MELANIE MORRIS KATIN, L.AC.
LICENSED ACUPUNCTURIST
BOARD CERTIFIED IN CHINESE HERBOLOGY

Confidential Health History

928 BROADWAY • # 1200
NEW YORK, NY 10010
TEL: 212.777.1318

First Name_____ Last Name_____ ☐ Female ☐ Male

Address_____Apt._____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell_____

Emergency Contact_____ Phone_____

Marital Status ☐ single ☐ committed ☐ married ☐ divorced Number of Children_____

Occupation_____ Email_____

Date of Birth_____ Age_____ Place of Birth_____

Current Physician_____ Phone_____

Whom may we thank for referring you?_____

Main Reason for Appointment: Please rank in order of importance to you, and indicate duration of symptoms:

_____

_____

_____

_____

_____

Is your condition getting worse? ☐ yes ☐ no

Is your discomfort ☐ constant? ☐ off and on?

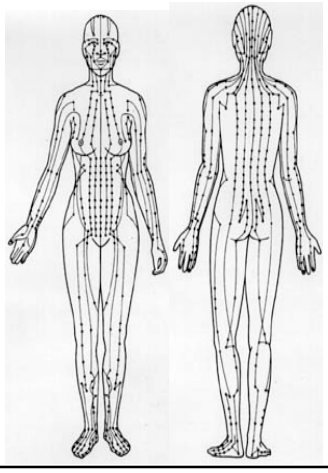
Have you visited any other doctor for these conditions? ☐ yes ☐ no

If yes, please list doctor, prior interventions, and treatments:_____

_____

_____

Please use the diagram to mark areas of discomfort:



Allergies:

_____

_____

_____

Current Medications / Vitamins / Herbs:

Name	Dosage	Duration	Reason

Patient Reported Symptoms

Name_____Date_____

Please mark "X" for current symptoms, experienced in the past few weeks, and "/" for symptoms experienced in the past.

CONSTITUTION
- ☐ fatigue
- ☐ poor appetite
- ☐ fevers
- ☐ chills
- ☐ food cravings
- ☐ weight loss
- ☐ weight gain

NERVES/BRAIN
- ☐ seizures
- ☐ poor balance
- ☐ poor coordination
- ☐ nerve pain
- ☐ tremors/shaking

VASCULAR/BLOOD
- ☐ anemia
- ☐ easy bruising
- ☐ chest pain
- ☐ light headed
- ☐ palpitations
- ☐ cold hands/feet
- ☐ fainting
- ☐ swelling feet
- ☐ blood clots
- ☐ varicose veins

SEXUAL ORGANS
- ☐ lumps or swelling
- ☐ sores on genitals
- ☐ low sex drive
- ☐ infertility
- ☐ repeated infections

HEAD/EAR/NOSE/THROAT
- ☐ headaches
- ☐ ringing ears
- ☐ poor hearing
- ☐ earaches
- ☐ nosebleed
- ☐ postnasal drip
- ☐ sinus problems
- ☐ trouble with taste/smell
- ☐ jaw clicking
- ☐ grinding teeth
- ☐ mouth sores
- ☐ bad breath
- ☐ facial pain
- ☐ sore throat

URINE/KIDNEY/BLADDER
- ☐ painful urination
- ☐ wake to urinate
- ☐ frequent urination
- ☐ urgency to urinate
- ☐ kidney stones
- ☐ blood/pus in urine

EMOTIONAL
- ☐ frustration
- ☐ anxiety
- ☐ panic attacks
- ☐ anger
- ☐ sadness
- ☐ worry
- ☐ overthinking

BREATHING/LUNGS
- ☐ short of breath
- ☐ wheezing/asthma
- ☐ frequent colds/flu
- ☐ chronic cough

EYES
- ☐ blurred vision
- ☐ eye pain
- ☐ poor vision
- ☐ near sighted
- ☐ far sighted
- ☐ red
- ☐ itching
- ☐ dry

JOINTS/MUSCLES
- ☐ neck pain
- ☐ back pain
- ☐ muscle pain
- ☐ painful joints
- ☐ shoulder
- ☐ elbow
- ☐ wrist
- ☐ finger(s)
- ☐ hip
- ☐ knee
- ☐ ankle
- ☐ joint swelling
- ☐ muscle weakness
- ☐ muscle cramps
- ☐ muscle spasm

SKIN/HAIR
- ☐ rashes
- ☐ itching
- ☐ dry skin
- ☐ eczema
- ☐ psoriasis
- ☐ hair loss

IMMUNE
- ☐ frequent infections
- ☐ allergies
- ☐ swollen lymph glands

DIGESTION
- ☐ indigestion
- ☐ belching
- ☐ heartburn/ reflux
- ☐ difficulty swallowing
- ☐ nausea
- ☐ vomiting
- ☐ diarrhea
- ☐ cramping bowels
- ☐ gas/flatulence
- ☐ constipation
- ☐ abdominal pain
- ☐ rectal pain/itching
- ☐ hemorrhoids
- ☐ blood in stool

