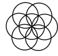
Ithaca Community Acupuncture

New Patient Form

CONFIDENTIAL

Ithaca Community Acupuncture does not discriminate or deny care based on history, body type or identity. We aim to be an equal partner in your health care.

Last Name:	First Name:
Legal Name (for emergencies/insurance):	Date of Birth: DD / MM / YYYY
Phone:	Occupation:
Address:	Postal Code:
Email:	
Emergency Contact (name and phone):	
How did you hear about us?	Have you been treated with acupuncture before? Y ☐ N ☐ Have you been treated with other complementary medicine? Y ☐ N ☐

Main Concerns

①

When did this start?

Heat makes it: better | no change | worse

Cold makes it: better | no change | worse

Exercise/Activity: better | no change | worse

1 (mild) ——— 10 (severe)

②

When did this start?

Heat makes it: better | no change | worse

Cold makes it: better | no change | worse

Exercise/Activity: better | no change | worse

1 (mild) ——— 10 (severe)

③________________________________

When did this start?

Heat makes it: better | no change | worse

Cold makes it: better | no change | worse

Exercise/Activity: better | no change | worse

1 (mild) ——— 10 (severe)

Injuries Traumas & Surgeries

Health History

	You	Family		You	Family
Cancer Type:	☐	☐	Allergies Type:	☐	☐
Lung disease	☐	☐	Asthma	☐	☐
Heart disease	☐	☐	Sleep Apnea	☐	☐
Blood Pressure high ☐ low ☐	☐	☐	Osteoporosis	☐	☐
Pacemaker	☐	☐	Thyroid high ☐ low ☐	☐	☐
Stroke	☐	☐	Diabetes	☐	☐
Kidney disease	☐	☐	High Cholesterol	☐	☐
Liver disease	☐	☐	Hepatitis	☐	☐
Seizures	☐	☐	HIV/AIDS	☐	☐
Dizzy/fainting	☐	☐	Other STI	☐	☐
Anemia	☐	☐	Gender Reassignment	☐	☐
			Bleeding/clotting disorder	☐	☐
Addiction Type:	☐	☐	Mental health Type:	☐	☐

Other:

Do you follow a special diet? Y ☐ N ☐

Describe:

Do you exercise regularly? Y ☐ N ☐

Describe:

	Amount	Quit
Sugar		☐
Caffeine		☐
Tobacco		☐
Other		☐

Medications
Note and drugs, hormones, supplements you take regularly

Acupuncturist Signature: ________________ Date: ____________

Body Temperature

Cold |—|—| Hot

- ☐ Cold hands/feet
- ☐ Chills
- ☐ Numbness
- ☐ Like hot drinks
- ☐ Excessive thirst
- ☐ Thirsty, but no desire to drink
- ☐ No thirst
- ☐ Unusual sweats
- When?
- Where?
- ☐ Don't sweat
- ☐ Hot hands/feet
- ☐ Hot flashes
- When?
- ☐ Like cold drinks

Moisture

Oily |—|—| Dry

- ☐ Dry skin
- ☐ Dry hair
- ☐ Brittle nails
- ☐ Dandruff
- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry throat
- ☐ Dry nose/nosebleeds
- ☐ Oily skin
- ☐ Oily hair
- ☐ Acne
- Where?
- ☐ Swelling/edema
- ☐ Itching/rashes
- ☐ Psoriasis
- ☐ Eczema

Digestion

Loose Stool |—|—| Dry Stool

- # of bowel movements? ____ every ____ days
- ☐ Tired after BM
- ☐ IBS
- ☐ Difficult to pass
- ☐ Hemorrhoids
- ☐ Foul smelling
- ☐ Gall stones
- ☐ Gas/bloating
- ☐ Bad breath
- ☐ Heartburn/belching
- ☐ Nausea
- ☐ High appetite
- ☐ Poor appetite
- ☐ Weight gain/loss
- ☐ Food Cravings

