

Name _____

Date _____

Address _____

Place of Birth _____

Date of Birth _____

Home Phone _____

Occupation _____

Business Phone _____

E-Mail _____

Personal History:

- Diabetes
- Drug Allergies
- Hepatitis
- Headaches
- Tuberculosis
- Other _____
- Asthma or Bronchitis
- Stomach or Intestinal Disorders
- Cancer
- Allergies
- Kidney Disorder

- Stroke
- Thyroid Disorder
- Organ Transplant
- High Blood Pressure
- Heart Disease
- Hormonal Disorder
- Seizures
- Skin Disorder
- Urinary Tract Infection
- Musculoskeletal Disorder
- Auto Immune Disease
- Specify _____

Major Hospitalizations:

<u>Year</u>	<u>Operation/Illness</u>	<u>Name of Hospital</u>	<u>City</u>
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Medicines:

- Aspirin
- Ibuprofen
- Antacid
- Oral Contraceptives
- Diet Pills
- Laxatives
- Tranquilizers
- Sleeping Pills
- Hay Fever Tablets
- Cold Tablets
- Vitamins
- Herbs

Please list the names of any medicines you are taking:

Please list any allergies to medicines you have:

Habits (Tobacco, Coffee, Tea's, Alcohol, Marijuana, Street Drugs) Please specify amount, and for how long.

Please tell us the primary reason (s) you are seeking treatment:

Who may we thank for this referral?

Date of Last Physical Exam: _____ Name of Physician: _____

Emergency Contact Information:

Name _____ Address _____

Please place a "C" next to any conditions you currently experience and a "P" for conditions in the past.

Skin

- Hives
- Rashes
- Eczema
- Night Sweating
- Excess Sweating
- Dryness
- Bruise easily
- Changes in Moles or Lumps
- Other

Head & Neck

- Dizziness
- Fainting
- Neck Stiffness
- Enlarged Lymph Glands
- Headaches
- Other

Eyes

- Blurred Vision
- Visual Changes
- Poor Night Vision
- Spots
- Eye Inflammation

Ears

- Infection
- Ringing
- Decrease Hearing
- Other

Nose & Throat

- Bleeding
- Sinus Infection
- Hay Fever or Allergies
- Sore Throat
- Hoarseness
- Difficulty Swallowing
- Changes in Taste
- Changes in Smell
- Oral Ulcers
- Others

Respiratory

- Chronic Cough
- Coughing up blood
- Coughing up phlegm
- Difficulty Breathing
- Wheezing/Asthma
- Frequent Colds

Cardiovascular

- Palpitations
- Chest pain or tightness
- Rapid Heart Beat
- Poor Circulation
- Swelling of Ankles
- Phlebitis
- Other

Gastrointestinal

- Nausea
- Indigestion
- Stomach Pain
- Diarrhea
- Constipation
- Poor Appetite
- Excessive Hunger
- Vomiting Blood
- Bloody or Black Stool
- Hemorrhoids
- Gallbladder Disorder
- Recent Changes in Weight
- Food Cravings
- Other

Male Reproductive System

- Pain/Itching of Genitalia
- Genital Lesions/Discharge
- Impotence
- Weak Urinary Stream
- Lumps in Testicles
- Other

Female Reproductive System

- Frequent Urinary Tract Infection
- Frequent Vaginal Infections
- Pain/Itching or Genitals
- Genital Lesions/Discharge
- Pelvic Inflammatory Disease
- Abnormal Pap smear
- Irregular menstrual periods
- Painful menstrual periods
- Premenstrual syndrome
- Abnormal Bleeding
- Menopausal Symptoms
- Breast Lumps
- Other

Muscle & Joint

- Joint Disorder
- Sore Muscles
- Weak Muscles
- Difficulty Walking
- Spinal Curvature
- Backache
- Other

Neurological

- Seizures
- Tremors
- Numbness or Tingling of Limbs
- Pain
- Paralysis
- Other

General

- Insomnia
- Frequent Dreams/Nightmares
- Depression
- Agitation
- Fatigue
- Aversion to Cold
- Aversion to Heat
- Frequent Urination
- Irritability
- History of Psychiatric Treatment
- Thirst
- Other

Infection Screening

- HIV risks: Self or Partner
- TB: Self or Partner
- Hepatitis risk: Self or Partner
- History of STD's
 - Gonorrhea: Self or Partner
 - Chlamydia: Self or Partner
 - Syphilis: Self or Partner
 - Genital warts: Self or Partner
 - Herpes: Self or Partner

Informed Consent to Acupuncture Treatment

I consent to Acupuncture treatments and other treatments associated with Traditional Oriental Medicine by Noah Rubinstein

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. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including Lung puncture (pneumothorax). Infection is another possible risk, although Noah uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this documentation 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 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, stomach ache, 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 Noah Rubinstein of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify Noah Rubinstein who is caring for me if I am or become pregnant.

I do not expect Noah Rubinstein to be able to anticipate and explain all possible risks and complications of treatment and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts known to them, and is in my best interest.

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

Date Consent Completed

Print Name of Patient

Practitioner Name

X _____
Signature of Patient

Signature

Patient Advisory to Consult a Physician

The entire staff of Longevity Health is committed to your health and well-being. While Traditional Chinese Medicine has a great deal to offer as a health care system, it cannot totally replace all of the resources available through biomedical physicians. Consequently, it is recommended 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 New York State Law, it is requested that you read and sign the following statement.

We, the undersigned, do affirm that _____ (patient) has been advised to consult a physician regarding the condition, or conditions for which they are seeking acupuncture treatments.

