**Acupuncture & Massage By Mara**
**3728 Park Avenue**
**Wantagh, NY 11793**
**516.697.7109**

First Name_____ Last Name_____ Date_____

Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Date of birth_____

Email_____ Occupation_____

Sex M F Height_____ Weight_____ Married/Divorced/Single/Widowed

Emergency Contact_____ Phone_____

Primary Physician_____ Phone_____ Referred by_____

How did you hear about us?_____

Reason you are seeking acupuncture_____

_____

How long ago did this problem begin?_____

Have you been given a diagnosis for this problem? Yes No

If so what?_____

What kind of treatments have you tried?_____

Does anything improve your problem?_____

Do you take blood thinners? Y N Do you have a pacemaker? Y N

Date Of Last Physical_____ Are you pregnant? Y N

**Medicines** (prescription and OTC, vitamins, herbs) **For what Conditions**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

**Current Symptoms** (please check if any of the following applies)

**Wood**
□ Irritability/Stressed
□ Depression
□ Headaches/migraines
□ Visual problems
□ Red eyes
□ Dry/itching eyes
□ Spots in front of eyes
□ Blurred vision
□ Feeling of lump in throat
□ Clenching of teeth at night
□ Muscle cramping
□ Muscle twitching
□ Joints feel tight/stiff
□ Soft/brittle nails
□ Craving or avoiding sour foods

**Water**
□ Urinary problems
□ Frequent urination
□ Incontinence
□ Weakness/pain in lower back
□ Aching bones
□ Feel cold easily (hands/feet)
□ Low sexual energy
□ Excess sexual desire
□ Poor memory
□ Loss of hair
□ Hearing problems
□ Ringing in ears
□ Craving or avoiding salty foods

**Fire**
□ Heart palpitations
□ Chest pain
□ Dizziness
□ Insomnia
□ Easily startled
□ Restlessness/agitation
□ Anxiety
□ Breathlessness
□ Vivid dreams
□ Dreams are bothersome
□ Lack of joy in life
□ Laughing for no reason
□ Craving or avoiding bitter foods

**Metal**
□ Dry cough
□ Cough with sputum
□ Nasal discharge
□ Poor sense of smell
□ Nose bleeds
□ Itchy, red or painful throat
□ Dry mouth
□ Skin rashes
□ Itchy skin
□ Grief, sadness
□ Shortness of breath
□ Allergies
□ Low resistance to colds/flu
□ Low physical stamina
□ Mild fever comes and goes
□ Craving/avoiding spicy foods

**Earth**
□ Heaviness anywhere in body
□ Fatigue
□ Hard to get up in the morning
□ Edema (swelling)
□ Muscles feel tired often
□ Easy bruising and bleeding
□ Bad breath
□ Low appetite
□ Snacking often
□ Hypoglycemia/low blood sugar
□ Difficulty digesting oily foods
□ Nausea
□ Vomiting
□ Gas/belching
□ Bloating
□ Hemorrhoids
□ Constipation
□ Diarrhea
□ Abdominal pain
□ Indigestion/heartburn
□ Over-thinking
□ Obsessive tendencies
□ Craving or avoiding sweets

**Significant Illnesses** (Please check if any of the following applies to you or blood relative)

| **Illness** | You | Relative | **Illness** | You | Relative | **Illness** | You | Relative |
|---|---|---|---|---|---|---|---|---|
| Cancer | _____ | _____ | Diabetes | ____ | ____ | Hepatitis | _____ | _____ |
| Heart Disease | _____ | ____ | Allergies | ____ | _____ | High BP | _____ | _____ |
| Seizures | _____ | _____ | Asthma | ____ | ____ | Strokes | _____ | _____ |
| Pulmonary | _____ | ____ | Alcoholism | ____ | ____ | STD's | _____ | _____ |
| Depression | _____ | ____ | Anxiety | ____ | ____ | Eating Disorder | _____ | _____ |

If you indicated a significant illness above provide details including the date and treatment:

