# AG ACUPUNCTURE
## 1 Riverdale Avenue, #1 (2nd floor)
## Bronx, NY 10463

**Please take the time to fill out the forms carefully. Please note this is a confidential record of your medical history and will be kept in the office. Information contained here will not be released to any person except when you have authorized us to do so.*

Last Name First Name Today's Date

Address: City State Zip

Home Phone ( ) Work ( ) Cell ( )

Date of Birth Age Male [ ] Female [ ] Email address

Social Security Number Occupation Employer

Education (highest grade or degree achieved) May I add you to my newsletter mailing list? [ ] Yes [ ] No

Married [ ] Single [ ] Divorced [ ] Partner [ ] Name of Spouse

Height Weight

Emergency Contact Phone ( ) Relationship to Patient

Referred by

Have you ever had Acupuncture or Oriental Medicine before? If so, when?

**MAJOR COMPLAINTS** (*in order of importance, along with duration of the symptoms*)

1. Severe [ ] Moderate [ ] Slight [ ]
2. Severe [ ] Moderate [ ] Slight [ ]
3. Severe [ ] Moderate [ ] Slight [ ]

Have you been given a diagnosis for this condition? If so, what?

What kinds of treatment have you tried?

Are you currently receiving treatment for this? If so, please describe

Does anything improve your condition? Does anything aggravate your condition?

**MEDICAL HISTORY**
*(Please check all that apply)*

| Diagnosed | Date Diagnosed | | Date |
|---|---|---|---|
| High Blood Pressure [ ] | ____ /____ / ____ | Diabetes [ ] | ____ /____ / ____ |
| High Cholesterol [ ] | ____ /____ / ____ | Thyroid Disease [ ] | ____ /____ / ____ |
| Cancer [ ] | ____ /____ / ____ | Hepatitis [ ] | ____ /____ / ____ |
| HIV [ ] | ____ /____ / ____ | Seizures [ ] | ____ /____ / ____ |
| Heart Disease [ ] | ____ /____ / ____ | Rheumatic Fever [ ] | ____ /____ / ____ |
| Birth Trauma [ ] (prolonged labor, forceps delivery, etc) | ____ /____ / ____ | Others [ ] | ____ /____ / ____ |

Surgeries/Dates

Significant Traumas (auto-accidents, falls, etc)

Please circle if you have one of the following: pacemaker cardiac arrhythmia epilepsy fever hypotension overall weakness

**MEDICATIONS/SUPPLEMENTS** *(List medications you are currently taking, including prescription medicine, supplements, herbal supplements, and over-the-counter medicines you take on a regular basis, the dosage, duration, reason)*

**ALLERGIES** *(to medications, chemicals, foods, etc)*

**FAMILY MEDICAL HISTORY** *(please check all that apply)*

| Conditions | Mother | Father | Sibling | Grandparent |
|---|---|---|---|---|
| Heart disease | | | | |
| Cancer | | | | |
| Hypertension | | | | |
| Stroke | | | | |
| Asthma | | | | |
| Allergies | | | | |
| Migraines | | | | |
| Depression | | | | |
| Other mental illness | | | | |
| Substance abuse | | | | |
| Osteoporosis | | | | |
| Diabetes | | | | |
| Glaucoma | | | | |

**LIFESTYLE HISTORY**

Do you typically eat at least three meals a day? If no, how many?

Do you exercise? What type of exercise? How long / how many days per week?

How many hours per night do you sleep? Do you wake up during the night?

Do you go back to sleep w/o problem? Do you wake up rested?

How many hours per week do you work? Do you enjoy work? Why/Why not?

Nicotine / Alcohol / Caffeine use per day:

Do you use recreational drugs? Other drugs:

Interests / Hobbies

**NUTRITION**

Do you follow a special diet? If yes, how would you describe the diet? (vegetarian, vegan, low carbs, etc)

What do you eat on a ‘typical’ day?

Foods you tend to crave

Foods you dislike

Are you interested in discussing Chinese herbal medicine for your condition?
Because this requires specific discussion and research to determine a formula, there is a one time fee of 50$ per condition.
The cost of herbs is passed through directly to the patient and usually runs between $20 and $40.

**PLEASE CHECK ALL THAT APPLY*:***

**GENERAL**

| | | | |
|---|---|---|---|
| ☐ Poor appetite | ☐ Fevers | ☐ Localized weakness | ☐ Changes in appetite |
| ☐ Excessive appetite | ☐ Night sweats | ☐ Poor coordination | ☐ Strong thirst |
| ☐ Insomnia | ☐ Sweat easily | ☐ Bleed or bruise easily | ☐ Sudden energy drop |
| ☐ Fatigue | ☐ Chills | ☐ Catch cold easily | ☐ Poor balance |

**CARDIOVASCULAR**

| | | | |
|---|---|---|---|
| ☐ High blood pressure | ☐ Phlebitis | ☐ Fainting | ☐ Difficult breathing |
| ☐ Low blood pressure | ☐ Chest Pain | ☐ Palpitations | ☐ Swelling of hands and feet |
| ☐ Blood clots | ☐ Irregular heart beat | ☐ Cold hands/feet | ☐ Dizziness |

**RESPIRATORY**

| | | | |
|---|---|---|---|
| ☐ Asthma | ☐ Pneumonia | ☐ Pain with deep inhalation | ☐ COPD |
| ☐ Bronchitis | ☐ Cough | ☐ Excessive phlegm (color?) | ☐ Other: |
| ☐ Frequent colds | ☐ Coughing blood | | |

**NEUROPSYCHOLOGICAL**

| | | | |
|---|---|---|---|
| ☐ Seizures | ☐ Easily susceptible to stress | ☐ Disorientation | ☐ Mania |
| ☐ Concussion | ☐ Areas of numbness | ☐ Anxiety | ☐ Irritability |
| ☐ Tremors | ☐ Lack of coordination | ☐ Poor memory | ☐ Paralysis |
| ☐ Headaches | ☐ Loss of balance | ☐ Easily agitated | ☐ Numbness/tingling of limbs |

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems?

