Joy Lindquist, MS, L.Ac.
401 Court Street, Brooklyn, NY 11231

YOUR CONTACT INFORMATION:

Name: ______________________________ Date: ____________________

Address: ______________________________ GENDER: Male_____ Female_____

______________________________ Zip: ________ Date of Birth: ____________________

Home Phone: ______________________________ Work Phone: ____________________

Email Address: ______________________________ Mobile Phone: ____________________

EMERGENCY CONTACT:

Name: ______________________________ Phone: ____________________

Relationship: ______________________________

REFERRED BY: Website_____ Friend/Relative_____ Walk-In _____ Other______________________________

REASON FOR VISIT TODAY: ______________________________

____

PLEASE INDICATE FAMILY HEALTH HISTORY:

Health Condition	**Father**	**Mother**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**
Allergies/Hayfever						
Asthma						
Blood Disorder/Anemia						
Diabetes – Juvenile						
Diabetes – Adult Onset (Type 2)						
Depression/Anxiety						
Cancer/Tumors						
Seizure Condition						
High Blood Pressure						
High Cholesterol						
Kidney/Bladder Disorder						
Stomach/Intestinal Disorder						
Substance Abuse/Alcoholism						
Rheumatoid Disease						
Heart Disease or Disorder						
Lung Disease						
Stroke						

Please explain any other family health condition that is of concern to you:

____

____

HOSPITALIZATIONS: If you have been hospitalized for any major surgeries or health conditions please record them below. *Women: Do not include normal deliveries*.

YEAR **ILLNESS/OPERATION**

____

____

____

LIST ANY MEDICATIONS YOU TAKE REGULARLY (including Tylenol, ibuprofen, aspirin, laxatives, diet pills, sleeping medication, antihistamines, etc.):

LIST ANY SUPPLEMENTS OR HERBS YOU TAKE REGULARLY:

LIST ANY FOOD OR MEDICATION ALLERGIES YOU HAVE:

THE FOLLOWING QUESTIONS ARE ASKED ONLY TO HELP ASSESS YOUR OVERALL STATE OF HEALTH. ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL.

Do you smoke tobacco? NO____ YES____ If yes, how many packs per day? ______________

If you have smoked in the past, when did you stop? ____

Do you smoke marijuana? NO____ YES____ If yes, how often? ______________________________

Do you drink alcohol? ____drinks daily ____drinks weekly **or** Please circle: Socially/Rarely/Never

Do you drink coffee/tea? ____cups daily ____cups weekly **or** Please circle: Occasionally/Never

Do you use recreational drugs (marijuana, cocaine, ecstasy, or other street drugs)? NO_____ YES______

If yes, what and how often? ____

NAME OF YOUR PRIMARY CARE PHYSICIAN: ____

TELEPHONE NUMBER: ____

PLEASE CHECK ANY CONDITION YOU ARE CURRENTLY EXPERIENCING. ANY CONDITION THAT HAS BEEN A SIGNIFICANT PROBLEM IN THE PAST, PLEASE NOTE IT WITH A "P".

General

____ Insomnia
____ Frequent Dreams/Nightmares
____ Depression/Anxiety/Agitation
____ Thyroid Disorder
____ Diabetes
____ Easily Cold
____ Easily Hot
____ Irritability
____ History of Psychiatric Treatment
____Fatigue

Nose, Throat & Mouth

____Bleeding
____Sinus Infection
____Hay Fever or Allergies
____Sore Throat
____Hoarseness
____Difficulty Swallowing
____Change in Taste
____Oral Ulcers

Skin

____Hives
____ Rashes
____ Eczema
____ Bruise Easily
____ Dryness
____ Clammy Skin
____ Excessive Sweating
____ Night Sweating

Muscles and Joints

____ Joint Disorder
____ Sore Muscles
____Weak Muscles
____ Difficulty Walking
____ Scoliosis/Spinal Curvature
_____Back Pain

