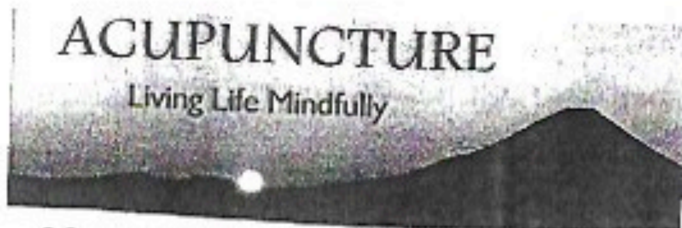


Date ____________

New Client Information

Personal Information

Name ____________

Address ____________

____

____

Home phone ____________

Work or cell phone ____________

Email ____________

Birth date ____________ Age ____________

Number of children ____________ Ages ____________

Marital status ____________

Occupation ____________

Referred by ____________

Physician name ____________

Physician's phone ____________

Emergency contact name ____________

Relationship ____________ Phone ____________

Main Concerns

Please tell me about your major health and wellbeing concerns in order of how important they are to you. It will help if you include when and where you first noticed them and to what extent they affect your daily life now.

____

____

____

____

____

____

Have you received a diagnosis for your concerns? If yes, what was the diagnosis? ____________

____

____

What kinds of treatment(s) have you tried or are currently using related to these concerns? ____________

____

____

What results have you seen from the above treatments? ____________

____

____

Please mark the severity of your chief concern today.

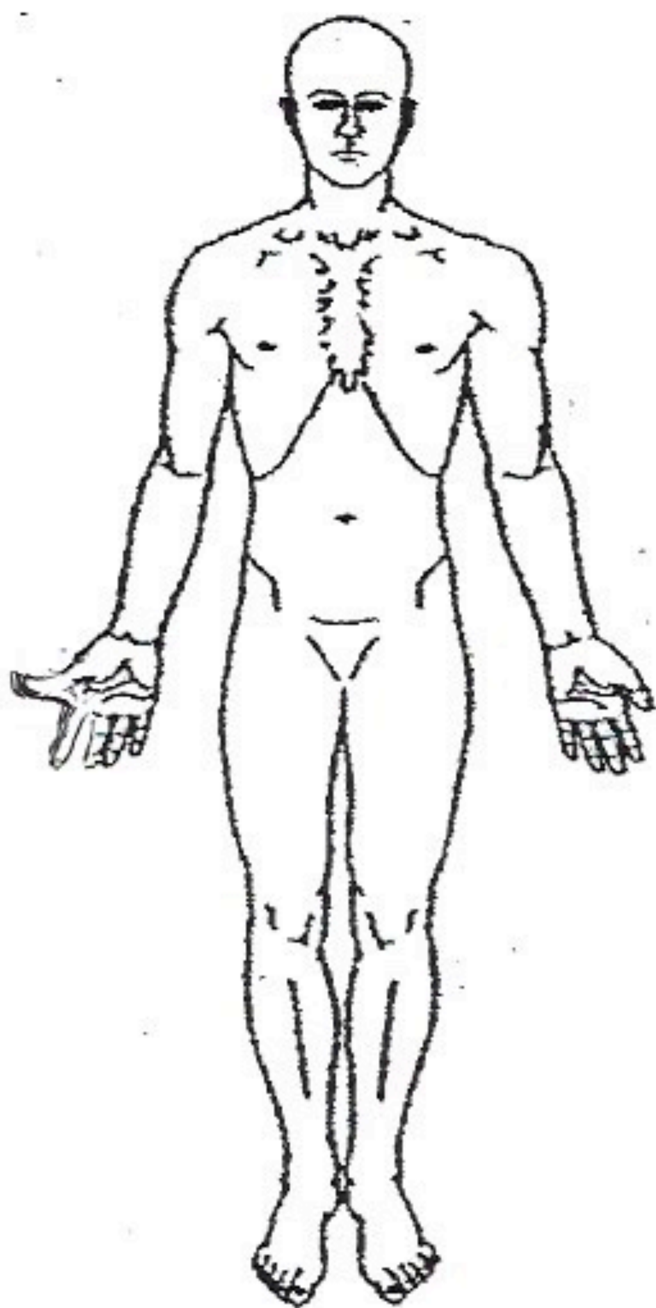
No problem ____________ Worst imaginable

