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

DATE: _____

PATIENT INFORMATION

Name: _____ Pronoun:_____

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)?:

_____

_____

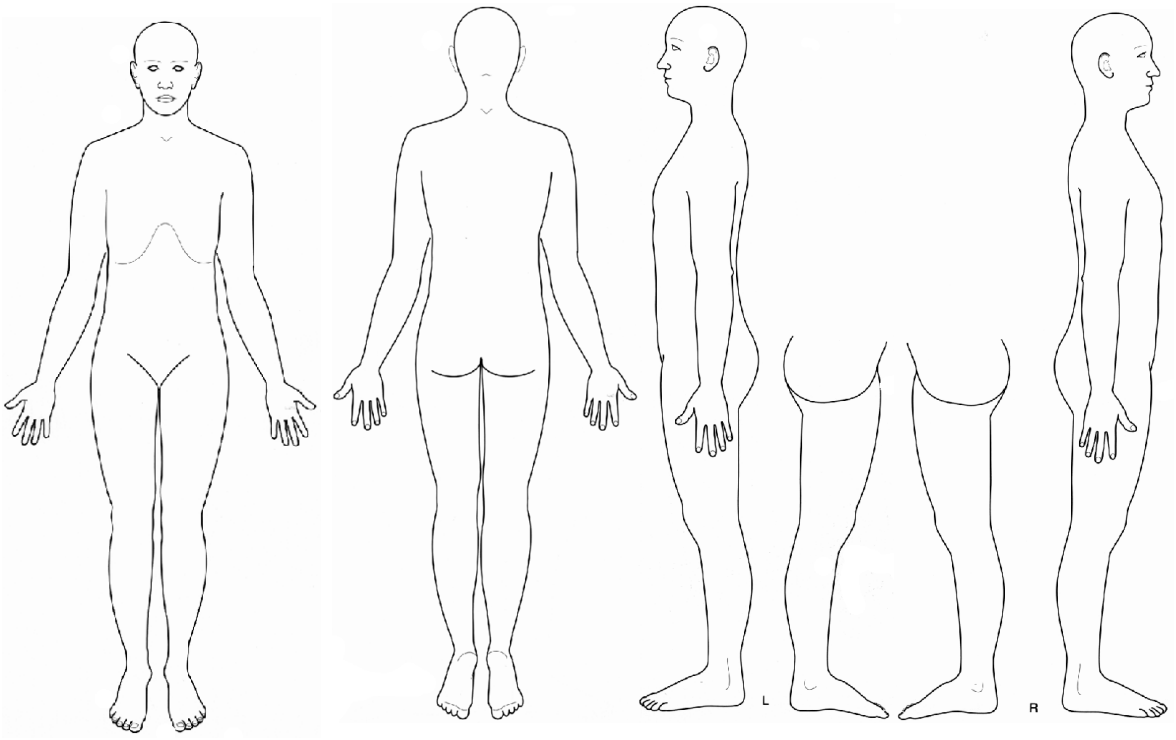
Does anything make your condition better? Does anything make it worse?:

_____

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._____	**1.**_____
2._____	**2.**_____
3._____	**3.**_____
4._____	**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? _____

_____