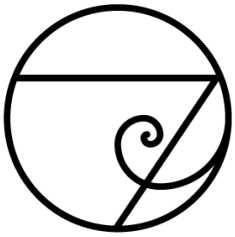

SEVEN SEAS ACUPUNCTURE
911 UNION ST., GARDEN FL, BROOKLYN, NY 11217
347.260.3072

Please note that all information is strictly confidential.

First Name: _____ Middle Initial: _____

Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____ Occupation: _____

In case of emergency contact: _____ Relationship & Phone: _____

Height: _____ Weight: _____ Age: _____

OBGYN Name: _____ Phone: _____

Reproductive Endocrinologist Name: _____ Phone: _____

Other relevant physicians/specialists: _____

_____

_____

_____

_____

May I discuss your treatment with your physicians? ☐ Yes ☐ No

How did you hear about the clinic? _____

Reason for today's visit: _____

_____

How, when, and where did this condition begin?

What types of treatment have you tried?

Please list the main health concerns you would like to address in order of importance:

1)

2)

3)

Medical History: Surgeries, Major Illnesses, Hospitalizations, and Major Accidents:

Current medications, supplements, and vitamins (including what they are for):

Do you have, or have you had any of the following illnesses? Please check any that apply.

- ☐ Mental Illness
- ☐ Heart Disease
- ☐ Herpes
- ☐ Tuberculosis
- ☐ Mononucleosis
- ☐ Diabetes
- ☐ Asthma
- ☐ AIDS
- ☐ Ulcers
- ☐ Kidney Stones
- ☐ Hepatitis
- ☐ Allergies
- ☐ Gallstones
- ☐ HIV+
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Cancer
- ☐ STDs (Please List)
- ☐ Seizures
- ☐ Arthritis
- ☐ Chronic Fatigue
- ☐ Thyroid Problems
- ☐ Osteporosis
- ☐ Rheumatic Fever
- ☐ Other

Lifestyle:

Vegetarian? ☐ Yes ☐ No

Please describe what you typically eat: _____

_____

Exercise? ☐ Yes ☐ No How often? _____

Type? _____

Hours of sleep per night: _____ Time to bed: _____ Time to rise: _____

Feel rested in the AM? ☐ Yes ☐ No

Trouble falling asleep? ☐ Yes ☐ No ☐ Sometimes

Wake during the night? ☐ Yes ☐ No

Get up to urinate more than once? _____

Work: Enjoy work? ☐ Yes ☐ No Hours working per week: _____ Profession: _____

Body Systems Review:

0=Never, 1=In the past but not now, 2=Occasionally, 3=Frequently 4=Almost always

0	Low appetite	0	Loose stools	0	Abdominal gas/ bloating after food	0	Fatigue after eating
0	Organ prolapse	0	Bruise easily	0	Obsessive thoughts/ worrying	0	Heavy limbs
0	Fatigue	0	Hemorrhoids	0	Belching	0	Nausea
0	Diarrhea	0	Craving for sweets				

0	Spontaneous sweat	0	Allergies	0	Feeling of sadness	0	Shortness of breath
0	Cough	0	Dry nose/mouth/ throat	0	Asthma	0	Catch cold easily
0	Feel tired after exercise	0	General weakness	0	Nasal discharge	0	Sinus congestion

0	Sore, cold, or weak knees	0	Low back pain	0	Frequent urination	0	Urinary incontinence
0	Ear problems	0	Early morning diarrhea	0	Craving salt	0	Hair loss
0	Memory loss	0	Hot flashes	0	Night sweats	0	Feeling cold
0	Edema	low	Libido				

0 Irritable
0 Feel better after exercise
0 Tight feeling in chest
0 Alternating diarrhea /constipation
0 Symptoms worse with stress
0 Muscle spasms/ twitches
0 Heartburn/acid reflux
0 Dry eyes/red eyes
0 Ear ringing
0 Anger easily
0 Neck/shoulder tension
0 Frequent headaches
0 Floaters in vision
0 Blurry vision
0 Feeling of heat rushing to head
0 Brittle or weak nails

