

Cornerstone Healing

HEALTH HISTORY

Date: ___ / ___ / ___

Name:				Sex:		Age:	
Address:			City:		State:		Zip Code:
Phone #1: Home Cell Other		Phone #2: Work Cell Other		Email:			
Date of Birth:		Emergency Contact: (name & relationship)			Phone #:		
Primary Insurance Provider:		Insurance ID Number:	Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living w/partner <input type="checkbox"/> Other : _____				
Occupation:			Employer:				
How did you hear of our clinic?: <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Craigslist <input type="checkbox"/> Flyer <input type="checkbox"/> Walk / Drive by <input type="checkbox"/> Print Ad <input type="checkbox"/> Other : _____				Referred by:			
Physician: _____ Phone #: _____			Have you been treated by Acupuncture or Oriental Medicine Before? <input type="checkbox"/> No <input type="checkbox"/> Yes ___/___/___				

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1

When did this start? _____ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 | _____ | 10

2

When did this start? _____ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 | _____ | 10

3

When did this start? _____ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 | _____ | 10

HEALTH HISTORY

Circle the ↑ if you have / had the condition and ncte the year it started.
Circle the 🧑🏠 if there is a family history of the condition.

	YOU	Year	FAMILY		YOU	Year	FAMILY
Cancer type(s)?	↑	_____	🧑🏠	Osteoporosis	↑	_____	🧑🏠
Diabetes	↑	_____	🧑🏠	Herpes	↑	_____	🧑🏠
Hepatitis	↑	_____	🧑🏠	AIDS / HIV	↑	_____	🧑🏠
High Blood Pressure	↑	_____	🧑🏠	Other STD	↑	_____	🧑🏠
Heart Disease	↑	_____	🧑🏠	Rheumatic Fever	↑	_____	🧑🏠
Stroke	↑	_____	🧑🏠	Alcoholism	↑	_____	🧑🏠
Seizure Disorder	↑	_____	🧑🏠	Allergies type(s)?	↑	_____	🧑🏠
Thyroid Disease	↑	_____	🧑🏠	Mental Illness	↑	_____	🧑🏠
Asthma	↑	_____	🧑🏠	Kidney Disease	↑	_____	🧑🏠
Pacemaker	↑	_____	🧑🏠	Anemia	↑	_____	🧑🏠

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

EXERCISE

Do you exercise regularly? Yes No
If so, what and how often:

DIET Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)
Describe w/ dates:

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)



Cornerstone Healing

HEALTH HISTORY FOR WOMEN



Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD

HOT

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Thirst for cold / hot drinks | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Hot hands, feet, chest |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Thirst, no desire to drink | <input type="checkbox"/> Unusual sweats | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Cold "in the bones" | <input type="checkbox"/> Absence of thirst | When _____ am / pm | <input type="checkbox"/> Hot in afternoon |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Excessive thirst | Where on body _____ | <input type="checkbox"/> Hot at night |

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY

OILY

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Edema / Swelling _____ | <input type="checkbox"/> Oily skin |
| <input type="checkbox"/> Dry hair | <input type="checkbox"/> Dry lips | <input type="checkbox"/> Rashes _____ | <input type="checkbox"/> Oily hair |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Dry throat | <input type="checkbox"/> Itching _____ | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dry brittle nails | <input type="checkbox"/> Dry nose / Nosebleeds | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Weight gain / loss |
- Where on your body?: _____

DIGESTION

DIARRHEA

CONSTIPATION

- | | | | |
|--|--|--|---|
| BM: How often? _____ x / every _____ days | <input type="checkbox"/> Gas | <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Dry Stools |
| Stools keep shape? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Bloating | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Difficult to pass |
| <input type="checkbox"/> Alternating diarrhea & constipation (IBS) | <input type="checkbox"/> Belching | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Tired after BM |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Foul smelling stools |

ENERGY

LOW

HIGH

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Dependence on caffeine / stimulants | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Hard to concentrate |
| Time of day: _____ am / pm | <input type="checkbox"/> Wired / ungrounded feeling | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Energy drop after eating | <input type="checkbox"/> Body / Limbs feel heavy | <input type="checkbox"/> Blood pressure High / Low | <input type="checkbox"/> Dizziness / lightheaded |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Body / Limbs feel weak | <input type="checkbox"/> Bleed / Bruise easy | <input type="checkbox"/> Headaches _____ x / week |

SLEEP

- # hours per night _____
- Difficulty falling asleep
 - Wake ___x/ night @ _____ am / pm
 - Wake to urinate How often? _____
 - Disturbing dreams
 - Restless sleep
 - Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Joy |
| <input type="checkbox"/> Worry | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Obsessive thinking | <input type="checkbox"/> Timid / shy |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Indecision |