WOMEN
- ☐ pelvic pain
- ☐ vaginal discharge
- ☐ painful periods
- ☐ PMS
- ☐ hot flashes
- ☐ itching/soreness

_____age period started
_____# of pregnancies
_____pregnancies lost
_____# of live births
_____# of children
_____date of last period

MEN
- ☐ lumps in testicles
- ☐ prostate problems
- ☐ weak urinary stream
- ☐ impotence
- ☐ other

Lifestyle / Self-Care

Do you allow time to relax? ☐ Yes ☐ No

If yes, how?_____

- ☐ Cigarettes _____pack/day
- ☐ Alcohol _____drinks/day
- ☐ Recreational Drugs
- ☐ Coffee/Tea

	great	good	ok	poor	bad
Family	☐	☐	☐	☐	☐
Partner	☐	☐	☐	☐	☐
Sex	☐	☐	☐	☐	☐
Self	☐	☐	☐	☐	☐
Work	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐
Emotions	☐	☐	☐	☐	☐

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Please check those that apply:

	You	Mother	Father	Grandparents	Sister/Brother
AIDS/HIV					
Alcoholism					
Allergies					
Alzheimer's					
Anemia					
Arthritis					
Asthma					
Breast Cancer					
Cancer					
Colon Cancer					
Chronic Lung Disease					
Depression					
Diabetes					
Drug Abuse					
Emphysema					
Epilepsy					
Glaucoma					
Heart Attack					
Heart Disease					
Hepatitis					
High Blood Pressure					
Inflammatory Bowel Disease					
Irritable Bowel Disease					
Kidney Disease					
Liver Disease					
Mental Illness					
Migraine Headaches					
Pneumonia					
Prostate Cancer					
Stroke					
Suicide					
Ulcers					

Past Hospitalizations / Illnesses / Accidents (please list):

_____

_____

_____

_____

Health Screening History: Please list the date of the most recent test or exam, if applicable:

Mammogram_____ Pap Smear_____ Breast Exam by MD_____ By Self_____

Prostate_____ Colonoscopy/Sigmoidoscopy_____ Stress Test_____

Melanie Katin, L.Ac.
Acupuncture & Chinese Herbs

INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE TREATMENT

I request and consent to the performance of acupuncture and other Chinese medicine procedures. I understand that my signature on this form indicates that I have read the following, and understand that if I have any questions, I should ask the practitioner.

1. Nature of Treatment: The treatment modalities may include acupuncture, massage therapy, acupressure, cupping, gua-sha, electric acupuncture, Chinese herbs. I understand that the treatments will be explained to me prior to the treatment of my condition.
2. Purpose of Treatment: I understand that the purpose of the treatment is to resolve my condition, the reason that I am requesting treatment. The procedures will attempt to remedy bodily dysfunction or diseases, to modify or prevent the perception of pain, and to make normal the body's physiological functions.
3. Risks of Treatment: I understand that Chinese medicine procedures have been shown to be safe and effective. However, I understand that there are some uncommon risks. These may include:
   - ❖ Mild discomfort during or after the insertion of a needle, dizziness, fainting, localized bruising or swelling, gastrointestinal upset with the use of Chinese herbs, temporary aggravation of symptoms that existed prior to treatment; some herbs and acupuncture points are contraindicated during pregnancy. *Please notify your practitioner if you are or might be pregnant.*
4. Use of Disposable Needles: I understand that to prevent any possibility of infection from acupuncture, all needles used are pre-sterilized, used one time only, surgical stainless steel needles that are disposed of after usage as medical waste. Needles are never reused.
5. Unforeseen Risks: I understand that the practitioner cannot anticipate or explain all risks and complications that may occur during or after treatment. I understand that they will exercise judgment based upon their determination of my best interest. I understand that I may stop treatment at any time.

PATIENT ADVISORY TO CONSULT A PHYSICIAN

To comply with Article 160, section 8211.1(b) of NYS Education law, we must advise that you consult a physician regarding your condition.

HIPAA Privacy Act: Ensures that all of your personal and health information remains confidential at all times between this office, your insurance company and you. Should you have any questions about the privacy of your information at this office, you may ask Melanie Katin at any time.

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OFFICE POLICIES AND PROCEDURES

Insurance Policies: I authorize payment of insurance benefits otherwise payable to me directly to the practitioner. I agree to pay for all treatment sessions, co-payments, deductibles, and coinsurances for the services performed in the event that my health insurance policy does not cover those services, or as required by my policy. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I understand that if my insurance plan does not fully cover acupuncture treatments, I will be held accountable to pay any balances due on account.

Your signature indicates that you have read, understand, and agree with the above information.

Signature of Patient (or patient representative/parent)_____Date_____