffee/Tea	___ Y ___ N	How much in a day?		Decaf or Reg?	

Major Sources of Stress:	1)
2)	3)

Energy Level:	**Sleep:**
Describe your energy level: _____ Do you have energy lows? What time? _____ Do you have energy highs? What time? _____ Do you experience low energy after meals? _____	Describe your sleep (# of hours/quality): _____ Check all of the following that apply to you: □ Insomnia □ Difficulty falling asleep □ Frequent waking □ Restlessness □ Vivid dreams □ Night sweats □ Too hot/cold □ Other _____

Digestion:		**Urination:**	
Daily bowel movement?	____ Y ____ N	Frequency?	____ Y ____ N
Loose Stools?	____ Y ____ N	Urgency?	____ Y ____ N
Constipation?	____ Y ____ N	Incontinence?	____ Y ____ N

Emotions:	
Would you say your emotions are most often: □ Even/balanced □ Erratic □ Other _____	Do you often feel: □ Angry □ Sad □ Frustrated □ Resentful □ Stressed □ Overwhelmed □ Worried □ Fearful □ Hopeless □ Anxiety □ Panic □ Depressed □ Irritable □ Weepy

Please check any of the following conditions that you have or have had in the past year:

□ Depression/Anxiety	□ Skin Disorders	□ Cancer	□ Diabetes
□ Heart Disease	□ High/Low BP	□ Hepatitis	□ Anemia
□ Seizures	□ Tuberculosis	□ STDs	□ Auto-Immune Dis.
□ Heart Attack	□ Paralysis	□ HIV/AIDS	□ High/Low thyroid
□ Arthritis	□ High Cholesterol	□ Stroke	□ Bleeding Disorder

Health History Continued…

Muscles/Joints/Bones:

- □ Tremors
- □ Cramping

Pain, weakness, numbness in:

- □ Arms or hands
- □ Back of legs
- □ Feet
- □ Neck
- □ Hips
- □ Shoulders
- □ Other _____

Eyes/Ears/Nose/Throat/Respiratory

- □ Asthma/wheezing
- □ Blurred or failing vision
- □ Difficulty breathing
- □ Earache
- □ Enlarged glands
- □ Eye pain
- □ Frequent colds
- □ Hay fever
- □ Hoarseness
- □ Gum trouble
- □ Nose bleeds
- □ Loss of hearing
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems
- □ Other _____

Skin

- □ Boils
- □ Bruise easily
- □ Dry skin
- □ Itching/rash
- □ Sensitive skin
- □ Sores that won't heal
- □ Sweating
- □ Other _____

Genito/Urinary

- □ Blood/pus in urine
- □ Discharge of pus or blood from penis
- □ Erection difficulties
- □ Frequent urination
- □ Inability to control urine
- □ Kidney infection/stones
- □ Low sperm count/motility
- □ Lowered libido
- □ Prostate issues
- □ Other _____

Cardiovascular

- □ Chest pain
- □ Hardening of arteries
- □ High or low blood pressure
- □ Pain over heart
- □ Poor circulation
- □ Previous heart attack
- □ Rapid/irregular heart beat
- □ Swelling of ankles
- □ Other _____

Gastrointestinal

- □ Belching, gas or bloating
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ Distention of abdomen
- □ Excessive hunger
- □ Gall bladder issues
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Pain over stomach
- □ Poor appetite
- □ Vomiting
- □ Other _____

Please fill in the following, if applicable:	
Are you or could you be pregnant?	Are you trying to become pregnant?
# of pregnancies:	# of births:
Date of last period:	Days in cycle:
# of days period lasts:	Are you on birth control?
Heavy, moderate or light flow?	Dark, bright or pale blood?
Are there clots?	PMS symptoms?
Are you undergoing fertility treatments? (If yes, are you in cycle and who is your RE) _____ _____	Have you ever been diagnosed with: □ PCOS □ Endometriosis □ Blocked fallopian tube □ Tilted uterus □ Other _____
Age of first period:	Age at menopause:
Have you had a: □ Hysterectomy, date: _____ □ Mastectomy, date: _____ □ Other _____	Symptoms associated with menopause: _____ _____
If you are or have been undergoing fertility therapies, please write a brief history below or attach a brief history to this packet: _____ _____ _____ _____ _____ _____	

By signing below, I certify that the information provided on this form is true and accurate to the best of my knowledge.
Signature: _____ Date: _____