

New Paltz Community Acupuncture

21 S. Chestnut Street, New Paltz, NY 12561 845-255-2145 www.newpaltzacu.com

DATE: _____

PATIENT INFORMATION

Name: _____ Gender: _____

Age: _____ Date of Birth: _____

Home Address: _____

Phone: _____

Email: _____

Can we email you our monthly newsletter? YES NO

Emergency Contact/Relationship to you: _____

Emergency Contact Phone number: _____

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

Do I have permission to contact your PCP regarding your treatment? Yes No

How did you hear about us? _____

EXPERIENCE WITH ACUPUNCTURE

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

What are your main complaints?

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

PRIMARY COMPLAINT: _____

Brief History of Complaint (i.e., How long have you had this condition? Was onset sudden or gradual? Was there any significant event that led to the condition?):

What treatment(s) (conventional or alternative) have you received for this complaint? What was the outcome of that/those treatment(s)?:

Does anything make your condition better? Does anything make it worse?:

SECONDARY COMPLAINT: _____

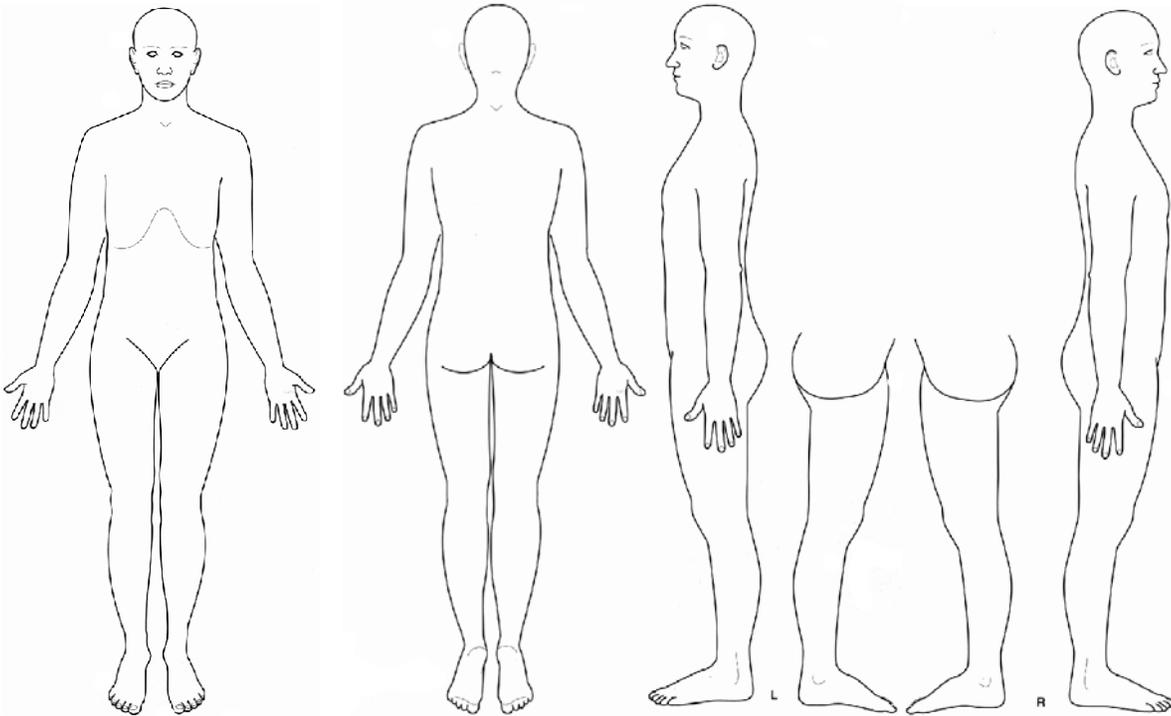
Brief History of Complaint (i.e., How long have you had this condition? Was onset sudden or gradual? Was there any significant event that led to the condition?):

What treatment (conventional or alternative) have you received for this complaint? What was the outcome of that/those treatment(s)?:

Does anything make your condition better? Does anything make it worse?:

What is your desired outcome for your acupuncture treatment?

On the diagram, please indicate the areas associated with your complaint(s):



Please list all medications, vitamins and supplements you are currently taking, and the condition for which you are taking them: (use back of page to continue list if necessary)

Medication/Supplement/Herb:

Condition:

1. _____
2. _____
3. _____
4. _____

1. _____
2. _____
3. _____
4. _____

Do you have any allergies? YES NO Allergic to: _____

(Women only) Is there any chance you could be pregnant? YES NO

Are you trying to conceive? YES NO

Do you have a pacemaker? YES NO

Do you have any other major health conditions or issues? _____