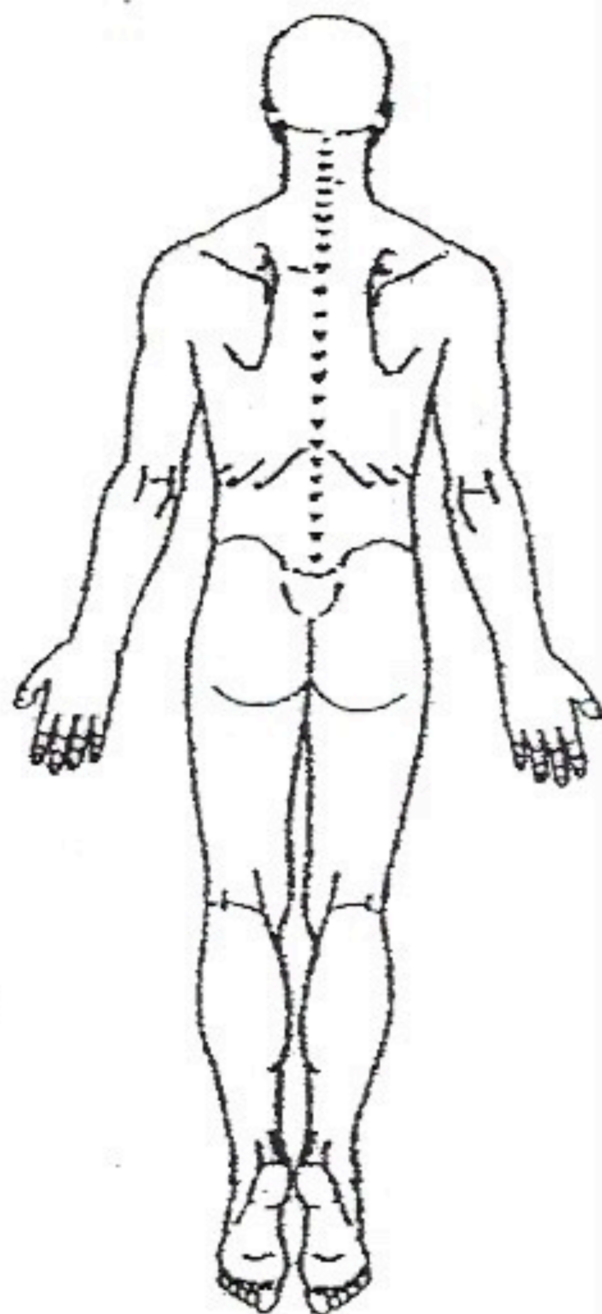
1 2 3 4 5 6 7 8 9 10

Please mark the greatest degree of severity of your chief concern that you have ever experienced.

No problem ____________ Worst imaginable

1 2 3 4 5 6 7 8 9 10





NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, ______________________ , ("Assignor") hereby assign to ______________________________ , ("Assignee")
(Print patient's name) (Print hospital or health care provider name)

all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on ______________________________ , not withstanding any other agreement to the contrary. (Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

______________________________ ______________________________
(Print name of Patient) (Signature of Patient)

______________________________ ______________________________
(Date of signature)

____
(Address of Patient)

______________________________ ______________________________
(Print name of Provider) (Signature of Provider)

______________________________ ______________________________
(Date of signature)

____
(Address of Provider)

Personal Medical History

Please mark all that apply and explain as necessary.