Cardiovascular

____Palpitations
____Chest Pain or Tightness
____Rapid Heart Beat
____ Poor Circulation
____ Swelling of Ankles
____ Phlebitis
____ Elevated Cholesterol
____ Hypertension/High Blood Pressure
____ Low Blood Pressure

Respiratory

____Chronic Cough
____Coughing Up Blood
____Excessive Phlegm
____ Difficulty Breathing
____ Asthma/Wheezing
____Frequent Colds
____COPD

Head and Neck

____Headaches
____ Migraines
____ Dizziness
____ Fainting
____ Neck Stiffness
____Enlarged Lymph Glands

Eyes and Ears

____ Blurred Vision
____ Visual Changes
____ Poor Night Vision
____ Spots/Floaters
____ Eye Inflammation
____Eye Dryness
____Ringing in Ears
____Frequent Ear Infections
____Decreased Hearing

Neurological

____ Epilepsy
____ Seizures
____ Tremors
____ Numbness/Tingling
____ Pain
____Paralysis

Gastrointestinal

____Indigestion/Acid Reflux
____Nausea
____Stomach Pain
____Diarrhea
____Constipation
____Vomiting Blood
____Bloody or Black Stools
____Poor/Excess Appetite
____Hemorrhoids
____Gallbladder Disorder
____Unusual Taste in the Mouth

Female Reproductive

____Frequent Infections
____Pain/Itching/Lesions/Discharge
____Pelvic Inflammatory Disease
____Abnormal PAP Smear
____Irregular Periods
____Painful Periods
____Excessive/Scanty Bleeding
____PMS
____Ectopic Pregnancy
____ History of Miscarriage(s)
____Sexually Transmitted Disease

Male Reproductive

____ Pain/Itching
____Lesions/Discharge
____Impotence
____Urination problems
____Testicular Lumps
____ Sexually Transmitted Disease

DO YOU HAVE, OR HAVE YOU EXPERIENCED, ANY OTHER CONDITION THAT IS OF CONCERN TO YOU (i.e.; Cancer, Stroke, Organ Transplant, etc)?

INFORMED CONSENT TO TREATMENT

I consent to acupuncture treatment and other procedures with traditional Chinese medicine by the licensed acupuncturist below and/or any other practitioner designated by below named practitioner. I have discussed the nature and purpose of my treatment with the practitioner named below.

I understand that methods may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Chinese massage (tui na), herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including but not limited to, bruising, numbness, or tingling near the needling site that may last for a few days and possibly dizziness or fainting. Bruising is a side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and pneumothorax (lung puncture). Infection may be a potential risk however, only disposable sterile needles are used and clean techniques are practiced at all times. Burns and/ or scarring is a risk of moxibustion. I understand that this document describes the major risks of treatment other side effects and risks may occur.

The herb and nutritional supplements (which are form plant, animal and mineral sources) that are recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs maybe inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, hives, and tingling of the tongue.

I understand that the herbs need to be prepared and the tea or pills consumed according to the instructions of the practitioner. The herbs may have an unpleasant odor or taste. I will immediately notify my practitioner of any unanticipated or unpleasant effects associated with the consumption of the herbal teas, pills, powders, or liniment use.

I WILL NOTIFY THE PRACTITIONER IF I AM PREGNANT.

I do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I wish the practitioner to exercise judgment during the course of treatment which the practitioner thinks at the time, based on the facts then known, is in my best interests.

I understand that all my records will be kept confidential and will not be released to anyone without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, having been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions concerning above. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I understand that I have the option to discontinue treatment at any time.

ADVISEMENT:

New York State law requires that the patient be advised to consult a physician regarding the condition or conditions for which she/he is seeking acupuncture treatment. By signing below I am confirming that I have been advised.

TO BE COMPLETED BY PATIENT
OR REPRESENTATIVE:

____
Printed Name of Patient

____
Signature of Patient or Representative

____
Printed Name of Representative (if applicable)

TO BE COMPLETED BY PRACTITIONER:

Joy Lindquist, L.Ac. NYS License #003649
Printed Name of Licensed Acupuncturist

____
Signature of Practitioner

____
Date Consent Completed