Yin and Tonic Acupuncture PC
265 W 37th st Suite 640
New York, NY 10018

Please note that all information is strictly confidential.

First Name: ______________________ Middle Initial: ______________________

Last Name: ______________________

Address: ______________________ City/State/Zip: ______________________

E-mail Address: ______________________ Cell Phone: ______________________

Home Phone: ______________________ Work Phone: ______________________

Occupation: ______________________

In Case of Emergency Contact: ______________________

Relationship & Phone: ______________________

Height__________ Weight___________ Age_________

OBGYN Name_________________________________ Phone ______________________________

Reproductive Endocrinologist:

Name_________________________________Phone________________________

Other relevant physicians/specialists____

____

How did you hear about Yin and Tonic?____

Reason for Today's Visit: ____

____

____

How, when and where did this condition begin ____

____

What types of treatments have you tried:

____

____

____

____

____

Please list your main health problems you would like to address in order of importance:

1. ____
2. ____
3. ____

Your Medical History:

Surgeries, Major Illnesses, Hospitalizations, and Major Accidents:

____

____

Current medications, supplements and vitamins (and what they are for)

____

____

____

Lifestyle:

Describe what you eat: ____

____

____

Exercise? Yes No How often? ______________________________________

Type? ____

Hours of work per week?____________

Sleep: Hours per night_______ Time to bed___________ Time to rise__________

Rested in AM? ________________ Trouble falling asleep? Yes No Sometime

Waking up at night? Yes No Get up to urinate more than once? Yes No

Body Systems Review (please check all that apply):

0 = never 1 = in the past but not now 2 = occasionally 3 = frequently
4 = almost always

Scale	Symptom	Scale	Symptom
0 1 2 3 4	low appetite	0 1 2 3 4	heavy limbs
0 1 2 3 4	loose stools	0 1 2 3 4	fatigue
0 1 2 3 4	abdominal gas/bloating after food	0 1 2 3 4	hemorrhoids
0 1 2 3 4	fatigue after eating	0 1 2 3 4	belching
0 1 2 3 4	organ prolapse	0 1 2 3 4	nausea
0 1 2 3 4	bruise easily	0 1 2 3 4	diarrhea
0 1 2 3 4	obsessive thoughts/worrying	0 1 2 3 4	craving for sweets

Scale	Symptom	Scale	Symptom
0 1 2 3 4	spontaneous sweat	0 1 2 3 4	feeling of sadness
0 1 2 3 4	allergies	0 1 2 3 4	catch colds easily
0 1 2 3 4	asthma	0 1 2 3 4	feel tired after exercise
0 1 2 3 4	shortness of breath	0 1 2 3 4	general weakness
0 1 2 3 4	cough	0 1 2 3 4	nasal discharge
0 1 2 3 4	dry nose/mouth/skin/throat	0 1 2 3 4	sinus congestion

Scale	Symptom	Scale	Symptom
0 1 2 3 4	sore, cold or weak knees	0 1 2 3 4	feeling cold
0 1 2 3 4	low back pain	0 1 2 3 4	edema
0 1 2 3 4	frequent urination	0 1 2 3 4	hair loss
0 1 2 3 4	urinary incontinence	0 1 2 3 4	memory loss
0 1 2 3 4	ear problems	0 1 2 3 4	hotflashes
0 1 2 3 4	early morning diarrhea	0 1 2 3 4	nightsweats
0 1 2 3 4	craving salt	high low normal libido	

Scale	Symptom	Scale	Symptom
0 1 2 3 4	irritable	0 1 2 3 4	muscle spasms/twitches
0 1 2 3 4	feel better after exercise	0 1 2 3 4	heartburn/acid reflux
0 1 2 3 4	tight feeling in chest	0 1 2 3 4	dry eyes/red eyes
0 1 2 3 4	alternating diarrhea/constipation	0 1 2 3 4	ear ringing
0 1 2 3 4	symptoms worse with stress	0 1 2 3 4	anger easily
0 1 2 3 4	neck/shoulder tension	0 1 2 3 4	sand in eyes
0 1 2 3 4	floaters in vision	0 1 2 3 4	hair loss
0 1 2 3 4	brittle or weak nails	0 1 2 3 4	frequent headaches
0 1 2 3 4	feeling of heat rushing to head	0 1 2 3 4	blurry vision