**GASTROINTESTINAL**

| | | | |
|---|---|---|---|
| ☐ Nausea | ☐ Blood in stools/black | ☐ Indigestion | ☐ Ulcers |
| ☐ Vomiting | ☐ Bad breath | ☐ Gallbladder disorder | ☐ Hernia |
| ☐ Diarrhea | ☐ Rectal pain | ☐ Gas / Bloating | ☐ Other: |
| ☐ Constipation | ☐ Hemorrhoids | ☐ Parasites | |
| ☐ Belching | ☐ Pain or cramps | ☐ IBS | |

**SKIN & HAIR**

| | | | |
|---|---|---|---|
| ☐ Rashes | ☐ Hives | ☐ Itching | ☐ Eczema |
| ☐ Hair loss | ☐ Dryness | ☐ Pimples / Acne | ☐ Tumors, lumps |
| ☐ Recent moles | ☐ Changes in hair or skin | ☐ Other: | |

**HEAD & NECK**

| | | | |
|---|---|---|---|
| ☐ Dizziness | ☐ Fainting | ☐ Neck stiffness | ☐ Enlarged lymph nodes |
| ☐ Headaches | ☐ Concussions | | |

**EARS**

| | | | |
|---|---|---|---|
| ☐ Infections | ☐ Ringing / Tinnitus | ☐ Decreased / poor hearing | ☐ Other: |

**EYES**

| | | | |
|---|---|---|---|
| ☐ Blurred vision | ☐ Visual changes | ☐ Poor night vision | ☐ Floaters / Spots |
| ☐ Cataracts | ☐ Glasses / contacts | ☐ Eye inflammation | ☐ Other: |

**NOSE, THROAT, MOUTH**

| | | | |
|---|---|---|---|
| ☐ Nose bleeds | ☐ Sinus infections | ☐ Hay fever or allergies | ☐ Recurring sore throats |
| ☐ Grinding teeth | ☐ Difficulty swallowing | ☐ sores on lips or tongue | ☐ Jaw clicks |

**GENITO-URINARY**

| | | | |
|---|---|---|---|
| ☐ Kidney stones | ☐ Painful urination | ☐ Frequent urination | ☐ Blood in urine |
| ☐ Urgency to urinate | ☐ Unable to hold urine | ☐ Night urination | ☐ Other: |

**MUSCULO-SKELETAL**

| | | | |
|---|---|---|---|
| ☐ Stiff neck / shoulders | ☐ Low back pain | ☐ Back pain | ☐ Knee pain |
| ☐ Muscle spasm, twitching | ☐ Sore, cold, weak knees | ☐ Joint pain | ☐ Arthritis |

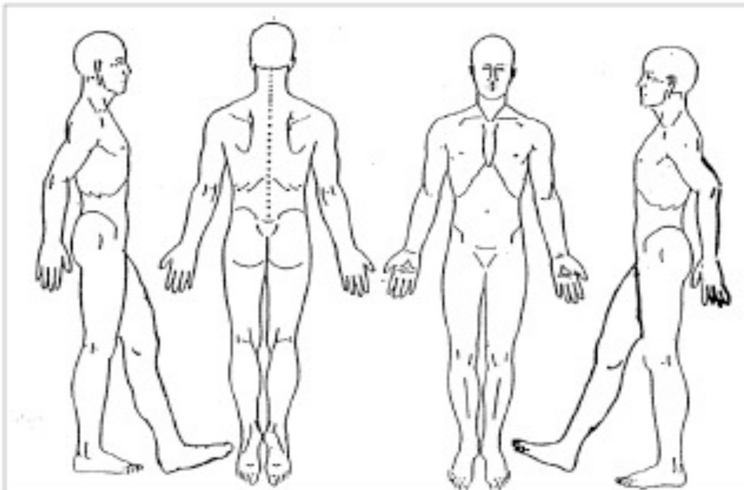
**FEMALE**

| | | | |
|---|---|---|---|
| ☐ Frequent urinary tract infection | ☐ Frequent vaginal infections | ☐ Pain / itching of genitalia | ☐ Genital lesions / discharge |
| ☐ Pelvic inflammatory disease | ☐ Abnormal pap smear | ☐ Irregular menstrual periods | ☐ Painful menstrual periods |
| ☐ Premenstrual syndrome | ☐ Abnormal bleeding | ☐ Menopausal syndrome | ☐ Break lumps |
| ☐ Hot flashes | ☐ Other: | | |

**MALE**

| | | |
|---|---|---|
| ☐ Pain / itching of genitalia | ☐ Genital lesions / discharge | ☐ Weak urinary stream |
| ☐ Lumps in testicles | ☐ Impotence | ☐ Other: |

**PLEASE MARK ALL AREAS OF PAIN ON THE DIAGRAM:**



**FOR WOMEN:**

Are you pregnant now? Yes [ ] No [ ]

Please indicate number of occurrences: Live Births: Pregnancies: Miscarriages: Abortions:

Age of First Period: Menopause (if applicable):

Date of Last Pap Smear: Last Mammogram:

**FOR MEN:**

Do you have any bothersome urinary symptoms? Yes [ ] No [ ]

Describe:

**OTHER INFORMATION:**

Please list and briefly describe any other information that might be important