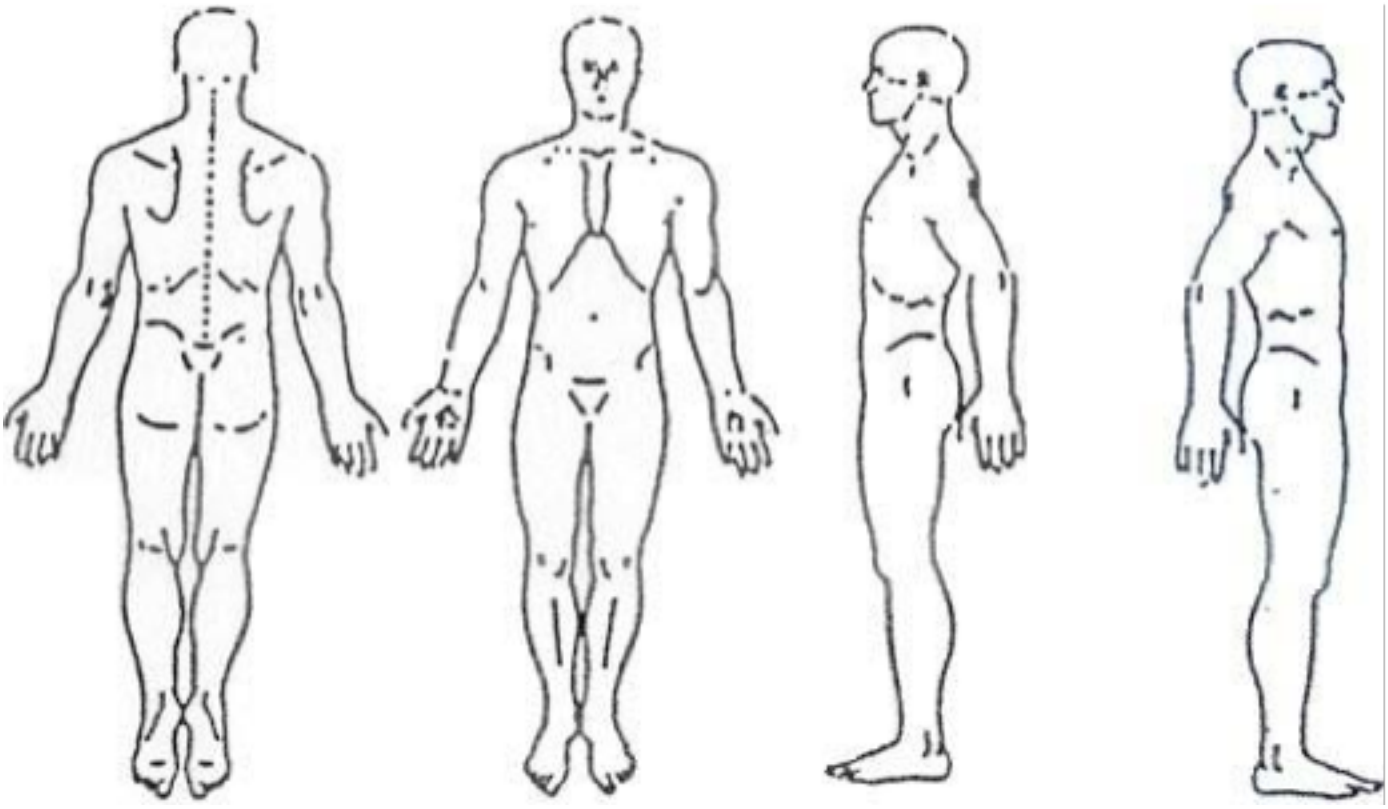
_____
_____
_____

List any other accidents, surgeries, or hospitalizations (please include date)

_____
_____
_____
_____

**Pain Diagram** (Please mark all areas of pain on diagram below)

**A-**Aching **B-**Burning **N-**Numbness **P-**Pins & needles
**S-** Stabbing **O-**Other type of sensation



Have you ever had any **Infectious Diseases (HIV, TB etc)**? □ Yes □ No

If so, please describe:

_____

_____

**Females**

Age at First Menses: ____Age stopped: _____# Days between period:_____# days in flow_____
Number of Pregnancies:_____Number of Births: _____Miscarriages:_____ Abortions: _____
Last period: _____Last PAP smear: _____ Pregnant: □Y □N Form of birth control: _____
**Date** of last Gynecological exam _____Mammogram_____ Bone Density Scan_____

□ Menstrual pain □ Low backache □ Irregular menses □ Painful breast □ Clots
□ Hot flashes □ Fertility problems □ Mood changes □ Hot flashes □ Vaginal dryness
□ Vaginal discharge □ Heavy bleeding

**Males**

□ Erectile dysfunction □ Premature ejaculation □ Nocturnal emission □ Pain/itching of genitalia
□ Lumps in testicles □ Increased libido □ Decreased libido □ Other: _____
Date of last prostate check up_____ PSA results_____

**Personal Habits**

□ Coffee # per day_____ □ Alcohol # drinks per week_____
□ Tobacco # per day_____ □ Former tobacco use # years quit _____
□ Recreational drugs # per day_____ □ Former alcohol use # years quit _____

Do you have a regular exercise program? _____If so, please describe: _____
_____

_____-

**Diet** (Please describe your typical daily diet)

Breakfast: _____ Morning Snack: _____
Lunch: _____ Afternoon Snack: _____
Dinner:_____ Dinner Snack:_____

It has been make clear to me that acupuncture is not a substitute for medical examinations and/ or diagnosis and that it is recommended that I see a physician for and physical ailments I may have. My acupuncturist must be aware of existing conditions; therefore I have stated all my known medical limitations and take it upon myself to keep the acupuncturist updated on my physical health

Print Name_____ Signature_____ Today's Date_____

**ALL INFORMATION IS CONFIDENTIAL UNLESS THE CLIENT REQUESTS AN AUTHORIZATION OR RELEASE OF INFORMATION**