Acupuncture Associates of Long Island
Your "AALI" in Health

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Patient Information

Please answer questions to the best of your knowledge.

Date: _____

Name:_____ SS #: _____

Address:_____

City: _____State: _____Zip: _____

Home Phone: _____Other: _____ Cell: _____

Fax: _____ Email: _____

Sex: male ( ) female ( ) Height _____ Weight ____ DOB _____ Age _____

Emergency Contact: Name_____Phone _____

Insurance Information:

Information of the Insured (if different from patient):

Name:_____ SS #: _____

Address:_____

City: _____State: _____Zip: _____

Home Phone: _____Other: _____ Cell: _____

Insurance Company Information:

Name: _____ ID #: _____ Group ID #:_____

Address:_____

City: _____State: _____Zip: _____

Phone: _____ Fax: _____

No Fault Information:

Is your Visit due to a car accident in New York State? Yes ( ) No ( )
If so, are you covered under No Fault? Yes ( ) No ( )

Policy Holder Name: _____ Policy #: _____
Date of Accident: _____ File #: _____

Your primary biomedical doctor's contact information:

Name: _____

Address: _____

Phone: _____ Fax: _____

Referred by _____ Have you received acupuncture before? Yes ( ) No ( )

If yes, what were you treated for?: _____

Please indicate any significant illness you or a blood relative have had:

	You	Relative	When		You	Relative	When
Cancer	( )	( )	_____	High Cholesterol	( )	( )	_____
Hepatitis	( )	( )	_____	Seizure	( )	( )	_____
HBP	( )	( )	_____	Emotional d/o	( )	( )	_____
Infectious dx	( )	( )	_____	Tuberculosis	( )	( )	_____
Diabetes	( )	( )	_____	HIV/AIDS	( )	( )	_____

Please list any medications and supplements you are currently taking: (continue on back if necessary)

Medicine	Dosage	Reason	How Long	Prescribed by	Last check up

Please check if any of the following statements are true for you.

( ) I have known allergies ( ) I am taking anticoagulants ( ) I have a pacemaker ( ) I am pregnant

Please indicate the use and frequency of the following:

	Yes	No	how much		Yes	No	how much		Yes	No	how much
Coffee/Black tea	( )	( )	_____	Water Intake	( )	( )	_____	Soda	( )	( )	_____
Non-medical drugs	( )	( )	_____	Alcohol	( )	( )	_____	Tobacco	( )	( )	_____

How do you FEEL about the following areas of your life:

	Good	Average	Poor	Your Comments:
Significant other	( )	( )	( )	_____
Family	( )	( )	( )	_____
Diet	( )	( )	( )	_____
Sex	( )	( )	( )	_____
Self	( )	( )	( )	_____
Work	( )	( )	( )	_____
Exercise	( )	( )	( )	_____
Spirituality	( )	( )	( )	_____

What are the main health problems for which you are seeking treatment?

_____

What other forms of treatment have you sought?

_____

Please list any other heath problems you now have:

_____

Please list any allergies or food sensitivities you may have **(including to Latex)**:

_____

Please list any accidents, surgeries or hospitalizations (including dates):

_____

_____

_____

Pleases list any special consideration or circumstances you would like your practitioner to be aware of:

_____

FOR MEN

Date of last prostate checkup: _____ PSA results: _____

Manual prostate exam results: _____

Frequency of urination: Day time _____ Night time _____

Color/Quality of urine: ( ) Clear ( )Cloudy ( )Red ( ) Odor

Symptoms related to prostate:

( ) Delayed stream ( ) Dribbling ( ) Incontinence ( ) Retention of urine

( ) Rectal dysfunction ( ) Increased libido ( ) Decrease libido ( ) Premature ejaculation

( ) Impotence ( ) Groin pain ( ) Testicular pain ( ) Back pain

FOR WOMEN

Age of first period (menarche) _____ Are you pregnant? ( ) Yes ( ) No

Age of last period (menopause)_____ Number of pregnancies _____

Number of days between periods_____ Number of live births _____

Number of days of flow _____ Number of miscarriages _____

Number of pads/tampons on heaviest day _____ Number of abortions _____

Color of flow: ( ) Red ( ) Purple ( )Dark ( ) Brown

Clots: ( ) Yes ( ) No

Date of last Gynecological exam _____ Pap smear _____ Mammogram _____

Results: _____

_____

Have you been diagnosed with:

( ) Fibroids ( ) Fibrocystic breasts ( ) Endometriosis ( ) PID ( ) Ovarian cysts

( ) Other: _____

Symptoms associated with menses:

Pain ( ) No ( ) Yes (if yes, check Nature of pain)

Nature of pain:

( ) Cramping ( ) Stabbing ( ) Burning ( ) Constant

( ) Aching ( ) Dull ( ) Intermittent ( ) Bear down sensation

Discharge: ( ) No ( ) Yes (if yes, check nature of discharge)

