Blair Acupuncture Intake

Date _____/_____/_____ Practitioner/s_____(/)_____(for office use)

PLEASE PRINT

Name _____ Gender _____

Date of Birth _____/_____/_____ Email address _____

Address _____

City _____ State _____ Zip Code _____

Occupation _____ Contact phone _____

Cell phone _____ Referred by _____

In emergency, notify _____ Telephone _____

Relationship to patient _____

Do you have insurance that covers acupuncture? ___ Yes ___No

Have you contacted the company to verify this? (If so, please download/request Insurance form)

Chief Complaint(s) _____

Condition onset (approximate date) _____ Was it ___ sudden ___ gradual

Symptoms are relieved by _____ worsened by _____

Is condition ___ getting worse ___ constant ___ comes and goes?

Have you received a medical diagnosis? __Yes __ No If yes, what? _____

When were you last seen by a Medical Doctor?_____

Describe recent treatments you have had for the above or other conditions _____

Medical History (please check all that apply)

____ Alcoholism
____ Allergies
____ Arthritis
____ Asthma
____ Birth trauma
____ Cancer
____ Chronic fatigue
Fibromyalgia
____ Diabetes
____ Digestive Problems

____ Drug abuse
____ Heart disease
____ Hepatitis A/B/C
____ High blood pressure
____ HIV/AIDS
____ Kidney/bladder disease
____ Liver Disease
____ Lung/Breathing Problems
____ Lyme disease

___ Mental illness
___ Metal allergies
___ Nervous system disease (MS etc)
___ Polio
___ Seizures
___ Stroke
___ Thyroid problems
___ Tuberculosis
___ Others _____

List major injuries, surgeries or illnesses. Include dates and hospitalizations, if appropriate.

_____

_____

Patient _____

List current Medications (please include hormones) and for what conditions you are taking them

_____

_____

List all Vitamins, Supplements, and Herbs (include any Chinese herbal formulas) you are taking _____

_____

_____

Do you generally feel hot or cold?_____

Gastrointestinal

Do you have (Check ALL that apply) ___ Belching ___ Nausea ___ Vomiting ___ Vomiting blood ___ Ulcers ___ Bloating ___ Acid ___ Regurgitation ___ Heartburn ___ Indigestion ___ Severe stomach pain __ Bitter/Sour taste in mouth ___ Weight gain ___ Weight loss ___ Other (describe) _____

How often do you have bowel movements? _____ days/week (circle) Are they painful? ___ Yes ___ No

Do you have (Check ALL that apply) ___ Irregularity ___ Constipation ___ Diarrhea ___ Gas ___ Burning ___ Hemorrhoids ___ Use laxatives ___Undigested food in stool ___ Loose stool ___ Hard stool ___ Blood in stool ___ Itchiness ___ Other (describe)_____

Exercise & Energy

How is your energy? ___ low ___ normal ___ high. At what time is it highest? _____ lowest? _____
Do you fatigue easily? ___ Yes ___ No. Do you exercise? ___Yes ___ No
If yes, what type of exercise? _____ How many times/week? _____

Women

___ Low sex drive ___ Lack of sex drive. ___High sex drive At what age did you start menstruating? _____
Number of days between cycles ____ Days of flow _____ Color _____
Menses: ___ Irregular menstruation ___ Heavy flow ___ Light flow ___ No flow ___Clots ___ Vaginal itching/burning ___ Spotting between periods _____ Discomfort/pain
Any vaginal discharge? ___ Yes ___ No Amount _____ Color _____ Frequency _____
PMS symptoms _____
Peri-menopausal symptoms _____
Menopausal symptoms _____
Birth control _____ Have you been pregnant? ___Yes _____# of pregnancies
Any issues during pregnancy? ___Yes Explain _____
Are you trying to get pregnant? ___ Yes ___ No Infertility Issues _____

Men

Do you have (Check ALL that apply) ___ Prostatitis ___ Impotence ____ Penis blood/mucous discharge ____ Low sex drive ____ Lack of sex drive ____ Very high sex drive ____ Pain when ejaculating ____ Premature ejaculation ___ Difficult ejaculation ____ Erectile dysfuncion ____ Peyronie's disease

Muscles, Joints, Bones & Nervous System

Do you have pain and tightness? ___ Yes ___ No If yes, where? (list all sites below)

