Scarsdale Acupuncture
Licensed Acupuncturists and Herbalists

531 Central Park Avenue, Suite 304
Scarsdale, New York 10583

928 Broadway, Suite 1200
New York, New York 10019

Patient Health History

Today's date ____/____/____

Thank you for taking the time to complete the following information, which will better help us to access your health needs. All information is confidential. We will be happy to answer any questions you may have.

Name _____ Age _____ Birth date ____/____/____ Gender _____

Address _____ City _____ State _____ Zip _____

Home ph _____ Cell ph _____ Work ph _____ Email _____

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partnership ☐ Referred by _____

Emergency contact _____ Relationship _____

Emergency contact home phone _____ Work phone _____

Physician's name _____ Phone _____

Physician's address _____ Date of last visit ____/____/____

Employment - Please check all that apply.

Full-time ☐ Part-time ☐ Student ☐ Unemployed ☐ Retired ☐ Occupation _____

Employer's name _____ Phone _____

Employer's address _____

Payment

Payment in full is due at the time services are rendered. Upon request a Superbill can be provided for you to submit directly to your insurance company to seek reimbursement for payments made.

Medicines, Herbs, and Supplements – Check any medicine you are currently taking.

Aspirin ☐ Ibuprofen/Advil/Motrin ☐ Acetaminophen (Tylenol) ☐ Antacids ☐ Diet pills ☐ Laxatives ☐ Insulin ☐

Sleeping pills ☐ Allergy medication ☐ Blood thinners ☐ Blood pressure pills ☐ Oral contraceptives ☐

Tranquilizers ☐ Anti-depressants ☐ Other ☐ Please list drug names _____

Herbs _____ Supplements/Vitamins _____

Medication allergies _____ Food allergies _____

Please describe your typical daily diet:

Breakfast _____ Morning snack _____

Lunch _____ Afternoon snack _____

Dinner _____ Evening snack _____

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Have you ever had acupuncture before? Yes ☐ No ☐ If yes, for what condition?_____

_____

Are you presently being treated for a medical condition? Yes ☐ No ☐ Please describe._____

_____

What treatment have you been using for relief of this issue?_____

Do you smoke cigarettes? Yes ☐ No ☐ Length of time?_____ Amount? _____

Did you quit? Yes ☐ No ☐ Year quit?_____

Please indicate amount per day/week consumed of the following: Alcohol _____ Coffee _____

Soda_____ Black tea _____ Green Tea _____

Family History - Place an X in the appropriate box indicating condition for each family member:

	Self	Mother	Father	Sister	Brother	Spouse	Child		Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies/asthma	☐	☐	☐	☐	☐	☐	☐	Drug abuse	☐	☐	☐	☐	☐	☐	☐
Blood disorder/anemia	☐	☐	☐	☐	☐	☐	☐	Alcohol abuse	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	Heart disease	☐	☐	☐	☐	☐	☐	☐
Cancer /tumors	☐	☐	☐	☐	☐	☐	☐	Stroke	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	Depression	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	Mental condition	☐	☐	☐	☐	☐	☐	☐
Kidney disease/stone	☐	☐	☐	☐	☐	☐	☐	Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Stomach/intestinal	☐	☐	☐	☐	☐	☐	☐	Age at death		___	___	___	___	___	___

List any illnesses in your immediate family (mother, father, siblings, grandparents)._____

_____

_____

Please list any serious diseases, hospitalizations, injuries, accidents or surgeries you have had and give approximate dates (if you need more space, use back)._____

_____

_____

_____

Describe your current program of fitness. _____

_____

What are your goals for your health? _____

_____

Total # pregnancies _____ Living_____ Abortions_____ Miscarriages _____ Ectopic_____

Have you been outside the U.S. in the past 12 months: Yes ☐ No ☐ Where? _____