Nature of discharge:

( ) Clear ( ) White ( ) Yellow ( ) Other color _____

( ) Thick ( ) Thin ( ) Scanty ( ) Copious

( ) Headache ( ) Swollen breasts ( ) Increase libido ( ) Constipation ( ) Insomnia

( ) Mood swings ( ) Irritability ( ) Decreased libido ( ) Vaginal dryness ( ) Nausea

( ) Hot flashes ( ) Poor appetite ( ) Night sweats ( ) Palpitations ( ) Diarrhea

( ) Increased appetite ( ) Other _____

GENERAL SYMPTOM SURVEY (for everyone)

Please check the symptoms you have experienced recently:

Gastrointestinal/Digestive Problems:

( ) Poor appetite ( ) Excessive appetite ( ) Full feeling ( ) Vomiting
( ) Nausea ( ) General fatigue/lack of energy ( ) Belching/Burping ( ) Gas/Bloating
( ) Indigestion ( ) Abdominal pain or cramping ( ) Constipation ( ) Tired after meals
( ) Easily bruised ( ) Heartburn/Acid Reflux ( ) Sudden weight loss ( ) Colitis/Diverticulitis
( ) Blood in Stools ( ) Excessive weight gain ( ) Pasty taste in mouth ( ) Bitter taste in mouth
( ) Gall stones ( ) Loose stools/diarrhea ( ) Hemorrhoids ( ) Jaundice
( ) Difficulty digesting fatty or oily foods
( ) Use of laxatives/fiber: _____
( ) Other: _____
( ) Food allergies: _____

Respiratory:

( ) Wheezing ( ) Frequency catching colds ( ) Asthma ( ) Hay fever
( ) Shortness of breath ( ) Intolerant to weather changes ( ) Bronchitis ( ) Nasal problems
( ) Skin Problems ( ) Recent use of antibiotics ( ) Difficulty breathing ( ) Frequent yawning
( ) Sighing often ( ) Tightness in chest ( ) Dry cough ( ) Cough with Phlegm
( ) Cough with blood
( ) Allergies: _____

Cardiovascular – Circulation

( ) Palpitations ( ) High Blood Pressure ( ) Low Blood Pressure ( ) Chest Pain
( ) High cholesterol ( ) Irregular Heart Beat ( ) Murmur ( ) Varicose Veins
( ) Too hot/cold ( ) Numbness in extremities ( ) Ankle/hand swelling ( ) Easy to faint
( ) Dizziness ( ) Normal Other _____

Urinary/Genital

( ) Frequent ( ) Bladder Infections ( ) Burning w/urination ( ) Urgency
( ) Incontinence ( ) Kidney stones or infections ( ) Night-time urination ( ) Edema
( ) Low Back Pain ( ) Knee problems ( ) Hearing Impairment ( ) Ear ringing
( ) Bone spurs ( ) Decreased sex drive ( ) Infertility ( ) Hair loss
( ) Sexual dysfunction ( ) Decreased sense of smell ( ) Normal

Appetite:

( ) Poor ( ) Good ( ) Hungry ( ) Loss of taste
Type of diet: ( ) Standard American Diet ( ) Vegetarian ( ) Vegan
( ) Macrobiotic ( ) Gluten Free ( ) Other

How often do you eat/drink in a week/month/year?

Eggs _____ Dairy _____ Fruits _____ Vegetables _____
Meat/Fish _____ Hot/Spicy Food _____ Sweets _____ Whole Grains _____
Alcohol/Type _____ Coffee/Tea _____
Soda (regular/diet) _____
Meals per day: _____
Do you eat at regular hours? ( ) Yes ( ) No
Cravings: _____
Food Allergies: _____

Thirst

( ) Less than normal ( ) Thirst but does not drink ( ) Excessive thirst ( ) Prefer cold drinks
( ) Prefer hot drinks ( ) Prefer room temperature drinks ( ) Normal

Weight:

( ) Normal ( ) Underweight ( ) Overweight ( ) Recent gain ( ) Recent loss

Energy:
( ) Normal ( ) Low after eating ( ) Low ( ) Excess ( ) Up and down
( ) Tired in the Afternoon ( ) Other: _____

Sleep:
( ) Dream Often ( ) Difficulty falling asleep ( ) Awake easily ( ) Nightmares
( ) Restless ( ) Difficulty going back to sleep ( ) Tired after sleeping ( ) Sleep too much
Average # of hours of sleep _____ Other: _____

Body Temperature:
( ) Warm ( ) Feel warmer late afternoon ( ) Cold ( ) Flushed face
( ) Night sweats ( ) Alternate chills and fever ( ) Warm Palms ( ) Profuse Perspiration
( ) Warm soles ( ) Cold hands and feet ( ) Normal Other: _____