_____

_____

The pain is (Check ALL that apply) ___ Sharp ___ Aching ___ Numb ___ Deep ___ Burning ___ Dull ___ Superficial ___ Tingling ___ Worse/Better with heat ___ Worse/Better with ice/cold
Does any particular movement make it Worse? _____ or Better?_____
Does rest improve it or make it worse _____

Patient _____

Do you have (Check ALL that apply) ___ Swollen joints ___ Arthritis/Joint pain ___ Tendonitis ___ Rheumatism
___ Bone pain ___ Muscle cramping ___ Muscle pain ___ Repetitive strain injury
____Other (describe) _____
Have you ever had seizures? ___ Yes ___ No Concussion? ____Yes ___No
Do you have tingling or numbness any where ? If so, where _____

Respiratory, Eyes, Ears, Nose, Throat & Head

Do you smoke? ___Yes ___ No. If yes, # of cigarettes/day _____ for _____ years? Cigars? ___ Yes ___ No

Do you have (check ALL that apply) ___ Frequent colds ___ Chronic runny nose ___ Chronic cough
___ Nose bleeds ___ Pained/red/dry eyes ___ Poor vision ___ See spots ____ Dizziness ___Ringing in ears
___ Clogged/popping ears ___ Frequent sore throat ____ Upper respiratory problems
___ Cough up mucus If yes, how much? _____ Color of phlegm _____
___ Frequent headaches/migraines If yes, describe _____
_____

Other (describe) _____

Cardiovascular

Have you ever been diagnosed with heart trouble? ___ Yes ___ No
Have yu ever been diagnosed with high blood pressure ___ Yes ___No
Do you have (check ALL that apply) ___ Chest pain ___Palpitations ___ Varicose veins ___ Phlebitis
___ Cold hands/feet ___ Irregular heart beat ___ Poor circulation
___ Other (describe) _____

Emotions & Sleep

How do you feel emotionally? _____

Do you have (check ALL that apply) ___ Panic attacks ___ Depression ___ Anxiety ___ Bad temper
___ Nervousness ___ Fear attacks ___ Poor memory ___ Difficulty concentrating
___ Other (describe) _____

Describe your stress level ___ None ___ Low ___ Moderate ___ Severe. Do you use prescription/non-prescription substances? ____ Anti-depressants ___ Anti-anxiety meds ___ Sleeping pills
Other (list) _____
How long do you normally sleep? _____ hours per night
Do you have difficulty (check ALL that apply) ___ Falling asleep ___ Staying asleep ___ Disturbed sleep
___ Waking up at about ____ am/pm and not being able to fall back asleep because _____
_____
Other sleep problems (describe) _____

Urinary & Genital

How often do you urinate? ___ times/day Color: _____
Do you have (answer ALL that apply) ___ Trouble starting stream ___ Frequent urination ___ Incontinence
___ Pain ___ Trouble holding urine ___ Burning ___ Dribbling when sneezing ___ Urinary tract infections
___ Blood in urine ___ Kidney stones ___ Other (describe) _____

Skin & Hair

I have (check ALL that apply) ___ Dry skin ___ Skin rashes ___ Itching ___ Acne ___ Eczema ___ Hives
___ Hair loss ___ Premature gray hair ___ Other (describe) _____

Patient _____

Please list significant family illnesses:

Mother_____

Father_____

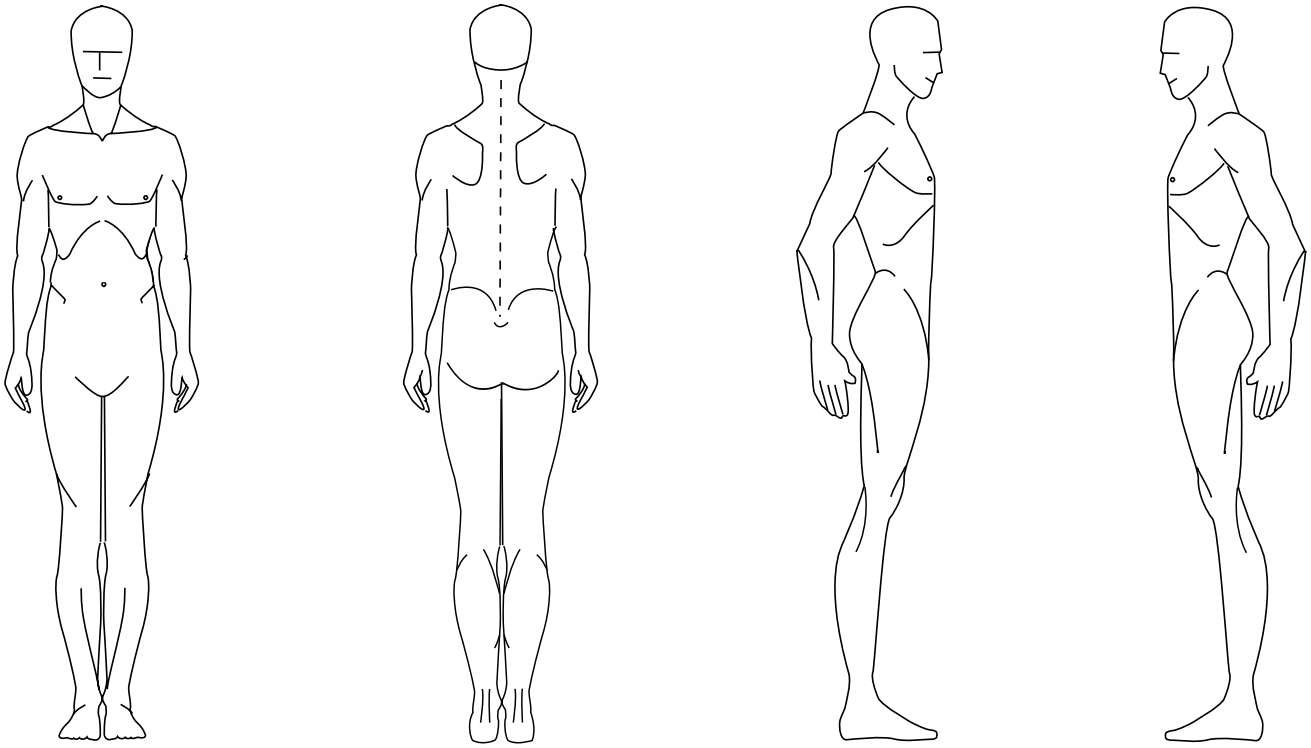
Siblings _____

Grandparents _____

What is your most important goal to achieve from your acupuncture treatment(s)?_____

_____

On the drawings below, please circle the areas where you have pain or discomfort.
Rate according to degree of discomfort using 1-5 (with 5 a the worst)



CONSENT TO FINANCIAL PAYMENT

The undersigned agrees to assign to the office of Alfred F. Blair, L. Ac., all insurance benefits available for any professional services rendered, payable directly to the office of Alfred F. Blair, L. Ac. The undersigned agrees to promptly pay any charges or residual insurance balances within 30 days, unless other written arrangements have been made. I also understand that I am responsible for any part of the charges that may not be covered by insurance and that I will be billed directly for those services.

I certify that I have read the foregoing and that I understand its contents. My questions have been answered to my satisfaction and I acknowledge receipt of a copy of this form.

_____ _____

Signature *Date*

_____

Print Name

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(917) 650-9361
NYS Lic# 002334

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*I, _____, hereby consent to be treated with acupuncture administered by Alfred F. Blair, L.Ac., Dipl. Ac.**

I understand that acupuncture is performed by the insertion of special needles through the skin, with or without the addition of heat or electrical stimulation, to certain points on the body with the intent of improving bodily functions and/or relieving pain. I further understand that only pre-sterilized disposable needles will be used in my treatments.

I understand that certain side effects may result from acupuncture. These could include some pain or discomfort, localized bleeding and/or bruising, weakness, fainting, nausea, and the possible temporary aggravation of symptoms that existed prior to treatment.

I accept the fact that no guarantee is made concerning the outcome of my acupuncture treatments, and I understand that I may stop treatment at any time.

I certify that all my questions have been answered.

_____ _____
Signature of Patient (or guardian) *Date*

_____ _____
Date of Birth *Witness*

**L.Ac. Licensed Acupuncturist, State of New York*
Dipl.Ac. Diplomate in Acupuncture, National Commission for the Certification of Acupuncture