

Yin and Tonic Acupuncture
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 _____ Date of Birth _____

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

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

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

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		

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

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
- Irritability
- Breast tenderness or swelling
- Food cravings
- Migraines
- Emotional upset
- 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
- Endometriosis
- LEEP procedure
- Chlamydia
- Fibroids
- Ectopic Pregnancy
- Polyps
- IUD

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 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. I have discussed the nature of my treatment with my practitioner at Yin and Tonic Acupuncture.

I understand that methods of treatment may include but are not limited to: Acupuncture, moxibustion, cupping, gua sha, 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 gua sha. 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:** _____