Scale	Symptom	Scale	Symptom
0 1 2 3 4	feel heart beating	0 1 2 3 4	chest pain
0 1 2 3 4	insomnia	0 1 2 3 4	disturbing dreams
0 1 2 3 4	sores on tip of tongue	0 1 2 3 4	excessive laughter
0 1 2 3 4	anxiety	0 1 2 3 4	palpitations
0 1 2 3 4	restlessness	0 1 2 3 4	excessive sweat
0 1 2 3 4	red cheeks		

Bowel Movements: Frequency ____________ When? ____________

Well-formed Hard Loose Alternates

Are you thirsty? Yes No If so do you crave warm or cold drinks? ________________

Do find that you "run" particularly hot or cold?_______________________________________

How is your energy in general? ____

Do you often get headaches or migraines? Yes No

If yes where do feel the pain?____

____

When do you normally get them?____

____

How do you feel emotionally right now? ____

____

Women Only:

No. of pregnancies: ________ No. of children: ______ Age of first period: _________

Infertility: Yes No Maybe On the Pill? Yes No Abortions? Yes No

Have you experienced menopause? Yes No When?___________________________

(If yes, please skip the next section)

If you are experiencing menopausal symptoms, please describe _____________________

____

____

Date of last menstrual cycle? ______________ Are you pregnant now? _____

Is your period regular? Yes No

No. of days from the start of one period to the start of the next:________________________

Average number of days of flow: ____

Flow is: Light Normal Heavy

Color is: Pale Red Dark Red Red Brown Purple

Blood clots? Yes No How big/color?______________________________________

Do you get pain or cramps? Yes No Severe? Yes No

Do you experience any of the following before or during your period each month?

□ Water retention □ Breast tenderness or swelling □ Emotional upset
□ Irritability □ Food cravings □ Migraines □ Other____________

Do you ever bleed between periods? Yes No

Do you have any unusual vaginal discharge? Yes No

Have you ever had any of the following:

□ Abdominal surgery □ LEEP procedure □ Fibroids □ Polyps □ IUD

□ Endometriosis □ Chlamydia □ Ectopic Pregnancy

Do you know your FSH level?_______________

Have you recently had your estrogen/progesterone levels taken? If so what are they?

____

Please describe any reproductive procedures you have been through or are going through currently that you have not listed above. Please include procedures that involve both sexes:____

____

____

____

We are committed to your health and well-being. While Chinese Medicine is a very thorough health care system it is not a replacement for western treatment including regular check ups with your primary care physician and OBGYN. We recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

We, the undersigned, do affirm that ______________________________ (print patient name) has been advised by Yin and Tonic Acupuncture PC to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

Patient Signature: ______________________________________**Date**:____________

Print Practitioner Name____

Practitioner Signature___________________________________**Date**____________

I consent to acupuncture treatments and other procedures associated with Traditional Oriental Medicine at Yin and Tonic Acupuncture PC. I have discussed the nature of my treatment with my practitioner at Yin and Tonic Acupuncture PC.

I understand that methods of treatment may include but are not limited to: Acupuncture, moxibustion, cupping, guasha, electrical stimulation, tui na (Chinese massage), Chinese herbal medicine.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and guasha. Unusual risks of acupuncture include pneumothorax and organ puncture. Slight superficial burns are a possible side effect of moxibustion.

I acknowledge that if I don't give 24 hours notice for cancellation of an appointment, I will be charged a full fee for the missed appointment.

Patient Signature: ____ **Date:** ______________