---

0 Feel heart beating
0 Chest pain
0 Insomnia
0 Disturbing dreams
0 Sores on tip of tongue
0 Excessive laughter
0 Anxiety
0 Restlessness
0 Excessive sweat
0 Red cheeks
0 Palpitations

Urination (check all that apply):

☐ Burning ☐ Urgent ☐ Retention ☐ Frequent ☐ Scanty

☐ Profuse ☐ Dribbling ☐ Cloudy ☐ Dark ☐ Pale

Wake up to urinate more than once? ☐ Yes ☐ No

Bowel movements: _____ Frequency: _____ When: _____

Feels complete? ☐ Yes ☐ No

Consistency: ☐ Well-formed ☐ Hard ☐ Loose ☐ Alternates

In stools? ☐ Undigested Food ☐ Blood ☐ Mucus

Are you thirsty? ☐ Yes ☐ No If so, do you crave warm or cold drinks? _____

Do you find that you "run" particularly hot or cold? _____

How is your energy in general? _____

Do you often get headaches or migraines? ☐ Yes ☐ No

If yes, where do you feel the pain? _____

Are they dull and aching or sharp and stabbing in nature? _____

When do you normally get them? _____

How do you feel emotionally right now? _____

Gynecological:

Number of pregnancies: _____ Number of children: _____ Age of first period: _____

Infertility: ☐ Yes ☐ No ☐ Maybe

On the Pill? ☐ Yes ☐ No Abortions? ☐ Yes ☐ No

Have you experienced menopause? ☐ Yes ☐ No When? _____

If you are experiencing menopausal symptoms, please describe: _____

_____

Date of last menstrual period? _____ Are you pregnant now? ☐ Yes ☐ No

Is your period regular? ☐ Yes ☐ No Number of days from one period to next? _____

Flow is: ☐ Light ☐ Normal ☐ Heavy

Color is: ☐ Pale Red ☐ Dark Red ☐ Red ☐ Brown ☐ Purple

Blood clots? ☐ Yes ☐ No How big/color? _____

Do you get pain or cramps? ☐ Yes ☐ No Severe? ☐ Yes ☐ No

Do you experience any of the following before or during your period each month?

☐ Water retention ☐ Breast tenderness or swelling ☐ Migraines ☐ Other

☐ Irritability ☐ Food craving ☐ Emotional Upset

Do you ever bleed between periods? ☐ Yes ☐ No

Do you have any unusual vaginal discharge? ☐ Yes ☐ No

Have you ever had any of the following?

☐ Abdominal Surgery ☐ LEEP Procedure ☐ Fibroids ☐ Polyps ☐ IUD

☐ Endometriosis ☐ Chlamydia ☐ Ectopic Pregnancy

Do you know your FSH level? _____

Have you recently had your estrogen/progesterone levels taken? If so, what are they? _____

_____

Please describe any reproductive procedures you have been through or are going through currently that you have not listed above. Please indicate procedures that involve both sexes:

_____

We are committed to your health and well-being. While Chinese Medicine is a very thorough health care system, it is not a replacement for western treatment including regular check ups with your primary care physician and/or OBGYN. New York State law requires us to recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

We, the undersigned, do affirm that _____ (print patient name), has been advised by Seven Seas Acupuncture to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

Patient Signature_____ Date _____

Print Practitioner Name _____

Practitioner Signature _____

I consent to acupuncture treatments and other procedures associated with Traditional Oriental Medicine, and I have discussed the nature of my treatment with Licensed Acupuncturist Rachel Esquilin of Seven Seas Acupuncture, P.C.

I understand that methods of treatment may include but are not limited to: Acupuncture, moxibustion, cupping, gua sha, electrical stimulation, tui na (Chinese massage), Chinese herbal medicine, other supplements.

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 and guasha. Unusual risks of acupuncture include pneumothorax and organ puncture. Slight superficial burns are a possible side effects of moxibustion.

I acknowledge that if I don't give 24 hours notice for cancellation of an appointment, I will be charged in full for the missed appointment. Any cancellations prior to the 24 hour window period will not incur any fees, as this allows Seven Seas Acupuncture to fill the appointment slot.

Patient Signature_____ Date _____