Manhattan Sports Acupuncture

MANHATTAN SPORTS ACUPUNCTURE

DATE: _____

PATIENT INFORMATION

Name: _____ Gender: _____

Age: _____ Date of Birth: _____

Home Address: _____

_____

Home Phone: _____ Cell: _____ Work Phone: _____

Email: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone number: _____

Primary Care Physician (PCP): _____ PCP Phone: _____

Date of last medical examination: _____

Occupation: _____

I. EXPERIENCE WITH ACUPUNCTURE

- Have you received acupuncture treatment before? YES NO
- If yes, for what conditions and what was the outcome?

II. DESCRIPTION OF MAJOR COMPLAINTS

A. What are your main complaints?

1. Primary Complaint: _____
2. Secondary Complaint: _____

B. Please describe your goals, hopes and expectation for your acupuncture treatment

C. PRIMARY COMPLAINT:

Please answer the following questions focusing on your Primary Complaint ONLY:

1. **Briefly explain history of your Primary Complaint, i.e. how long have you had this condition; was the onset SUDDEN or GRADUAL; was there a significant event that lead to this condition?**

2. **Have you seen a physician (or other primary care provider) for your Primary Complaint? If yes, when and what diagnosis did you receive?**

3. **Other Care: what other therapies are you doing/ have you done to manage your Primary Complaint, e.g. physical therapy, medication, chiropractic, etc.? Did these/ are these other therapies helping?**

D. SECONDARY COMPLAINT:

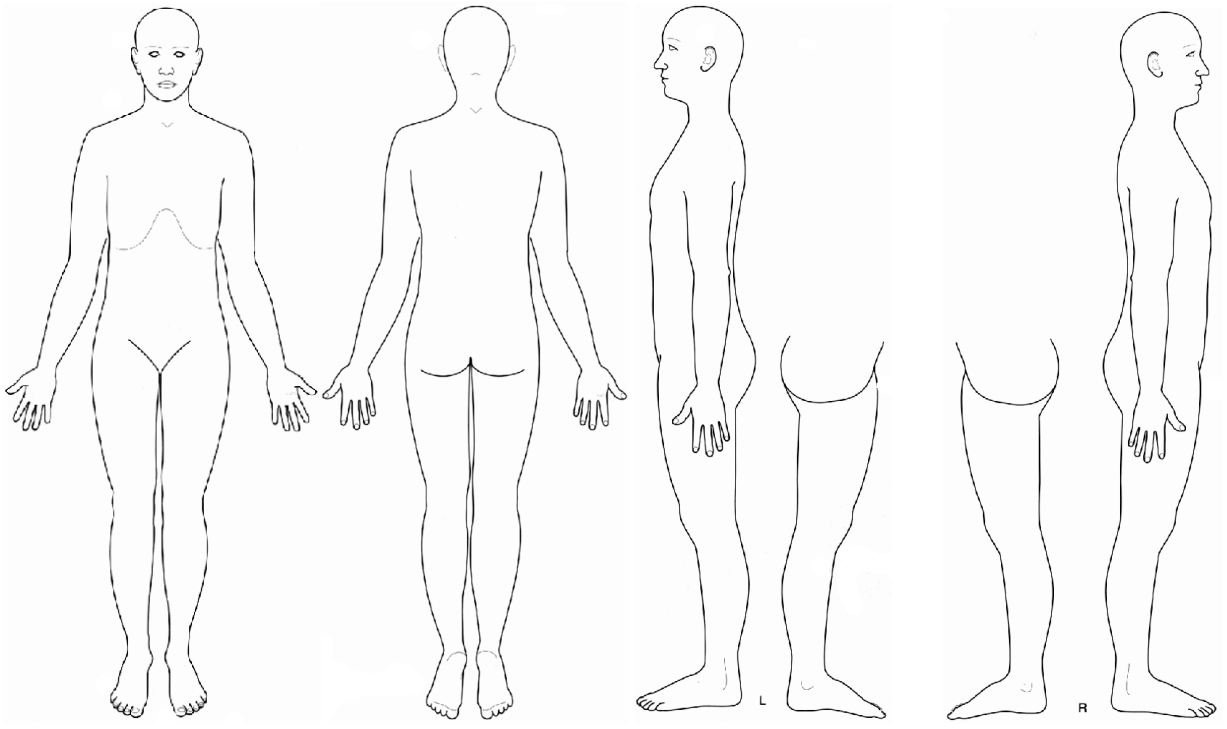
Please answer the following questions focusing on your Secondary Complaint ONLY:

1. **Briefly explain history of your Secondary Complaint, i.e. how long have you had this condition; was the onset SUDDEN or GRADUAL; was there a significant event that lead to this condition?**

2. **Have you seen a physician (or other primary care provider) for your Secondary Complaint? If yes, when and what diagnosis did you receive?**

3. **Other Care: what other therapies are you doing/ have you done to manage your Secondary Complaint, e.g. physical therapy, medication, chiropractic, etc.? Did these/ are these other therapies helping?**

E. On the diagram, please shade in the areas where you feel symptoms associated with your complaints. PLEASE NUMBER THE COMPLAINTS (Primary Complaint = #1; Secondary Complaint = #2):



III. MEDICATIONS, SUPPLEMENTS AND HERBS

Please list all medications, (prescriptions and over-the-counter drugs) supplements and/or herbs you are **CURRENTLY** taking:

Medications, supplements, or herbs:	*Indication/For treatment of:*
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

LIST ANY ALLERGIES (to medications, supplements, herbs):

_____

IV. PERSONAL MEDICAL HISTORY

II. **BIRTH:** Describe anything significant/traumatic about your birth:

III. **VACCINATION HISTORY:** Any unusual reaction? Any unusual vaccination?

IIII. **CHILDHOOD ILLNESSES (0-12 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

IIV. **ADOLESCENCE ILLNESSES (13-17 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

IV. **ADULTHOOD ILLNESSES (18 – 35 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

IVI. **ADULTHOOD ILLNESSES (36 & up):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

V. FAMILY MEDICAL HISTORY

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

MOTHER _____
FATHER _____
SIBLINGS _____
MATERNAL GRANDPARENTS _____
PATERNAL GRANDPARENTS _____

VI. SYMPTOM OVERVIEW BY SYSTEM

Please check all symptoms that you are CURRENTLY experiencing AND/OR experience FREQUENTLY. Please indicate (by circling) if the symptom is acute, chronic or experienced frequently.

- A = Acute (under 3 months)
- C = Chronic (over 3 months—experience at some point most days)
- F = Experience frequently (on & off)

MUSCULOSKELETAL

☐ A C F Joint clicking
☐ A C F Limitation of movement
☐ A C F Stiffness
☐ A C F Spasms or cramps
☐ A C F Swelling
☐ A C F Weakness
☐ A C F Pain: Full body
☐ A C F Pain: Facial (e.g. jaw)
☐ A C F Pain: Neck
☐ A C F Pain: Upper Back
☐ A C F Pain: Mid Back
☐ A C F Pain: Low Back
☐ A C F Pain: Shoulder
☐ A C F Pain: Elbow
☐ A C F Pain: Wrist
☐ A C F Pain: Hand
☐ A C F Pain: Hip
☐ A C F Pain: Knee
☐ A C F Pain: Ankle
☐ A C F Pain: Foot
☐ A C F OTHER (Please list)

_____
_____

EYES, EARS, NOSE & THROAT

☐ A C F Loss of vision
☐ A C F Eye pain
☐ A C F Tearing or eye dryness
☐ A C F Eye discharge
☐ A C F Eye redness
☐ A C F Ear discharge
☐ A C F Ear itching
☐ A C F Ear pain &/or infections
☐ A C F Loss of hearing
☐ A C F Ringing or buzzing in ears
☐ A C F Problems with balance (vertigo)
☐ A C F Olfaction (sense of smell) impaired
☐ A C F Nose obstruction (stuffiness)
☐ A C F Nose bleeds
☐ A C F Sinus pain, pressure &/or infections
☐ A C F OTHER (Please list)

_____
_____

RESPIRATORY

☐ A C F Chest pain &/or tightness
☐ A C F Bluish discoloration of skin
☐ A C F Cough
☐ A C F Coughing up blood (hemoptysis)
☐ A C F Shortness of breath (dypsnea)
☐ A C F Sore throat
☐ A C F Sputum production
☐ A C F Voice changes
☐ A C F Wheezing
☐ A C F OTHER (Please list)

_____
_____

CARDIOVASCULAR

☐ A C F Changes in skin temperature & color
☐ A C F Chest pain &/or pressure
☐ A C F Edema
☐ A C F Fainting (syncope)
☐ A C F Fatigue
☐ A C F Palpitations
☐ A C F Skin ulceration
☐ A C F Swelling of the ankles &/or legs
☐ A C F OTHER (Please list)