EYES, EARS NOSE THROAT

- | | |
|---|--|
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Excess earwax |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> Phlegm (color _____) | <input type="checkbox"/> Cough |

MENSES

- Age at first menses: _____
- Length of full cycle: _____ days
- Length of menses: _____ days
- Last menses start date: ____ / ____
- # of pregnancies: _____
- # of births: _____ premature _____
- # of abortions / miscarriages: _____

MENOPAUSE

Age at last menses : _____ Hot flashes _____ x / day Vaginal dryness

Year changes began: _____ Night sweats _____ x / week Loss of sex drive

- | | | |
|---|--|--|
| <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Cramps | <input type="checkbox"/> Mood changes |
| <input type="checkbox"/> Light periods | <input type="checkbox"/> Before bleeding | <input type="checkbox"/> Fatigue w/ menses |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> First day | <input type="checkbox"/> Digestive changes w/ menses |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> During period | <input type="checkbox"/> Midcycle spotting |
| <input type="checkbox"/> Changes in body/psyche prior to menstruation (PMS) | <input type="checkbox"/> Clots | <input type="checkbox"/> Yeast infections |
| | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Birth control pill (hormonal) |



Cornerstone Healing

HEALTH HISTORY FOR MEN



Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE			
How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.			
COLD			HOT
<input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Chills <input type="checkbox"/> Cold "in the bones" <input type="checkbox"/> Areas of numbness	Thirst for cold / hot drinks <input type="checkbox"/> Thirst, no desire to drink <input type="checkbox"/> Absence of thirst <input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Night sweats <input type="checkbox"/> Unusual sweats <i>When _____ am / pm</i> <i>Where on body _____</i>	<input type="checkbox"/> Hot hands, feet, chest <input type="checkbox"/> Hot flashes <input type="checkbox"/> Hot in afternoon <input type="checkbox"/> Hot at night

MOISTURE			
Your overall body moisture (hair, skin, mouth, bowels, etc.)			
DRY			OILY
<input type="checkbox"/> Dry skin <input type="checkbox"/> Dry hair <input type="checkbox"/> Dry eyes <input type="checkbox"/> Dry brittle nails	<input type="checkbox"/> Dry mouth <input type="checkbox"/> Dry lips <input type="checkbox"/> Dry throat <input type="checkbox"/> Dry nose / Nosebleeds	<i>Where on your body?:</i> <input type="checkbox"/> Edema / Swelling _____ <input type="checkbox"/> Rashes _____ <input type="checkbox"/> Itching _____ <input type="checkbox"/> Dandruff	<input type="checkbox"/> Oily skin <input type="checkbox"/> Oily hair <input type="checkbox"/> Pimples <input type="checkbox"/> Weight gain / loss

DIGESTION			
DIARRHEA			CONSTIPATION
BM: How often? _____ x / every _____ days Stools keep shape? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Alternating diarrhea & constipation (IBS) <input type="checkbox"/> Indigestion	<input type="checkbox"/> Gas <input type="checkbox"/> Bloating <input type="checkbox"/> Belching <input type="checkbox"/> Poor appetite	<input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Bad breath <input type="checkbox"/> Heartburn <input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Dry Stools <input type="checkbox"/> Difficult to pass <input type="checkbox"/> Tired after BM <input type="checkbox"/> Foul smelling stools

ENERGY			
LOW			HIGH
<input type="checkbox"/> Sudden energy drop <i>Time of day: _____ am / pm</i> <input type="checkbox"/> Energy drop after eating <input type="checkbox"/> Fatigue	<input type="checkbox"/> Dependence on caffeine / stimulants <input type="checkbox"/> Wired / ungrounded feeling <input type="checkbox"/> Body / Limbs feel heavy <input type="checkbox"/> Body / Limbs feel weak	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Blood pressure High / Low <input type="checkbox"/> Bleed / Bruise easy	<input type="checkbox"/> Hard to concentrate <input type="checkbox"/> Poor memory <input type="checkbox"/> Dizziness / lightheaded <input type="checkbox"/> Headaches _____ x / week

SLEEP
hours per night _____ <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Wake ___x/ night @ _____ am / pm <input type="checkbox"/> Wake to urinate <i>How often? _____</i> <input type="checkbox"/> Disturbing dreams <input type="checkbox"/> Restless sleep <input type="checkbox"/> Not rested upon waking

