

Patient Intake Form Iris Netzer, L.Ac.

Midtown East
201 East 56th St.
(Inform Fitness)
NY, NY 10022
917-744-4403

Name (last, first) _____ **Date** _____

Address _____

City / State / Zip _____

Home phone _____ **Work Phone** _____

Cell Phone _____ **Email** _____

Occupation _____ **Birth Date** _____

Emergency contact _____

(name & phone)

Referred by _____

___ Single ___ Married ___ Divorced ___ Significant Other ___ Widowed

___ Caregiver for dependent Number of Children _____

Have you ever had acupuncture? _____ If yes, when? _____

For what condition? _____

Are you currently under the care of a physician? _____ If so, who, _____

For what condition(s)?

Main reason(s) for seeking acupuncture

How long have you experienced symptoms? _____



Your condition is improved by _____

Your condition is aggravated by _____

List all current medications, prescribed or over the counter _____

List all current vitamins, herbs and other supplements _____

Significant illnesses (please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> HIV / Aids | <input type="checkbox"/> Obesity | <input type="checkbox"/> Other _____ |

Please list any surgeries you've had including dates _____

Please list any Allergies _____

Please list any major emotional or physical traumas you've experienced

Lifestyle (please check all that apply, and note frequency of use)

- Tobacco
- Alcohol
- Recreational drugs
- Caffeinated beverages

Do you exercise? _____ Please list types of activity and frequency

Dietary preferences

- | | | |
|--|---|---|
| <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Fish / seafood | <input type="checkbox"/> Salty |
| <input type="checkbox"/> Vegan | <input type="checkbox"/> Red meat | <input type="checkbox"/> Cold drinks |
| <input type="checkbox"/> Raw foods diet | <input type="checkbox"/> Artificial sweeteners | <input type="checkbox"/> Hot drinks |
| <input type="checkbox"/> Low fat diet | <input type="checkbox"/> Fast food/ burgers/fries | <input type="checkbox"/> Ice chewing |
| <input type="checkbox"/> High protein/low carb | <input type="checkbox"/> Spicy / hot | <input type="checkbox"/> Extreme thirst |
| <input type="checkbox"/> Dairy /milk /cheese | <input type="checkbox"/> Sweet | <input type="checkbox"/> Thirst with no desire to drink |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Sour | |
| <input type="checkbox"/> Chicken | | |

General symptoms

- | | | |
|---|--|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Bleed / bruise easily |
| <input type="checkbox"/> Sweat without exertion | <input type="checkbox"/> Fever / chills | <input type="checkbox"/> Low immunity |
| | <input type="checkbox"/> Dizziness / vertigo | <input type="checkbox"/> Other _____ |

Digestion

- | | | |
|---|---|---|
| <input type="checkbox"/> Extreme appetite | <input type="checkbox"/> Bloating | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> No appetite | <input type="checkbox"/> Gas | <input type="checkbox"/> Bulimia |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Irritability or low energy between meals |
| <input type="checkbox"/> Dieting | <input type="checkbox"/> Heartburn/Ulcers | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Tired after eating | <input type="checkbox"/> Nausea | |

How many meals per day? _____ How many snacks per day? _____

Intestinal

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Mucous in stool | <input type="checkbox"/> IBS |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Anal fissures | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Intestinal pain/cramping | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Anal itching / burning | <input type="checkbox"/> Incomplete evacuation | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Laxative use | | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bloody stool | | |

Sleep

- | | |
|---|---|
| <input type="checkbox"/> Fall asleep easily | <input type="checkbox"/> Vivid or Lucid Dreams |
| <input type="checkbox"/> Lie in bed with eyes open | <input type="checkbox"/> Wake up not feeling rested |
| <input type="checkbox"/> Wake at specific times | <input type="checkbox"/> Nightmares or frightening dreams |
| <input type="checkbox"/> Wake repeatedly | <input type="checkbox"/> Need drugs or supplements to fall asleep |
| <input type="checkbox"/> Wake frequently to urinate | |

Head, Eyes, Ears, Nose and Throat

- | | |
|---|--|
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Spots / flowery vision | <input type="checkbox"/> Post-nasal drip |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Tinnitus / ringing |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Deafness |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Nosebleed |
| <input type="checkbox"/> Sores on tongue or mouth | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dry mouth | |
| <input type="checkbox"/> Excess saliva | |

Cardiovascular / respiratory

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Heart valve abnormality | <input type="checkbox"/> Difficult inhalation |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficult exhalation |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Cold hands / feet | <input type="checkbox"/> Productive cough (color of phlegm?) |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Dry cough | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Wheezing | |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Chest tightness | |
| <input type="checkbox"/> Swollen ankles | | |