Headaches – Dizziness:
( ) Headaches ( ) Get dizzy when stands ( ) Vertigo ( ) Dizziness
( ) Motion sickness ( ) Poor balance ( ) Faint easily ( ) Migraines
( ) Poor memory ( ) Other: _____
Location of headaches: _____

Skin:
( ) Dry ( ) Bruises easily ( ) Hives ( ) Itching
( ) Oily ( ) Cuts heal slowly ( ) Acne ( ) Eczema
( ) Rashes ( ) Normal Other: _____

Hair:
( ) Dry ( ) Oily ( ) Dandruff ( ) Falling out ( ) Early grey ( ) Normal

Nails:
( ) Soft ( ) Ridges and lines ( ) Spots ( ) Grow slowly ( ) Purple ( ) Pale
( ) Break easily ( ) Yellow ( ) Normal Other: _____

Eyes:
( ) Wear glasses/contacts ( ) Eyelids swollen ( ) Normal ( ) Poor night vision ( ) Itchy ( ) Dry
( ) Sensitive to light ( ) Painful ( ) Twitch ( ) Color blindness ( ) Tear easily ( ) Red
Other: _____

Ears:
( ) Poor hearing ( ) Ringing (high pitch) ( ) Ringing (low pitch) ( ) Discharges
( ) Ear aches ( ) Normal Other: _____

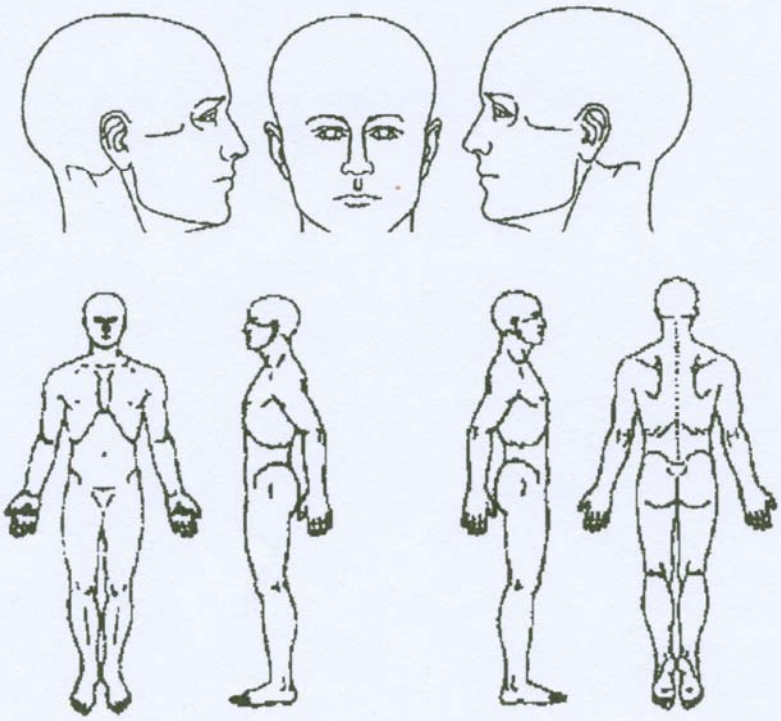
Nose:
( ) Stuffy nose ( ) Environmental sensitivity ( ) Sneezes a lot ( ) Bleeding
( ) Loss of smell ( ) Sinusitis ( ) Normal Other: _____

Mouth and Throat:
( ) Dry ( ) Difficulty swallowing ( ) Gum problems ( ) TMJ
( ) Mouth sores ( ) Feel lump in throat ( ) Grind teeth ( ) Normal
Other: _____

Emotional/Stress Level:
( ) Depression ( ) Insomnia/difficult sleeping ( ) Difficulty making decisions ( ) Often sad
( ) Easily Frightened ( ) Frequently laughing ( ) Often angry ( ) Anxiety
( ) Difficulty sleeping ( ) Heart palpitations ( ) Nightmare ( ) Insomnia
( ) Thinking a lot ( ) Cold hands and feet ( ) Often crying ( ) Worry a lot

Please Indicate Areas of Pain

1 – being least pain **5 – being most severe pain**



☐ Back pain or trouble ---------- 1 2 3 4 5
☐ Muscle pain, spasm, cramping - 1 2 3 4 5
☐ Muscle weakness ---------- 1 2 3 4 5
☐ Restless or nervous legs --------- 1 2 3 4 5

☐ Spinal disc problems ---------- 1 2 3 4 5
☐ Stiff or painful neck ---------- 1 2 3 4 5
☐ Swelling ---------- 1 2 3 4 5
☐ Tendonitis (where:_____)

Please tell me everything you can about your pain:

_____
_____
_____
_____
_____
_____
_____
_____

X _____ X _____

NYS Licensed Acupuncturist with Date Patient/Legal Guardian with Date