



Sacred Space Acupuncture NYC
 39 W 32nd Street, Suite 1702
 New York, New York 10001

Sacred Space Acupuncture Nyack
 97 South Broadway
 South Nyack, NY 10960

Note: The information provided on this form is confidential.

Today's Date ___ / ___ / ___

Name: _____ Age: _____ Sex: Male Female

Address _____ Occupation _____

City _____ State _____ Zip _____ Date of birth ___ / ___ / ___

Phone: mobile _____ work _____ home _____

How did you hear about us? _____ Email _____

Physicians care? _____ Name & phone of physician: _____

What would you like treated by Acupuncture? _____

How long have you had this condition? _____ Was onset sudden gradual

Symptoms are worsened by _____ Symptoms better by _____

What medical diagnosis have you received? _____

What other treatments have you received for this and/or other conditions? _____

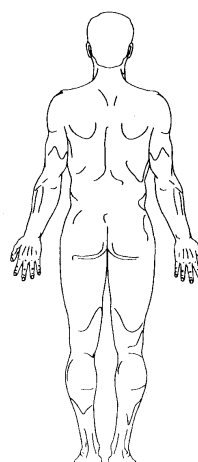
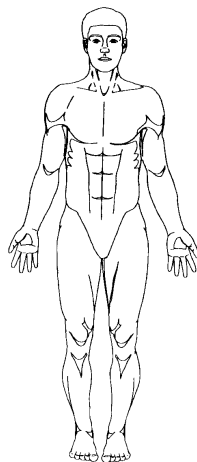
How has this condition changed your life? _____

Are you taking any medication? Please note all medication, herbs, vitamins and minerals you take even if you take them only occasionally. _____

Are you currently pregnant? Yes No

Are you presently trying to get pregnant? Yes No

On the following drawing shade the areas which you feel should be addressed. _____



Medical History

Birth: Anything significant about your birth? _____

Vaccination history: Any reaction that you remember? Any unusual vaccination? _____

Childhood illnesses: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

_____ age: _____

_____ age: _____

_____ age: _____

Adolescence illnesses: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

_____ age: _____

_____ age: _____

_____ age: _____

Adulthood: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

_____ age: _____

_____ age: _____

_____ age: _____

Family history: please note all major illnesses in your close family such as diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders etc.

Underline current conditions. Put a **check mark** in the box for **former conditions**. Add any additional information regarding duration, frequency, intensity and pain regarding current symptoms.

Have you had any of these?

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lymph nodes removed | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Headache | <input type="checkbox"/> Birth Trauma |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Hyperthyroid | (your own birth) |
| <input type="checkbox"/> Vaccinations | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Rheumatoid Arthritis | |

Diet and Food:

How is your appetite? Good Poor No appetite Hungry all the time

Any food cravings?: _____

List any food intolerances: _____

How do you feel emotionally around food? _____

History of Anorexia or Bullemlia? _____

Describe meals for a typical day: Breakfast _____

Lunch: _____ Dinner: _____

How often do you have: meat _____ day/wk Coffee or Tea (caffeinated) _____ day/wk

Sugar/Sweets _____ day/wk Dairy (milk, cheese, yogurt) _____ day/wk

Are you always thirsty? Yes No Do you prefer Hot or Cold drinks?

How many glasses/cups do you have daily: Water _____ soda _____ Coffee/Tea _____

Alcohol _____ day/wk

Rate your taste preferences 1 to 5 (1=like most to 5=dislike):

Salty _____ Sour _____ Bitter _____ Sweet _____ Spicy _____

Exercise and Energy:

How is your energy? _____

What time of day is your energy: Highest? _____ Lowest _____

Do you fatigue easily? _____

Does movement make you feel : less tired or more tired

What kind of exercise do you do? _____

How often do you exercise? _____ Are you consistent? _____

Do you have unusual sweating? When? _____ other _____

Do you get dizzy with or after exercise? _____

Emotions and Sleep:

How do you feel emotionally? _____

Do you have (check all that apply): Panic attacks Depression Anxiety Bad Temper
Nervousness Fear attacks Poor memory Difficult concentration Moody in the morning
Other: _____ Married or Stable relationship Single

How do you feel about your relationship? _____

How do you hold stress? _____

If you hold your stress in the body, where? _____ Or do you brood? _____

How do you relax? _____

How do you feel about your work? _____

Do you use any prescription or non-prescription substances? Anti-depressants Sleeping pills

Other: _____

How long do you normally sleep? _____ hours per night

I have difficulty with (check all that apply): Falling asleep Staying asleep Disturbed Sleep

Waking up at about _____ am/pm and not being able to fall asleep again because

Skin and Hair:

I have (check all that apply): Dry skin Skin rashes Itching Acne Eczema Hives
Hair loss Premature graying Psoriasis Other: _____

Respiratory, Eyes, Ears, Nose, Throat & Head:

Do you smoke? Yes No _____ per day, for _____ years

I have (check all that apply): Frequent colds Chronic runny nose Chronic cough

Coughing blood Pain inhaling Shortness of breath on exertion/at rest Asthma Nose bleeds

