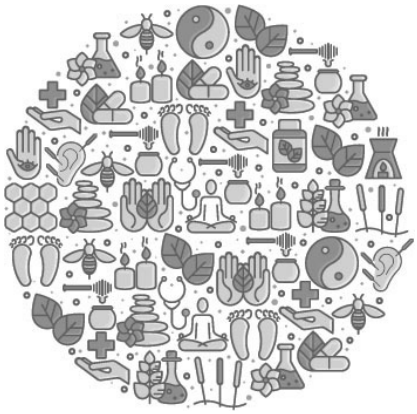


NAN YI CHUN | ACUPUNCTURE

Name: _____ Date: _____

Address: _____

Date of Birth: _____ Age: _____ Place of Birth: _____

Cell Phone: _____ Work Phone: _____ E-mail: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Relationship: _____

Address: _____

Cell Phone: _____ Work Phone: _____ E-mail: _____

MARITAL STATUS

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Living common-law
- ☐ Same Sex Relationship
- ☐ SEPARATED

Highest level of education attained: _____

ETHNIC BACKGROUND

- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Hispanic / Latino
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White
- ☐ Other_____

INSURANCE

- ☐ ACN (w/discount)
- ☐ CIGNA
- ☐ AETNA
- ☐ Oxford Freedom / HP (w/discount)
- ☐ BCBS
- ☐ UHC

HOW DID HEAR ABOUT US?

- ☐ Colleagues
- ☐ Family
- ☐ Friends
- ☐ Google
- ☐ New York City Research
- ☐ Yelp
- ☐ Other_____

Name: _____ Date: _____

List the names of any medications you are currently taking:

_____

_____

_____

_____

List any mediations allergies you have:

_____

_____

_____

_____

Please check any current conditions or those that you have had in the past.

PERSONAL HEALTH

- ☐ Allergies
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Drug Allergies
- ☐ Frequent/Server Headache
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disorder
- ☐ Musculoskeletal Disorder
- ☐ Organ Transplants
- ☐ Seizures
- ☐ Skin Disorder
- ☐ Stomach / Internal Disorder
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Transfusion-prior to 1985
- ☐ Tuberculosis
- ☐ Urinary Trace Disorder
- ☐ Other_____

CARDIOVASCULAR

- ☐ Chest Pain or Tightness
- ☐ Palpitation
- ☐ Phlebitis
- ☐ Poor Circulation
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Other_____

GASTROINTESTINAL

- ☐ Blood in Stool / Black Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Food Cravings / Addiction
- ☐ Gallbladder Removal / Disorder
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Recent Change in Weight
- ☐ Stomach Pain
- ☐ Vomiting Blood
- ☐ Other_____

GENERAL

- ☐ Agitation
- ☐ Aversion to Cold
- ☐ Fatigue
- ☐ Frequent Dreams / Nightmares
- ☐ Frequent urination
- ☐ Insomnia
- ☐ Irritability
- ☐ Thirst
- ☐ Other _____

Name: _____ Date: _____

RESPIRATORY

- ☐ Chronic Cough
- ☐ Coughing up Blood
- ☐ Coughing up Phlegm
- ☐ Difficulty Breathing
- ☐ Frequent Cold
- ☐ Wheezing / Asthma
- ☐ Other_____

EARS

- ☐ Decrease / Loss hearing
- ☐ Ringing
- ☐ Infection
- ☐ Other _____

EYES

- ☐ Blurred Vision
- ☐ Eye infection / Inflammation
- ☐ Poor Night Vision
- ☐ Spots
- ☐ Visual Changes
- ☐ Other _____

HEAD / NECK

- ☐ Dizziness
- ☐ Enlarged Lymph Glands
- ☐ Fainting
- ☐ Headaches / Migraine
- ☐ Neck Stiffness
- ☐ Other _____

NOSE / THROAT /MOUTH

- ☐ Bleeding
- ☐ Changes in Taste
- ☐ Difficulty Swallowing
- ☐ Hay Fever / Allergies
- ☐ Hoarseness
- ☐ Oral Ulcers
- ☐ Sinus Infection
- ☐ Sore throat
- ☐ Other _____

FEMALE

- ☐ Abnormal Bleeding
- ☐ Abnormal Pap Smear
- ☐ Breast Lumps
- ☐ Frequent Vaginal Infection
- ☐ Frequent UTI
- ☐ Genital Lesions / Discharge
- ☐ Irregular Periods
- ☐ Pelvic Inflammatory Disease
- ☐ Pain / Itching of Genitals
- ☐ Painful Menstrual Periods
- ☐ Premenstrual Syndrome
- ☐ Menopausal Symptoms
- ☐ Other _____

