**Main Office**
37 W. 20th Street, Suite 607
New York, NY 10011

**Satellite NJ Office - Seven Point Wellness**
187 Millburn Ave Suite #101
Millburn, NJ 07041

212-226-2066
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# New Patient Initial Form

1. **Please enter your information.**

Legal Name: _____ Preferred Name: _____

DOB: _____ Address: _____

Apt./Unit #: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

In Case of Emergency: _____ Phone: _____

Sex assigned at birth: _____
☐ Male ☐ Female
☐ Intersex ☐ Other

Gender you Identify with: _____ Pronouns: _____

Do you have a Physician Referral?
○ Yes ○ No

If yes, who is your physician? _____

Insurance
☐ Self Pay ☐ Private Insurance ☐ Medicare

If private Insurance please tell us what insurance you have. _____

Which office is your appointment in?
☐ New York ☐ New Jersey

We have acupuncture in our office. Would you like us to check your insurance benefits for Acupuncture
☐ Yes ☐ No

2. **If you would like us to submit to your insurance for you, please attach a picture or copy of your insurance card:**

**Notes/Comments:**

_____

# Health History

3. **Describe the current problem that brought you here?**

4. **When did your problem first begin?**

5. **Was your first episode of the issue related to a specific incident?**

   ○ Yes
   ○ No

6. **If yes, please describe and specify date:**

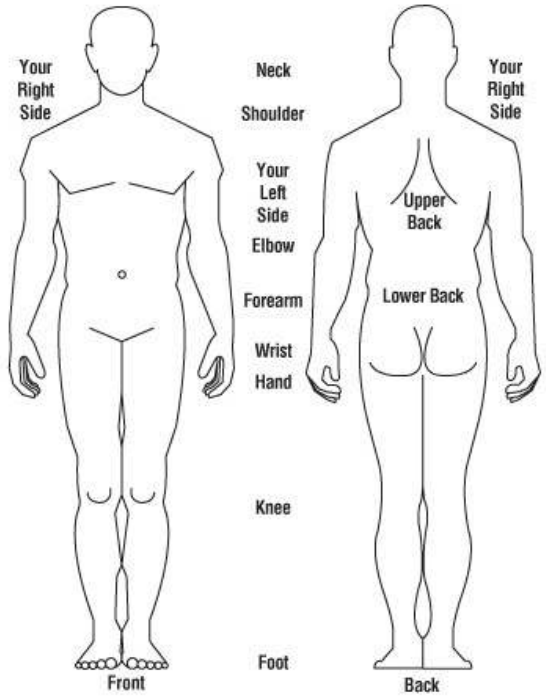
7. Since that time is it: staying the:
   ○ same ○ getting worse ○ getting better

   Why or how?

8. If pain is present rate pain on a 0-10 scale 10 being the worst:
   ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

   Describe the nature of the pain (i.e. constant burning, intermittent ache):

9. Please indicate areas of concern:




10. Describe previous treatment/exercises:

_____

_____

_____

_____

11. Activities/events that cause or aggravate your symptoms. Check all that apply.

| | | |
|---|---|---|
| ☐ Walking | ☐ Light activity (light housework) | ☐ Sitting |
| ☐ Vigorous activity/exercise (run/weight lift/jump) | ☐ With laughing/yelling | ☐ With triggers -running water/key in door |
| ☐ Standing | ☐ With cough/sneeze/straining | ☐ With lifting/bending |
| ☐ With nervousness/anxiety | ☐ With cold weather | ☐ Sexual activity |
| ☐ Changing positions (ie. - sit to stand) | ☐ No activity affects the problem | ☐ Other |

12. If other, please list:

_____

_____

_____

_____

13. **What relieves your symptoms?**

14. **How has your lifestyle/quality of life been altered/changed because of these issues?**

Social activities (exclude physical activities), specify:

Diet /Fluid intake, specify:

Physical activity, specify:

Work, specify:

Other:

15. **Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst:**

- ○ 0
- ○ 8
- ○ 5
- ○ 2
- ○ 10
- ○ 7
- ○ 4
- ○ 1
- ○ 9
- ○ 6
- ○ 3

16. **What are your treatment goals/concerns?**

17. Date of Last Physical Exam:

Tests performed:

18. General Health:

○ Excellent ○ Good ○ Average ○ Fair ○ Poor

Occupation:

Hours/week:

On disability or leave?

