WELCOME!

We are delighted that you have decided to join us for acupuncture! Here are a few things that we think it will be helpful for you to know:
We provide community-style acupuncture. You will receive your treatment sitting in a "zero-gravity" type recliner in quiet, comfortable room. You do not need to disrobe – just take off your shoes and socks. It will also help if you can roll your sleeves up to your elbows and your pants up to your knees. On your first visit we will start with a short conversation in a private space. Generally you will want to leave at least half an hour for your acupuncture treatment. If you need to be done with your treatment by a certain time, please let us know.

- Remember that community works best when everyone is both considerate and flexible.
- Speak in whispers while in the treatment room
- Refrain from wearing strong scents as some patients are chemically sensitive
- Turn off your cell phone
- Don't forget to use a bathroom before your treatment

Please also remember that there are always some inconveniences that are possible in any community situation. Along with these slight inconveniences, receiving acupuncture in a community setting also has many benefits. Community-style acupuncture makes it easy for you to get a treatment whenever you want, to be treated with your family and friends, and to feel comfortable rather than isolated. Most importantly, community-style acupuncture also allows for the creation of a deep collective energetic field which makes the individual treatments more powerful and clinically effective.
Traditionally acupuncture has been a "people's medicine": low-tech, inexpensive and easily available. Only in the US in the last thirty years did acupuncture become a luxury item for wealthy people, with a cost of $60 to $200 per treatment in individual treatment cubicles and lots of time for chitchat. We have eliminated the unnecessary talking, the unnecessary separation of spaces and the unnecessarily high prices. You pay only $25-30 per treatment, but keep in mind that you may need a series of treatments and most of the time more than one treatment per week. The purpose of such a low fee for a treatment is to separate the issues of money and treatment. We understand that everyone's situation is different, and our primary goal is to make acupuncture available to you as often as you need it. We want you to come in for acupuncture frequently enough and regularly enough to really feel better and stay healthy!
Also remember that acupuncture is a process. Every now and then, acupuncture will act like a "miracle cure" and a person will have all of their symptoms disappear after only one or two treatments – but that is a rare event. Acupuncture works by stimulating the body's own self-healing mechanisms; it is gentle and safe and usually gradual. Almost everybody who gets acupuncture will need a series of treatments to get good results, which is one big reason we came up with our low fee. If you don't come in often enough or long enough, acupuncture probably won't work well for you. So if we decide on a treatment plan together, please stick with it to the best of your ability.

How can you help us? We are a community-supported business. Our business model depends on three things:
(1) making our treatments as effective as possible,
(2) making our treatments affordable so that everyone can come as often as they need to,
(3) treating lots of people in order to keep costs down.

So please keep telling everyone you know about how amazingly effective and affordable our treatments are. And don't forget yourself: the best way you can support us is by continuing to let us support you. So say "Yes!" to achieving and maintaining your own optimum state of health, happiness and well-being and let us support you in this endeavor.

Welcome again and thank you for joining us!

Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Indicate areas of confusion with a question mark. Thank you.

1. Please identify the health concerns that have brought you to our clinic in order of importance below:

Condition and Past Treatment

1. _____

How does this condition affect you? _____

2. _____

How does this condition affect you? _____

3. _____

How does this condition affect you? _____

2. When and where did you last receive health care? _____

For what reason? _____

3. Has your case been referred to an attorney? Y N

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

6. Do you have any reason to believe you may be pregnant? Y N

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. Have you experienced any major traumas? Y N Explain: _____

9. **Height:** _____ **Weight:** _____

10. **Blood Pressure:** _____

11. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	

12. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When
_____		_____	
_____		_____	

13. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Depression Anxiety Irritability

14. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

15. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

16. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: _____

17. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

18. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

19. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

20. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

21. **Menstrual/Birthing History:**

1. Age of First Menses: _____
2. # of Days of Menses: _____
3. Length of Cycle: _____
4. Birth Control Type: _____
5. # of Pregnancies: _____
6. # of Miscarriages: _____
7. # of Abortions: _____
8. # of Live Births: _____

22. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

23. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

24. **Neurological** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

25. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hyperthyroid Hypoglycemia Diabetes Mellitus Night Sweats Feeling Hot or Cold

26. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

_____

26. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. How many hours per night do you sleep? _____ Do you wake rested? Y N

d. Level of education completed: High School Bachelors Masters Doctorate Other

e. Occupation: _____ Do you enjoy work? Y/N Why/Why not? _____

f. Nicotine/Alcohol/Caffeine Use: _____

g. Interests and hobbies: _____

How did you hear about us? _____

Would you like to receive our email newsletter? Yes No

CONSENT TO ACUPUNCTURE TREATMENT

By signing below, I do hereby voluntarily consent to be treated by Yuly Fridman, L. Ac. I understand that acupuncturists practicing in the state of New York are not primary care providers and that regular primary care by a licensed physician is an important choice that is recommended.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: pain or discomfort, local bruising, numbness or tingling near the needling sites that may last a few days, minor bleeding, dizziness or fainting and the possible temporary aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Gua-Sha/Cupping: I understand that I may also be given gua-sha (rubbing massage with a special tool) or cupping as part of my treatment. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible temporary aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment at any time.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, and to normalize the body's physiological functions. I understand that I must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort. Should I experience any problems, which I associate with these substances, I should suspend taking them and call the acupuncturist as soon as possible.

Missed appointment and cancellation policy: You will be charged $25 for a missed appointment or last minute cancellation.

Three or five treatments package deals policy: All treatments must be completed within one month.

I, the undersigned do affirm that I have been advised by Yuly Fridman, L.Ac to consult a physician regarding the condition or conditions for which I seek acupuncture treatment.

Printed Name: _____ Date of Birth: _____

Address: _____

Phone: (mobile) _____ (home) _____ Email: _____

I have carefully read and understand all of the above information and I am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____