☐ Allergies ________ ☐ Heart disease ________ ☐ Seizures ________

☐ Asthma ________ ☐ Hepatitis ________ ☐ Stroke ________

☐ Cancer ________ ☐ High blood pressure ________ ☐ Thyroid disease ________

☐ Diabetes ________ ☐ HIV/AIDS ________ ☐ Other ________

Please date and describe all hospitalizations and surgeries ________

Please date and describe significant traumas ________

What do you know about your birth (prolonged labor, forceps, premature, etc.) ________

List all known allergies (food, chemicals, drugs, seasonal, insects, etc.) ________

Have you undergone a course of antibiotics lately? ________

Have you been under the care of a licensed health care professional in the past year? ________

If so, for what reasons? ________

Family Medical History

Please mark which apply, elaborate as appropriate and indicate which family member.

☐ Allergies ________ ☐ Drug/alcohol abuse ________ ☐ Seizures ________

☐ Asthma ________ ☐ Heart disease ________ ☐ Stroke ________

☐ Cancer ________ ☐ High blood pressure ________ ☐ Thyroid disease ________

☐ Diabetes ________ ☐ Mental disorder ________ ☐ Other ________

Review of Symptoms

General

Past / Current

☐ ☐ Catch cold easily
☐ ☐ Recurrent infections
☐ ☐ Night sweats
☐ ☐ Bleed or bruise easily
☐ ☐ Organ prolapse
☐ ☐ Strong thirst (hot or cold)
☐ ☐ Fatigue/low energy
☐ ☐ Sudden drops of energy
Time of day ________
☐ ☐ Sudden change in weight

Skin and Hair

Past / Current

☐ ☐ Dry skin/scalp/hair
☐ ☐ Rashes/hives
☐ ☐ Itching
☐ ☐ Eczema
☐ ☐ Warts
☐ ☐ Acne
☐ ☐ Change in moles
☐ ☐ Hair loss/thinning hair
☐ ☐ Graying of hair
☐ ☐ Other ________

Sleep

Past / Current

☐ ☐ Difficulty falling asleep
☐ ☐ Wake up easily during the night
Times per night? ________
At a particular time? ________
☐ ☐ Wake up too early in the am
What time? ________
☐ ☐ Nightmares
☐ ☐ Vivid dreams
☐ ☐ Grinding teeth
☐ ☐ Talking in sleep
☐ ☐ Snoring

Circulation

Current / Past

- ☐ ☐ Cold hands or feet
- ☐ ☐ Swelling of hands/feet
- ☐ ☐ Blood clots
- ☐ ☐ Varicose veins
- ☐ ☐ Edema/swollen ankles
- ☐ ☐ Puffy eyes

Head, Ears, Eyes, Nose, Throat

Current / Past

- ☐ ☐ Headaches
  - Where ____________
  - When ____________
- ☐ ☐ Migraines
- ☐ ☐ Dizziness/vertigo
- ☐ ☐ Fainting spells
- ☐ ☐ Earache
- ☐ ☐ Change in hearing
- ☐ ☐ Ringing in the ears
- ☐ ☐ Blurry vision
- ☐ ☐ Night blindness
- ☐ ☐ Color blindness
- ☐ ☐ Spots before eyes
- ☐ ☐ Dry eyes
- ☐ ☐ Eye pain/sore eyes
- ☐ ☐ Excessive tearing
- ☐ ☐ Glasses/contacts
- ☐ ☐ Facial pain
- ☐ ☐ Facial paralysis
- ☐ ☐ Nosebleeds
- ☐ ☐ Blocked nose/sinuses
- ☐ ☐ Sinus infections
- ☐ ☐ Jaw pain
- ☐ ☐ Teeth/gum problems
- ☐ ☐ Recurrent sore throat
- ☐ ☐ Hoarseness/loss of voice
- ☐ ☐ Tonsillitis/swollen glands
- ☐ ☐ Sores on lips/mouth/gums
- ☐ ☐ Strange taste in mouth
- ☐ ☐ Swollen glands/lumps
- ☐ ☐ Oral ulcers
- ☐ ☐ Other ____________

Nervous System

Current / Past

- ☐ ☐ Loss of taste/smell/touch
- ☐ ☐ Tingling sensations/numbness
- ☐ ☐ Tremors
  - Where? ____________
- ☐ ☐ Lack of coordination/balance
- ☐ ☐ Paralysis or seizures
- ☐ ☐ Stroke
- ☐ ☐ Concussion
- ☐ ☐ Other ____________