Energy

Low |—|—| High

- ☐ Sudden energy drop
- When?
- ☐ Tired after eating
- ☐ Ungrounded feeling
- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ Bruise easily
- ☐ Body feels heavy/weak
- ☐ Poor concentration
- ☐ Poor memory
- ☐ Headaches
- ☐ Lightheaded/dizziness

Eyes/Ears/Nose/Throat

- ☐ Poor vision
- ☐ Night blindness
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Floaters
- ☐ Sinus congestion
- ☐ Phlegm
- ☐ Cough
- ☐ Sore throat
- ☐ Poor hearing
- ☐ Ear ringing
- ☐ Excessive earwax
- ☐ Dental problems
- ☐ Mouth sores
- ☐ TMJ
- ☐ Grind/clench teeth

Emotions

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Grief
- ☐ Depression
- ☐ Easily excitable
- ☐ Easily startled
- ☐ Fear
- ☐ Timid/shyness
- ☐ Indecision

Stress

Low |—|—| High

Sleep

- # hours per night? ________
- ☐ Trouble falling asleep
- ☐ Wake _____ x / night
- When?
- ☐ Wake to urinate
- How often?
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested

Reproductive Health

- Are you sexually active? Y ☐ N ☐
- ☐ Change of sexual drive (↑ / ↓)
- ☐ Infertility
- ☐ Vasectomy / Hysterectomy
- ☐ Hormone Therapy
- ☐ Prostate problems
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Candida / yeast infections

Urinary Health

- Fluid in = Fluid out? Y ☐ N ☐
- ☐ Decreased flow
- ☐ Dribbling
- ☐ Incontinence/urgency
- ☐ Increased frequency
- ☐ Kidney/bladder stones
- ☐ Pain on urination
- ☐ Burning
- ☐ Cloudy
- ☐ Blood in urine

Menses

- Are you/could you be pregnant? Y ☐ N ☐
- Are you using contraception? Y ☐ N ☐
- Age of first menses: ________
- Duration of bleeding: _______
- Length of cycle: _______
- # of pregnancies: _______
- # of miscarriages/abortions: _______
- ☐ Heavy periods
- ☐ Light periods
- ☐ Irregular periods
- ☐ Cramps
- When?
- ☐ Clots
- ☐ Chest tenderness
- ☐ Mood changes
- ☐ Fatigue
- ☐ Sleep changes
- ☐ Digestive changes
- ☐ Bloating
- ☐ Cravings
- ☐ Mid-cycle spotting

Menopause

- Age of last menses: _______
- Year changes began: _______
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Vaginal dryness
- ☐ Other:

Acupuncturist Signature: ________________ Date: ____________

I. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of acupuncture treatments on me for the relief of presenting symptoms, improved health and wellbeing, reduced stress and general relaxation.

While acupuncture is a very safe, natural method of treatment, certain side effects may result. These could include, but are not limited to: local bruising of the skin and/or slight bleeding, temporary pain and discomfort, numbness or tingling near the needling sites that may last a few days, weakness, dizziness or fainting and temporary aggravation of symptoms existing prior to acupuncture treatment. There is little to no risk of infection when all needles are sterile. ICA uses only one-time use, sterile disposable needles.

Acupuncture can be very beneficial in the treatment of symptoms during pregnancy, assisting in the birthing process and postpartum. Please notify the acupuncturist should you become pregnant or if you are in the process of trying to get pregnant so that the acupuncturist can make necessary adjustments to your treatment plan.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

II. PATIENT ADVISORY TO CONSULT A PHYSICIAN

Ithaca Community Acupuncture is committed to your health and wellbeing. We believe that while Acupuncture and Chinese Medicine has a great deal to offer as a health care system, it cannot replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment. To comply with Article 160, Section 821.1(b) of NYS Education law, we request that you read and sign the following statement:

I, THE UNDERSIGNED DO AFFIRM THAT I HAVE BEEN ADVISED BY Coleen Foley, Timothy Foley, or other staff acupuncturist TO CONSULT A PHYSICIAN REGARDING THE CONDITION(S) FOR WHICH I AM SEEKING ACUPUNCTURE TREATMENT.

PATIENT (or representative) SIGNATURE: ___________________________

Date: ___________________