531 Central Park Avenue, Suite 304
Scarsdale, New York 10583

928 Broadway, Suite 1200
New York, New York 10010

Patient Health History

Today's date ____/____/____

Thank you for taking the time to complete the following information, which will better help us to access your health needs. All information is confidential. We will be happy to answer any questions you may have.

Name _____ Age _____ Birth date ____/____/____ Gender _____

Address _____ City _____ State _____ Zip _____

Home ph _____ Cell ph _____ Work ph _____ Email _____

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partnership ☐ Referred by _____

Emergency contact _____ Relationship _____

Emergency contact home phone _____ Work phone _____

Physician's name _____ Phone _____

Physician's address _____ Date of last visit ____/____/____

Employment - Please check all that apply.

Full-time ☐ Part-time ☐ Student ☐ Unemployed ☐ Retired ☐ Occupation _____

Employer's name _____ Phone _____

Employer's address _____

Payment

Scarsdale Acupuncture accepts insurance as an out-of-network provider. Please provide us with your insurance information *before* your first visit so that we can verify your coverage. If you have coverage, we will submit the insurance bills on your behalf. We will need to know:

- The name and phone number of the insurance company _____
- The patient's name and date of birth _____
- The name of the insured, if different from the patient _____
- The name of the employer of the insured _____
- Policy number, ID number, and Group number _____

If your insurance does not cover your visit, you are responsible for payment in full at time of service. We will provide you with a superbill receipt so that you can seek reimbursement through your plan. If your insurance does cover acupuncture, you may still be responsible for a co-payment at time of service.

Medicines, Herbs, and Supplements – Check any medicine you are currently taking.

Aspirin ☐ Ibuprofen/Advil/Motrin ☐ Acetaminophen (Tylenol) ☐ Antacids ☐ Diet pills ☐ Laxatives ☐ Insulin ☐

Sleeping pills ☐ Allergy medication ☐ Blood thinners ☐ Blood pressure pills ☐ Oral contraceptives ☐

Tranquilizers ☐ Anti-depressants ☐ Other ☐ Please list drug names _____

Herbs _____ Supplements/Vitamins _____

Medication allergies _____ Food allergies _____

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Please describe your typical daily diet:

Breakfast _____ Morning snack _____

Lunch _____ Afternoon snack _____

Dinner _____ Evening snack _____

Have you ever had acupuncture before? Yes ☐ No ☐ If yes, for what condition? _____

Are you presently being treated for a medical condition? Yes ☐ No ☐ Please describe. _____

What treatment have you been using for relief of this issue? _____

Do you smoke cigarettes? Yes ☐ No ☐ Length of time? _____ Amount? _____

Did you quit? Yes ☐ No ☐ Year quit? _____

Please indicate amount per day/week consumed of the following: Alcohol _____ Coffee _____

Soda _____ Black tea _____ Green Tea _____

Family History - Place an X in the appropriate box indicating condition for each family member:

	Self	Mother	Father	Sister	Brother	Spouse	Child		Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies/asthma	☐	☐	☐	☐	☐	☐	☐	Drug abuse	☐	☐	☐	☐	☐	☐	☐
Blood disorder/anemia	☐	☐	☐	☐	☐	☐	☐	Alcohol abuse	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	Heart disease	☐	☐	☐	☐	☐	☐	☐
Cancer /tumors	☐	☐	☐	☐	☐	☐	☐	Stroke	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	Depression	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	Mental condition	☐	☐	☐	☐	☐	☐	☐
Kidney disease/stone	☐	☐	☐	☐	☐	☐	☐	Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Stomach/intestinal	☐	☐	☐	☐	☐	☐	☐	Age at death		___	___	___	___	___	___

List any illnesses in your immediate family (mother, father, siblings, grandparents). _____

Please list any serious diseases, hospitalizations, injuries, accidents or surgeries you have had and give approximate dates (if you need more space, use back). _____

Describe your current program of fitness. _____

What are your goals for your health? _____

Total # pregnancies _____ Living _____ Abortions _____ Miscarriages _____ Ectopic _____

Have you been outside the U.S. in the past 12 months: Yes ☐ No ☐ Where? _____