Chest

Current / Past

- ☐ ☐ Pain in chest
- ☐ ☐ Tightness or pressure in chest
- ☐ ☐ Pain with breathing
- ☐ ☐ Difficulty breathing
- ☐ ☐ Shallow breathing
- ☐ ☐ Shortness of breath
- ☐ ☐ Recurrent/chronic cough
- ☐ ☐ Coughing up blood
- ☐ ☐ Coughing up phlegm
- ☐ ☐ Asthma/wheezing
- ☐ ☐ Production of phlegm
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Heart palpitations or rapid heartbeat
- ☐ ☐ Irregular heartbeat
- ☐ ☐ Other ____________

Digestion

Current / Past

- ☐ ☐ Little appetite
- ☐ ☐ Strong appetite
- ☐ ☐ Hunger but no desire to eat
- ☐ ☐ Food cravings
- ☐ ☐ Belching
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Heartburn
- ☐ ☐ Indigestion
- ☐ ☐ Abdominal pain
- ☐ ☐ Regurgitation
- ☐ ☐ Weight loss
- ☐ ☐ Weight gain
- ☐ ☐ Loose stools/diarrhea
- ☐ ☐ Dysentery
- ☐ ☐ Strong smelling stools
- ☐ ☐ Blood in stools
- ☐ ☐ Constipation (< 1 b.m. /day)
- ☐ ☐ and dry stools
- ☐ ☐ not daily
- ☐ ☐ with difficulty
- ☐ ☐ Alternating constipation and diarrhea
- ☐ ☐ Gas/flatulence
- ☐ ☐ Hernia
- ☐ ☐ Rectal pain/prolapse
- ☐ ☐ Hemorrhoids
- ☐ ☐ Anorexia nervosa
- ☐ ☐ Bulimia
- ☐ ☐ Bad breath
- ☐ ☐ Other ____________

Urinary

Current / Past

- ☐ ☐ Pain on urination
- ☐ ☐ Urgent urination
- ☐ ☐ Frequent urination
- ☐ ☐ Blood in urine
- ☐ ☐ Cloudy urine
- ☐ ☐ Dribbling urination
- ☐ ☐ Urinary incontinence/retention
- ☐ ☐ Incontinence at night
- ☐ ☐ Do you wake to urinate?
  - How many times? ____________
- ☐ ☐ Bladder/kidney infections
- ☐ ☐ Recurrent yeast infections
- ☐ ☐ Kidney stones

Male System

Current / Past

- ☐ ☐ Prostate problems
- ☐ ☐ Change in sexual drive
- ☐ ☐ Rashes/itching
- ☐ ☐ Genital discharge
- ☐ ☐ Erection difficulty
- ☐ ☐ Low sperm count/motility

Muscles and Joints

Current / Past

- ☐ ☐ Neck pain
- ☐ ☐ Shoulder pain
- ☐ ☐ Back pain
  - Where ____________
- ☐ ☐ Hand/wrist pain
- ☐ ☐ Knee pain
- ☐ ☐ Foot/ankle pain
- ☐ ☐ Joint/bone problems
- ☐ ☐ Muscle pain/weakness
- ☐ ☐ Tremors/tics in muscles
- ☐ ☐ Osteoporosis
- ☐ ☐ Herniated disc
- ☐ ☐ Sciatica
- ☐ ☐ Other ____________

Mind and Emotions

Current / Past

- ☐ ☐ Poor memory
- ☐ ☐ Difficulty concentrating
- ☐ ☐ Depression
- ☐ ☐ Often stressed
- ☐ ☐ Lose control of emotions
- ☐ ☐ Substance abuse
- ☐ ☐ Anxiety/nervousness
- ☐ ☐ Manic behavior
- ☐ ☐ Panic attacks
- ☐ ☐ Easily angered
- ☐ ☐ Aggressive behavior