Skin / hair

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Pimples / acne | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Rashes / hives | <input type="checkbox"/> Fungal infections | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Brittle nails | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Ridged nails | |

Musculoskeletal

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Spinal pain | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Vertebral disc degeneration | <input type="checkbox"/> Carpal tunnel |
| <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Swelling | | |
| <input type="checkbox"/> Arthritis | | |

Neuropsychological

- Anxiety
- Irritability
- Insomnia
- Depression
- Easily stressed
- Poor memory
- Seasonal mood disorder
- Tics
- Tremors
- Death of someone close
- Job stress
- Recent divorce
- Currently in therapy
- Financial setback
- Other _____

Emotional stress scale

1 2 3 4 5 6 7 8 9 10
 no stress moderate extremely stressed

Rate your stress level regarding

- Work _____
- Health _____
- Love _____
- Money _____
- Family _____
- The future _____
- General _____

Genito-urinary

- Frequent urination
- Loss of urine when laughing or sneezing
- Incomplete urination / retention
- Dribbling
- Burning urination
- Blood in urine
- Wake frequently to urinate
- Kidney stones
- Bedwetting
- Decreased libido / sexual desire
- Impotency
- Infertility
- Other _____

Men only

- Prostate problems
- Erectile dysfunction
- Herpes

Women only

Age menses began _____

Age menses ended (if applicable) _____

Date of last ob/gyn exam _____

Hysterectomy? ___ partial ___ full
 ___ hormone replacement therapy

Headaches ___ before menstrual cycle ___ during cycle ___ after cycle

- | | |
|---|--|
| <input type="checkbox"/> Abortion(s) | <input type="checkbox"/> STD history (chlamydia, PID, etc) |
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Fibrocystic breast |
| <input type="checkbox"/> Live births | <input type="checkbox"/> Pain at ovulation |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Cramps / low back pain |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Acne associated with period |
| <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Constipation or diarrhea associated with period |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Emotional irritability or depression associated with period |
| <input type="checkbox"/> Candida / yeast | <input type="checkbox"/> Bleeding outside of regular menstrual cycle |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> No period / skipped cycles |
| <input type="checkbox"/> Vaginal odor | <input type="checkbox"/> Irregular cycle |
| <input type="checkbox"/> Vaginal sores | |
| <input type="checkbox"/> Herpes | |
| <input type="checkbox"/> Human Papilloma Virus positive | |

Period lasts _____ days Usual number of days between periods _____

Menstrual flow

- | | |
|--|---|
| <input type="checkbox"/> Clotting | <input type="checkbox"/> Normal red |
| <input type="checkbox"/> Brownish | <input type="checkbox"/> Flooding and trickling |
| <input type="checkbox"/> Watery, thin and bright red | <input type="checkbox"/> Stop and start flow |

If you have been evaluated for infertility, what was your diagnosis?



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Acupuncture is NOT a substitute for conventional medical diagnosis and treatment.

Techniques commonly employed in the application of acupuncture:

- Acupuncture needling – treatment will consist of the insertion of sterile disposable needles at specific sites on the body. Stimulation of said needles may be by manipulation, electrical stimulation or the application of warming substances (moxa) on the needle itself.
- Auxiliary / Associated therapies – massage, assisted stretching, topical application of liniments

There is no guarantee that acupuncture will help any condition. Certain medications and social habits may decrease the beneficial effects of acupuncture. These include the use and abuse of alcohol, tobacco, steroids, painkillers, narcotics, stimulants, antidepressants, psychopharmaceuticals and illegal drugs.

I, _____, certify that I have read and understood
(Print Name)
the statements above. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her updated on any changes.

Signature: _____ Date: _____



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Payments can be made by Visa, Master Card, American Express, Discover, check or cash. Make checks payable to Acupuncture Remedies, P.C.. Full payment is expected at the time the services are rendered. There are no refunds for unused package sessions. All sales are final.

Explanation of Insurance Coverage: Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

A \$20 charge for the first check returned by the bank. If a second check is returned, subsequent payments must be money order or cash.

If you must cancel your appointment, call as soon as possible to give Iris a chance to rebook your time slot. You must call before 5:00 pm the day before your appointment or else you will be charged in full for your cancelled appointment. Exceptions can be made for medical emergencies.

If you miss an appointment, you will be charged for it.

I, _____, certify that I have read and understood
(Print Name)
the statements above and agree to abide by them.

Signature: _____ Date: _____