☐ Pregnancy / Number of Children _____ / Last Pregnancy: Month _____ Year_____

☐ Abortion / Number of Abortions _____ / Last Abortion: Month _____ Year_____

MALE

- ☐ Genital Lesions / Discharge
- ☐ Impotence
- ☐ Lump in Testicles
- ☐ Pain / Itching of Genitals
- ☐ Weak Urinary System
- ☐ Other _____

INFECTION SCREENING

- ☐ Clamydia: Self / Partner
- ☐ Genital Warts: Self / Partner
- ☐ Gonorrhea: Self / Partner
- ☐ Herpes: Oral / Genital: Self / Partner
- ☐ HIV: Self / Partner / Pos. / Neg.
- ☐ Hepatitis: Self / Partner / Pos. / Neg.
- ☐ Syphilis: Self / Partner
- ☐ TB: Self / Partner / Pos. / Neg.

MUSCLE / JOINT

- ☐ Back Pain (Upper / Mid / Lower)
- ☐ Difficulty Walking
- ☐ Hives
- ☐ Joint Disorder
- ☐ Sciatica
- ☐ Sore Muscle
- ☐ Spinal Curvature
- ☐ Rashes
- ☐ Weak Muscle
- ☐ Other _____

NEUROLOGICAL

- ☐ Numbness or Tingling of Limbs
- ☐ Pain
- ☐ Paralysis
- ☐ Seizures
- ☐ Tremors
- ☐ Other _____

Name: _____ Date: _____

MENTAL

☐ Anxiety ☐ Depression ☐ Schizophrenia
☐ Bipolar ☐ Panic Attack ☐ Other _____

☐ Have you ever been treated for psychiatric treatment or hospitalized? Please specify _____

☐ Have you ever been prescribed for the symptoms? Please specify _____

SKIN

☐ Bruise Easily ☐ Eczema ☐ Other_____
☐ Changes in Moles or Lumps ☐ Hives
☐ Dryness ☐ Rashes

HABIT: Please check any of the habits below which apply to you now or in the past.

☐ Use of Tobacco:
_____# of Cigarettes per day / _____#of pack per day / _____ Age began smoking / Stopped_____ Years / Months ago

☐ Use of Marijuana:
_____Use per day / _____ Age began smoking / Stopped_____ Years / Months ago

☐ Use of Alcohol:
_____# of drinks per week / _____ Age began drinking / Stopped_____ Years / Months ago

☐ Use of Caffeine:
_____# of Coffee per day / _____ # of Tea per day / _____ # of Colas per day / Stopped_____ Years / Months ago

☐ Use of Crack or Cocaine:
Please specify frequency: _____ / Stopped _____ Years / Months ago

☐ Use of Street Drugs:
Please specify drugs and frequency: _____ / Stopped_____ Years / Months ago

Post Medical History: Hospitalization and Surgeries

Please write in your most recent hospitalization or surgeries. Do not include normal pregnancies.
Reason / Diagnosis / Procedure Month / Year

_____

_____

_____

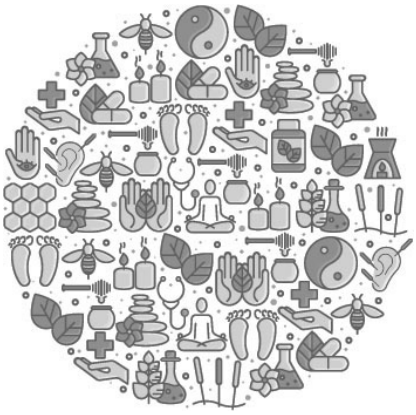
_____

_____

_____

_____

_____



NAN YI CHUN | ACUPUNCTURE

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with Traditional Oriental Medicine by the Licensed Acupuncturist named below. I discussed the nature and propose of my treatment with this person.

I understand that methods of treatment may include but are not limited to: acupuncture, moxabustion, cupping, guasha, electrical stimulation and Tui Na(Chinese massage).

I have been informed that acupuncture is a safe method of treatment, but that is may have side effects, including bruising, numbness and tingling near to needling sites that may last a few days, and dizziness or fainting, nerve damage and organ puncture, including lung puncture (Pneumothorax). Infection is another possible risk, although this clinic uses sterile, disposable needle and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxabustion.

I understand that while this document describes that major risks of treatment, other side effects and risks may occur.

The herbs which may be recommended are traditionally considered safe, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of talking practitioner on any unanticipated or unpleasant side effects associated with the consumption of herbs.

I will notify my practitioner if I become pregnant. I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on my practitioner to exercise judgment during the courses of treatment which the practitioner thinks at the time, based upon the facts known to her, is in my best interests.

_____ _____

Print Name of Patient Signature of Patient

_____

Date Consent Completed

CANCELLATION POLICY

I understand that I will be CHARGED for missed or short notice appointment that was not cancelled within 24 hours.

I understand that my insurance will be CLAIMED for missed or short notice appointment that was not cancelled within 24 hours.

_____

Patient Signature