☐ ☐ Other ____________
Current

Past

Female System

☐ ☐ Premenstrual irritability
☐ ☐ Clots in menstrual blood
Color of blood ____________
☐ ☐ Irregular menses
☐ ☐ Painful menses
☐ ☐ Heavy/prolonged bleeding
☐ ☐ Missed menses
☐ ☐ Spotting/abnormal bleeding
☐ ☐ Vaginal discharge
☐ ☐ Vaginal dryness
☐ ☐ Genital sores
☐ ☐ Ovarian cysts
☐ ☐ Fibroids
☐ ☐ Endometriosis

☐ ☐ Breast lumps
☐ ☐ Breast swelling or redness
☐ ☐ Nipple discharge
☐ ☐ Abnormal Pap smear
☐ ☐ Infertility
☐ ☐ Other ____________

Are you pregnant now? ____________
Is it possible you're pregnant now? ____________

Are you trying to get pregnant? ____________

Do you practice birth control? ____________

What type and for how long? ____________

Number of pregnancies ____________
Number of births ____________
Num. of premature births ____________
Number of abortions ____________
Age of first menses ____________
Duration of menses ____________
First day of last menses ____________
Number of days in cycle ____________
Age of menopause ____________
Date of last Pap ____________

Comments ____________

Daily Routines

Please describe your daily activities from when you awake until you go to sleep. Include types of food you eat, exercise, work and other activities.

	Time	Activities, Foods, Routine	Variation
Morning			
Awaken			
Breakfast			
Activities after breakfast			
Midday			
Lunch			
Activities after lunch			
Evening			
Dinner			
Activities after dinner			
Night			
Activities			
Bed time			

List other regular activities not included above. These could be exercise, meditation, spiritual practices, etc. ____________

Are you sexually active? Yes ________ No ________ Frequency ____________

How many hours per week do you work? ____________ Do you enjoy what you do? ____________

How far is your commute? ____________

How many hours a day do you spend sitting or driving? ____________

Other comments about your daily routine ____________

____

General Health Habits

Are you a vegetarian or vegan? Yes ______ No ______ If yes, how long ____________

What are the major stressors in your life? ____________

How much water do you drink per day? Number of cups ____________

Do you exercise regularly? Yes_____ No_____ Length of time ________ Times per week ____________

Types(s) of exercise ____________

Please mark any of the following that apply.

Aspirin	currently ______	occasionally ______		Diet pills	currently ______	occasionally ______
Tranquilizers	currently ______	occasionally ______		Vitamins	currently ______	occasionally ______
Antacids	currently ______	occasionally ______		Sleeping pills	currently ______	occasionally ______
Laxatives	currently ______	occasionally ______		Herbs	currently ______	occasionally ______
Cold tablets	currently ______	occasionally ______		Antihistamines	currently ______	occasionally ______
Ibuprofen	currently ______	occasionally ______		Oral contraceptives	currently ______	occasionally ______

List any medications you are currently taking ____________

Please mark your current use levels of the following:

Tobacco	frequently_____	occasionally_____	never_____	Number of cigarettes per day _____	Age started _____
Alcohol	frequently_____	occasionally_____	never_____	Number of drinks per week	Type of drinks _____
Caffeine	frequently_____	occasionally_____	never_____	Number of cups per day _____	Type of drinks _____
Marijuana	frequently_____	occasionally_____	never_____	Number of times per week _____	
Ecstasy	frequently_____	occasionally_____	never_____	Number of times per month _____	
Cocaine	frequently_____	occasionally_____	never_____	Number of times per month _____	
Other	frequently_____	occasionally_____	never_____	Describe _____	

Do you have any current or past problems with addiction or substance abuse? Yes_____ No_____

Substance__________ Amount__________ When did you quit? __________

Signature ____________________ **Date** ____________

PATIENT ADVISORY TO CONSULT A PHYSICIAN

WE, THE UNDERSIGNED, DO AFFIRM THAT

(PATIENT)______________________________ HAS BEEN ADVISED BY

______________________________(LICENSED ACUPUNCTURIST) TO

CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT

______________________________ Patient sign and date

______________________________ Licensed acupuncturist sign and date

I hereby request and consent to acupuncture and other procedures associated with the practice of traditional Oriental Medicine as per NYS licensure. I understand that methods of treatment include but are not limited to acupuncture, moxibustion, cupping, and electrical acupuncture.

I have been informed that acupuncture is a safe method of treatment, but 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 affect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture. Infection is another possible risk, although this site uses sterile, disposable needles and maintains a clean and safe environment. Burns and scarring are a potential risk of moxibustion. I understand that while this document describes some of the major risks of treatment, other side effects and risks may occur.

I will notify the Acupuncturist who is caring for me if I should become pregnant.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

______________________________ DATE

______________________________ PRINT NAME OF PATIENT

______________________________ SIGNATURE OF PATIENT OR REP.

______________________________ PRINT NAME OF REPRESENATIVE

______________________________ NAME OF ACUPUNCTURIST

______________________________ SIGNATURE OF ACUPUNCTURIST

Acknowledgement of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for the office of (Doctors Name), detailing how my information may be used and disclosed as permitted under federal and state law.

Signed: ______________________________ **Date:** ______________

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Patient: ______________________________

Relationship: __________________________

Acknowledgement of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for the office of (Doctor's Name)., detailing how my information may be used and disclosed as permitted under federal and state law.

Signed: ______________________________ **Date:** ______________

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Patient: ______________________________

Relationship: __________________________

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE

(Roland-Morris)

NAME: ______________________________ DATE: ________________

AGE: ________ SCORE: ____________

When your back hurts, you may find if difficult to do some of the things you normally do. Mark only the sentences that describe you today.

1. ☐ I stay at home most of the time because of my back.
2. ☐ I walk more slowly than usual because of my back.
3. ☐ Because of my back, I am not doing any jobs that I usually do around the house.
4. ☐ Because of my back, I use a handrail to get upstairs.
5. ☐ Because of my back, I lie down to rest more often.
6. ☐ Because of my back, I have to hold onto something to get out of an easy chair.
7. ☐ Because of my back, I try to get other people to do things for me.
8. ☐ I get dressed more slowly than usual because of my back.
9. ☐ I stand up only for short periods of time because of my back.
10. ☐ Because of my back, I try not to bend or kneel down.
11. ☐ I find it difficult to get out of a chair because of my back.
12. ☐ My back or leg is painful almost all of the time.
13. ☐ I find it difficult to turn over in bed because of my back.
14. ☐ I have trouble putting on my socks (or stockings) because of pain in my back.
15. ☐ I sleep less well because of my back.
16. ☐ I avoid heavy jobs around the house because of my back.
17. ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
18. ☐ Because of my back, I go upstairs more slowly than usual.

*Roland Morris Citation info - Roland, M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." <u>Spine</u> **25**(24): 3115-24.*

Copenhagen Neck Disability Scale

		Yes	Occasionally	No
1.	Can you sleep at night without neck pain interfering?	☐	☐	☐
2.	Can you manage daily activities without neck pain reducing activity levels?	☐	☐	☐
3.	Can you manage daily activities without help from others?	☐	☐	☐
4.	Can you manage putting on your clothes in the morning without taking more time than usual.	☐	☐	☐
5.	Can you bend over the washing basin in order to brush your teeth without getting neck pain?	☐	☐	☐
6.	Do you spend more time than usual at home because of neck pain?	☐	☐	☐
7.	Are you prevented from lifting objects weighing from 2-4kg due to neck pain?	☐	☐	☐
8.	Have you reduced your reading activity due to neck pain?	☐	☐	☐
9.	Have you been bothered by headaches during the time that you have had neck pain?	☐	☐	☐
10.	Do you feel that your ability to concentrate is reduced due to neck pain?	☐	☐	☐
11.	Are you prevented from participating in your usual leisure time activities due to neck pain?	☐	☐	☐
12.	Do you remain in bed longer than usual due to neck pain?	☐	☐	☐
13.	Do you feel that neck pain has influenced your emotional relationship with your nearest family?	☐	☐	☐
14.	Have you had to give up social contact with other people during the past two weeks due to neck pain?	☐	☐	☐
15.	Do you feel that neck pain will influence your future?	☐	☐	☐