_____
_____

DIGESTIVE

☐ A C F Abdominal distention/bloating
☐ A C F Abdominal mass
☐ A C F Abdominal pain
☐ A C F Acid regurgitation &/or Heartburn
☐ A C F Alternating constipation/diarrhea
☐ A C F Rectal bleeding
☐ A C F Constipation
☐ A C F Diarrhea
☐ A C F Gas
☐ A C F Eating disorder
☐ A C F Indigestion
☐ A C F Jaundice (yellow tint to skin &/or eyes)
☐ A C F Nausea
☐ A C F Vomiting
☐ A C F OTHER (Please list))

_____
_____

UROGENITAL

- ☐ A C F Difficulty with urine flow
- ☐ A C F Incontinence
- ☐ A C F Painful urination (dysurea)
- ☐ A C F Rashes
- ☐ A C F Red urine
- ☐ A C F Urinary tract infection (UTI)
- ☐ A C F OTHER (Please list)

_____

_____

NEUROLOGICAL

- ☐ A C F Changes in consciousness
- ☐ A C F Confusion
- ☐ A C F Difficulty concentrating
- ☐ A C F Dizziness
- ☐ A C F Dysphasia (impaired ability to speak)
- ☐ A C F Gait disturbance
- ☐ A C F Headache
- ☐ A C F Numbness and/or tingling
- ☐ A C F Loss of consciousness
- ☐ A C F Paralysis
- ☐ A C F Post shingles pain
- ☐ A C F Problems coordinating movements
- ☐ A C F Severe forgetfulness
- ☐ A C F Tremor
- ☐ A C F Visual disturbance
- ☐ A C F Weakness
- ☐ A C F OTHER (Please list)

_____

_____

INTEGUMENTARY (SKIN)

- ☐ A C F Changes in hair
- ☐ A C F Changes in nails
- ☐ A C F Changes in skin color
- ☐ A C F Itching (prurites)
- ☐ A C F Never sweat
- ☐ A C F Rash and/or skin lesion
- ☐ A C F Unusual sweating
- ☐ A C F Wounds that will NOT heal
- ☐ A C F OTHER (Please list)

_____

_____

PSYCHOLOGICAL

- ☐ A C F Feelings of grief
- ☐ A C F Feeling of sadness
- ☐ A C F Feeling fearful/anxious/nervous
- ☐ A C F Difficulty managing anger
- ☐ A C F Feeling manic
- ☐ A C F Feeling worried or overly pensive
- ☐ A C F Feelings of panic
- ☐ A C F Feeling overwhelmed
- ☐ A C F Extreme mood swings
- ☐ A C F Extreme lack of emotion
- ☐ A C F OTHER (Please list)

_____

_____

SLEEP

- ☐ A C F Difficulty falling asleep
- ☐ A C F Dream disturbed sleep
- ☐ A C F Wake up & cannot fall back asleep
- ☐ A C F OTHER (Please list)

_____

_____

MISCELLANEOUS

- ☐ A C F Extremely low energy/fatigue
- ☐ A C F OTHER (Please list)

_____

_____

FOR WOMEN ONLY

- ☐ A C F Abnormal vaginal bleeding
- ☐ A C F Changes in hair distribution
- ☐ A C F Fertility concerns
- ☐ A C F Irregular menstruation
- ☐ A C F Menopausal symptoms
- ☐ A C F No menses
- ☐ A C F Pain with menses (dysmenorrhea)
- ☐ A C F Pain during or after sexual relations
- ☐ A C F Pelvic pain
- ☐ A C F Premenstrual symptoms
- ☐ A C F Sexual dysfunction
- ☐ A C F Unusual discharge
- ☐ A C F OTHER (Please list)

_____

_____

Are you pregnant OR trying to become pregnant?
YES NO

Have you ever been pregnant? YES NO If yes, how many pregnancies: _____

Births _____
Miscarriages _____
Abortions _____

FOR MEN ONLY

- ☐ A C F Fertility concerns
- ☐ A C F Prostate problems
- ☐ A C F Sexual dysfunction
- ☐ A C F Unusual discharge
- ☐ A C F OTHER (Please list)

_____

_____

VII. MEDICAL DISEASES/CONDITIONS. **Please check all that apply AND indicate (by circling) if it is chronic or if you had the problem in the past, but is now resolved.**

- C = Current condition
- P = Past condition, but is now resolved.