Pain/red eyes Poor vision See spots Dizziness Cold sores Bleeding gums Dry mouth

Ear pain Ringing in ears (high pitch / low pitch) Clogged/popping ears Sinusitis Motion sick

Frequent sore throat Cough up mucous How much? _____ Color of phlegm? _____

Frequent headaches/migraines Describe: _____

Other: _____

Cardiovascular:

Blood pressure: ____ / ____ Have you been diagnosed with heart trouble? Yes No

I have (check all that apply): Chest pain Palpitations Irregular heart beat Phlebitis

Varicose veins Cold hands and feet Poor circulation Diabetic Neuropathy

Gastrointestinal:

I have (check all that apply): Belching Nausea Vomiting Vomiting of blood Ulcers
Acid regurgitation Heartburn Hernia Indigestion Severe stomach pains
Other : _____ Bowel movements: How often? _____ day/week

Painful bowel movement? Yes No

I have (check all that apply): Irregular Constipation Diarrhea Gas Burning Hemorrhoids
Use laxatives Undigested food in stool Loose stool Hard stool Blood in stool
Itchiness Other: _____

Muscles, Joints and Bones:

Do you have pain or tightness? Where? _____

The pain is (check all that apply): Sharp Aching Numb Deep pain Burning Dull
Superficial pain Tingling Pain worse or better with heat Pain worse or better with cold
Pain worse in am or pm TMJ Pain worse or better with movement

I have (check all that apply): Swollen joints Arthritis/joint pain Tendonitis Rheumatism
Bone pain Muscle cramping Muscle pain Repetitive strain
Other: _____

Urinary & Genital:

Urination: How often? _____ times per day. Color: Pale yellow Dark yellow/orange

I have or have had (check all that apply): Trouble starting stream Frequent urination

Incontinence Trouble holding urine Pain Burning Dribbling when sneezing

Urinary tract infections Blood in urine Kidney stones Other: _____

How is your sexual energy? _____

What kind of birth control do you use? _____

Do you have (check all that apply): Infertility Pain during sexual relations

Other: _____

Women:

At what age did you start menstruation? _____ Number of days between cycles: _____

Number of days of flow _____ Color _____

I have or have had (check all that apply): Irregular menstruation Heavy flow Light flow

No flow Clots Vaginal itching/burning Spotting between periods

Discomfort/pain before period Discomfort/pain during period Other: _____

Any vaginal discharge? Yes No Amount _____ Color _____ Frequency _____

Lumps in the breast Congested breast Breast tenderness

Blood or mucous discharge from breasts? Yes No Amount _____ Frequency _____

PMS symptoms: _____

What makes these symptoms better? _____

Are you using birth control? What type? _____

Number of pregnancies? _____ Number of deliveries? _____ Abortion(s)/Miscarriage(s)? _____

Pregnancy complications? Please describe: _____

Menopausal Symptoms: _____

Reduced sexual energy? Yes No

If you are trying to conceive, do you have the following information?

FSH _____ LH _____ IUI attempts _____ IVF attempts _____

Men:

I have (check all that apply): Prostatitis Impotence Penis blood/mucous discharge

Pain associated with genitals Premature ejaculation Reduced sexual energies

Seminal emission Testicular pain / Swelling Inguinal Hernia

Other: _____

PLEASE READ AND SIGN:

While Oriental Medicine has a great deal to offer as a health care system, it cannot replace the resources available through medical physicians. It is recommended that you consult a physician regarding any conditions for which you are seeking acupuncture treatment(s). This is a recommendation ONLY. The state of NY does NOT require an MD script for Acupuncture.

I, (print name) _____ have been advised by Sacred Space Acupuncture to consult a physician regarding the conditions, for which I seek acupuncture treatment(s).

Signature of patient or patient representative _____ **Date** _____

Signature of Practitioner _____ **Date** _____

Informed Consent

I consent to acupuncture treatments and related procedures, associated with Oriental Medicine, by Bianca Beldini, L.Ac or Jodie Tassello, LAc. I have discussed the nature and purpose of my treatment with her and I understand that the methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, gua sha and electrical stimulation.

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 needle sight, which may last a few days. An unusual risk of acupuncture includes spontaneous miscarriage, nerve damage and organ puncture. Infection is another possible risk, however since this office uses only sterilized, disposable needles while maintaining a clean and safe environment, this is unlikely. Burns and scarring are potential risks of using moxibustion.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgments during the course of treatment, and decide what she thinks is in my best interest, based upon the facts that are known at the time. I understand that the practitioner and administrative staff may review my medical records and reports, but all of my records will be kept confidential and will not be released without my written consent.

I will notify the acupuncturist, who is caring for me, if I become pregnant.

By voluntarily signing below, I show that I have read or have had read to me, this consent to treatment. I 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 both the present condition and for any future conditions for which I seek treatment(s).

Signature of patient or patient representative

Date

Cancellation Policy

I agree to pay the full price of a session if I do not comply with notifying Sacred Space Acupuncture within 24 hours before my scheduled appointment time.

Signature of patient

Date