EMOTIONS
What emotion(s) dominate your experience? <input type="checkbox"/> Anger <input type="checkbox"/> Irritability <input type="checkbox"/> Anxiety <input type="checkbox"/> Worry <input type="checkbox"/> Obsessive thinking <input type="checkbox"/> Sadness <input type="checkbox"/> Grief <input type="checkbox"/> Depression <input type="checkbox"/> Joy <input type="checkbox"/> Fear <input type="checkbox"/> Timid / shy <input type="checkbox"/> Indecision

EYES, EARS NOSE THROAT
<input type="checkbox"/> Poor vision <input type="checkbox"/> Night blindness <input type="checkbox"/> Red eyes <input type="checkbox"/> Itchy eyes <input type="checkbox"/> Spots in front of eyes <input type="checkbox"/> Sinus congestion <input type="checkbox"/> Phlegm (<i>color</i> _____) <input type="checkbox"/> Poor hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Excess earwax <input type="checkbox"/> Sore throat <input type="checkbox"/> Dental problems <input type="checkbox"/> Mouth sores <input type="checkbox"/> Cough

URINARY
Fluid in = fluid out? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Decrease in flow <input type="checkbox"/> Dribbling <input type="checkbox"/> Difficulty starting / stopping <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney stones <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> Frequent urination <input type="checkbox"/> Pain on urination <input type="checkbox"/> Burning sensation <input type="checkbox"/> Cloudy urine <input type="checkbox"/> Blood in urine

REPRODUCTIVE
Are you sexually active? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Change of sexual drive: ↑ ↓ <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Premature ejaculation <input type="checkbox"/> Sores on genitals <input type="checkbox"/> Discharge <input type="checkbox"/> Prostate disease <input type="checkbox"/> Genital Pain <input type="checkbox"/> Jock Itch <input type="checkbox"/> Vasectomy <input type="checkbox"/> Hernia <input type="checkbox"/> Hemorrhoids



NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to collect that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or complex us to do so. You may see your record or get more information about it by contacting Anne Mok, LAc/Peggy Regis, LAc.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Signature of Patient or legally authorized individual

Date

Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

(Notation, if any, by staff)

This form will be retained in your medical record.

Last Update ____ / ____ / ____

CONSENT TO CONTACT

I _____ give my permission to Cornerstone Healing to contact me (e.g. to confirm appointments or to discuss my condition and treatment) at the following address(s), phone number(s) and email address(es).

I understand that messages may be left for me on the voicemail(s) or with the people who answer the phone at these number(s).

Address: _____ Home Phone #(s): _____

_____ Work Phone #(s): _____

_____ Cell Phone #(s): _____

Email Address(es): _____

Which phone # would you prefer we use to contact you? _____

Signature of Patient or Representative

Date

Print Name of Patient

Print Name of Patient Representative



I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

Cornerstone Healing is committed to your health and well-being. Although Anne Mok, LAc/Peggy Regis, LAc has a great deal to offer as an acupuncturist, she cannot totally 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 8211.1 (b) of NYS Education Law, we request that you read and sign the following statement:

WE, THE UNDERSIGNED, DO AFFIRM THAT _____
(Patient)

HAS BEEN ADVISED BY Anne Mok LAc/Peggy Regis LAc
(Licensed Acupuncturist)

TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

_____	_____
<i>Patient Signature</i>	<i>Date</i>
_____	_____
<i>Licensed Acupuncturist Signature</i>	<i>Date</i>

II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with Traditional Oriental Medicine by Anne Mok/Peggy Regis, a Licensed Acupuncturist. I have discussed the nature and purpose of my treatment with Anne Mok, LAc/Peggy Regis, LAc.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, and Tui Na (Chinese Massage).

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Bruising is a common side effect of cupping. Burns and/or scarring are a potential risk of moxibustion. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although Anne Mok, LAc/Peggy Regis, LAc uses sterile, disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) which may be recommended are traditionally considered safe, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify Anne Mok, LAc/Peggy Regis, LAc of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify Anne Mok, LAc/Peggy Regis, LAc if I am or intend to become pregnant.

I do not expect Anne Mok, LAc/Peggy Regis, LAc to be able to anticipate and explain all possible risks and complications of treatment and I wish to rely on her to exercise judgment during the course of the treatment which she thinks, at the time and based upon the facts known to her, is in my best interests.

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

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated).

To be completed by Anne Mok, LAc/Peggy Regis, LAc
Providing information and obtaining consent

Date Consent Completed

Print Name of Patient

Signature of Patient or Representative

Print Name of Patient Representative

Anne Mok, LAc/Peggy Regis, LAc