○ Disability ○ Leave

Activity Restrictions?

19. **Mental Health:**

Current level of stress:
○ High ○ Med ○ Low

Current psych therapy?
○ Yes ○ No

20. Activity/Exercise:
○ None ○ 1-2 days/week ○ 3-4 days/week ○ 5+ days/week

Describe:

_____

_____

21. **Have you ever had any of the following conditions or diagnoses? Check all that apply.**

| | | |
|---|---|---|
| ☐ Anemia | ☐ Allergies - List: | ☐ Alcoholism/Drug problem |
| _____ | _____ | _____ |
| ☐ Anorexia/bulimia | ☐ Arthritic conditions | ☐ Asthma |
| _____ | _____ | _____ |
| ☐ Bone Fracture | ☐ Chronic Fatigue Syndrome | ☐ Childhood bladder problems |
| _____ | _____ | _____ |
| ☐ Cancer | ☐ Depression | ☐ Epilepsy/seizures |
| _____ | _____ | _____ |
| ☐ Diabetes | ☐ Emphysema/chronic bronchitis | ☐ Fibromyalgia |
| _____ | _____ | _____ |
| ☐ Heart problems | ☐ Headaches | ☐ Hepatitis/HIV/AIDS |
| _____ | _____ | _____ |
| ☐ Hearing loss/problems | ☐ High Blood Pressure | ☐ Hypothyroid/Hyperthyroid |
| _____ | _____ | _____ |
| ☐ Irritable Bowel Syndrome | ☐ Joint Replacement | ☐ Kidney disease |
| _____ | _____ | _____ |
| ☐ Latex sensitivity | ☐ Low back pain | ☐ Multiple sclerosis |
| _____ | _____ | _____ |
| ☐ Osteoporosis | ☐ Pelvic pain | ☐ Physical or Sexual abuse |
| _____ | _____ | _____ |
| ☐ Rheumatoid Arthritis | ☐ Sexually transmitted infection | ☐ Smoking history |
| _____ | _____ | _____ |
| ☐ Sacroiliac/Tailbone pain | ☐ Sports Injuries | ☐ Stress fracture |
| _____ | _____ | _____ |
| ☐ Stroke | ☐ TMJ/neck pain | ☐ Other - Describe: |
| _____ | _____ | _____ |

## 22. Surgical /Procedure History:

| | Yes | No |
|---|---|---|
| Surgery for your back/spine | | |
| Surgery for your brain | | |
| Surgery for your reproductive organs | | |
| Surgery for your bladder/prostate | | |
| Surgery for your bones/joints | | |
| Surgery for your abdominal organs | | |
| Other | | |

**If yes and or other, please describe**

_____

## 23. OB/GYN History:

| | Yes | No | Add'l Info |
|---|---|---|---|
| Childbirth vaginal deliveries: | | | |
| Episiotomy : | | | |
| C-Section: | | | |
| Difficult childbirth: | | | |
| Prolapse or organ falling out | | | |
| Vaginal dryness | | | |
| Painful periods | | | |
| Menopause - when? | | | |
| Painful vaginal penetration | | | |
| Pelvic pain | | | |
| Other | | | |

## 24. If other, describe:

_____

_____

_____

_____

## 25. Pelvic Health (Assigned Female at Birth)

Are you currently pregnant?
○ Yes ○ No

If 'yes", what is the due date?
_____

Number of prior pregnancies, if any:
_____

Have you experienced any changes to your continence?

○ Yes ○ No

If "yes", please describe.

_____

## 26. Pelvic Health (Assigned Male at Birth):

| | Yes | No |
|---|---|---|
| Prostate disorders | | |
| Shy bladder | | |
| Pelvic pain | | |
| Erectile dysfunction | | |
| Painful ejaculation | | |
| Other | | |

## 27. If other, describe:

_____

_____

_____

_____

## 28. Medications - pills, injection, patch:

| | Medication Name | Dosage | Frequency | Start Date | Reason for Taking |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |

## 29. Over the counter -vitamins etc:

| | Name | Dosage | Frequency | Start Date | Reason for Taking |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |

30. Please list the names and contact information of any other practitioners that are participating in your care, that you would like us to communicate with.