☐ C P AIDS/HIV
☐ C P Alcoholism &/or substance addiction
☐ C P Allergies (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P Anemia
☐ C P Asthma
☐ C P Bell's Palsy
☐ C P Blood clotting disorder (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P Bipolar disorder
☐ C P Cancer (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P Chron's Disease &/or colitis
☐ C P Chronic Fatigue Syndrome (CFIDS)
☐ C P Depression (Major)
☐ C P Diabetes
☐ C P Eczema
☐ C P Endometriosis
☐ C P Fibroids
☐ C P Infertility
☐ C P Lung disease, e.g. COPD (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P Fibromyalgia
☐ C P Gallstones
☐ C P Heart disease (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P Hepatitis A / B / C
☐ C P Hernia
☐ C P Herpes
☐ C P Hypertension
☐ C P Hypoglycemia
☐ C P Irritable Bowel Syndrome (IBS)
☐ C P Joint Replacement (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P Kidney Stones and/or Disease (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P Lupus
☐ C P Lyme Disease
☐ C P Lymph node removal
☐ C P Mitral valve prolapse
☐ C P Mood Disorder
☐ C P Mononucleosus
☐ C P Multiple Sclerosis
☐ C P Organ removal or transplant (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P Osteoarthritis
☐ C P Osteoporosis
☐ C P Pacemaker (heart or stomach)
☐ C P Parkinson's Disease
☐ C P Pelvic Inflammatory Disease
☐ C P Polio
☐ C P Psoriasis
☐ C P PTSD (Post-Traumatic Stress Disorder)
☐ C P Reflux esophagistis (GERD)
☐ C P Rheumatic fever
☐ C P Rheumatoid arthritis
☐ C P Scarlet Fever
☐ C P Schizophrenia
☐ C P Scoliosis
☐ C P Seizures and /or epilepsy
☐ C P Shingles
☐ C P Sleep Disorder
☐ C P Stroke
☐ C P Schizophrenia
☐ C P Thyroid disease (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P Ulcer
☐ C P Trigeminal Neuralgia
☐ C P Tuberculosis
☐ C P Vascular disease (e.g. phlebitis) (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P OTHER (pls list)

_____
_____

VII. LIFESTYLE INFORMATION

A. Stress, Energy Level & Sleep

1. Do you think that stress, including recent major life changes, is contributing to your main complaints and/or negatively impacting any other aspect of your physical or mental health? If yes, briefly describe:

2. Do you have any problems with your energy level? If yes, please briefly describe:

3. Do you have any problems with sleep? If yes, please briefly describe:

4. Do you have any problems with your sexual drive? If yes, please briefly describe:

B. Smoking, Alcohol & Drugs

1. Do you smoke tobacco? YES NO If yes, do you believe that this is a problem for you?

2. Do you drink alcohol? YES NO If yes, do you believe that this is a problem for you?

3. Do you use recreational drugs and/or prescription medications that your physician does not know about? YES NO Do you believe that this is a problem for you?

C. Diet and Nutrition

1. If applicable, briefly describe any problems you think you have with your eating habits and appetite. Do you believe that your diet has any impact on your complaints? YES NO

2. Are you concerned about your weight and/or appetite (under or overweight, too much or too little appetite)? YES NO

VIII. LIFESTYLE COUNSELING OPTION

Would you be interested in developing an acupuncture treatment plan that includes helping you with lifestyle issues?

MANHATTAN SPORTS ACUPUNCTURE

Notice of Privacy Practices

This notice describes how health information about you may be used, disclosed and hoe you can get access to this information.

Respect for patient privacy is highly valued in this practice. As required by law, we will protect the privacy of your health information that may reveal your identity.

Use and Disclosure of Your Protected Health Information

We will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment for treatments received, and conduct clinical operations. This general written consent will be obtained the first time you receive services. This general written consent is a broad permission that does not have to be repeated each time you receive services from Manhattan Sports Acupuncture.

Uses and Disclosures

We use health information about you for treatment, to obtain payment for treatments, for administrative purposes and to evaluate the quality of care you receive. Outside of these instances, we will ask you for your written authorization before using or disclosing any identifiable health information about you.

Your Rights

In most cases, you have the right to look at or get a copy of health information about you at the clinic. You also have the right to receive a list of certain types of disclosures of your information we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. You can find a copy of this notice at anytime. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:

Edd Lee, MS LAc LMT
Manhattan Sports Acupuncture
347-948-3533
edd@ManhattanSportsAcupuncture.com

By voluntarily signing below, I show that I have read, or have had read to me, and the Notice of Privacy Practices, have been told I can find a copy of this document online at XXX, been give the Privacy Officer's contact information and have had the opportunity to ask questions.

Patient Signature X

MANHATTAN SPORTS ACUPUNCTURE

Informed Consent to Treat

I hereby request and consent to the performance of acupuncture and other procedures within the scope of the practice of acupuncture on me (or on the person named below, for whom I am legally responsible) by the acupuncturists indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risk may occur. The herbs and the nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all the possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above 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 over the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature X