## Regenerative Acupuncture and Wellness 3664 Route 212 Shady (Woodstock), Ny 12409

## 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 Emergenc	y Contact:		
Relationship & Phone	):		
Height	Weight	Age	
How did you hear ab	oout Yin and Tonic?		
How, when and whe	re did this condition begin _		
What types of treatm	ents have you tried:		

Please list your main health probl	ems you would like to ad	dress in order of importance:	
1			
2			
3			_
Your Medical History:			
Surgeries, Major Illnesses, Hospital	izations, and Major Accid	dents:	
Current medications supplemen	ts and vitamins (and who	it thou are for	
Current medications, supplemen	is and vitamins (and who	ir iriey dre for)	
Lifestyle:			
Describe what you eat:			
Exercise? Yes No Ho	w 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		o? Yes No Sometime	
Waking up at night? Yes No	Get up to urinate ma	ore than once? Yes No	

## Body Systems Review (please check all that apply):

0 = never 4 = almost alv	· · · · · · · · · · · · · · · · · · ·	2 = occasionally 3 = frequently	
0 1 2 3 4 0 1 2 3 4	low appetite loose stools abdominal gas/bloating after f fatigue after eating organ prolapse bruise easily obsessive thoughts/worrying	0 1 2 3 4 heavy limbs 0 1 2 3 4 fatigue food 0 1 2 3 4 hemorrhoids 0 1 2 3 4 belching 0 1 2 3 4 nausea 0 1 2 3 4 diarrhea 0 1 2 3 4 craving for sweets	
0 1 2 3 4 0 1 2 3 4	spontaneous sweat allergies asthma shortness of breath cough dry nose/mouth/skin/throat	0 1 2 3 4 feeling of sadness 0 1 2 3 4 catch colds easily 0 1 2 3 4 feel tired after exercise 0 1 2 3 4 general weakness 0 1 2 3 4 nasal discharge 0 1 2 3 4 sinus congestion	Ð
0 1 2 3 4 0 1 2 3 4	sore, cold or weak knees low back pain frequent urination urinary incontinence ear problems early morning diarrhea craving salt	0 1 2 3 4 feeling cold 0 1 2 3 4 edema 0 1 2 3 4 hair loss 0 1 2 3 4 memory loss 0 1 2 3 4 hotflashes 0 1 2 3 4 nightsweats high low normal libido	_
0 1 2 3 4 0 1 2 3 4	irritable feel better after exercise tight feeling in chest alternating diarrhea/constipation symptoms worse with stress neck/shoulder tension floaters in vision brittle or weak nails feeling of heat rushing to head	<ul> <li>0 1 2 3 4 anger easily</li> <li>0 1 2 3 4 sand in eyes</li> <li>0 1 2 3 4 hair loss</li> <li>0 1 2 3 4 frequent headache</li> </ul>	JX
0 1 2 3 4 0 1 2 3 4		0 1 2 3 4 chest pain 0 1 2 3 4 disturbing dreams 0 1 2 3 4 excessive laughter 0 1 2 3 4 palpitations 0 1 2 3 4 excessive sweat	
	red cheeks	o i z o a okcessive swedi	
Bowel Moven	red cheeks		

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?

	n <b>&amp;</b> Breast tenderne			-
Irritability <b></b>	Food cravings <b>•</b>	Migraines <b>¢</b> O	itner	
Do you ever bleed betw	een periods? Ye	s No		
Do you have any unusua	al vaginal discharge? `	es No		
Have you ever had any	of the following:			
<ul><li>Abdominal surgery</li></ul>	<b>₡</b> LEEP procedur	e <b>É</b> Fibroids	Polyps	<b>É</b> IUD
<ul><li>Endometriosis</li></ul>	Chlamydia	<b>É</b> Ectopic	Pregnancy	
Do you know your FSH le	vel?			
Have you recently had y	our estrogen/progeste	rone levels taker	n? If so what a	re they?
has been advised by Yin condition or conditions f	ot a replacement for whysician and OBGYN. or conditions for which do affirm that and Tonic Acupuncturor which such patient s	restern treatmen We recommend I you are seeking Te PC to consult eeks acupunctu	t including reg that you consi g acupuncture (prina physician reg re treatment.	ular check ups ult a physician treatment. nt patient name) garding the
Patient Signature:		Do	ıte:	
Print Practitioner Name_				_
Practitioner Signature		Da	te	

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:
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