# Becky J Hinman, Licensed Acupuncturist

**Master of Science in Oriental Medicine** **301 W Broad St, Horseheads**
**New York State License #1598** **(607) 734-8849 voice or text**
**Professional Esogetic Colorpuncture Certification** **www.BeckyHinmanLac.com**

**HIPAA PRIVACY**

Please check all the ways that you wish to be contacted. Generally, I would only need to contact you regarding schedule changes or office information changes.

Leave message with detailed information ( ) home phone ( ) work phone ( ) cell phone

**OR** Leave message with call-back number only ( ) home phone ( ) work phone ( ) cell phone

Mail to ( ) home address ( ) work address Fax to _____

Other _____

**CONSENT FOR TREATMENT**

Patient's Last Name _____ First Name _____ Initial _____

Patient's Date of Birth _____

In conjunction with New York State law, I must advise all of my patients to seek consultation with a physician concerning any conditions(s) for which you are seeking my services.

Patient Signature_____ Today's Date _____

I hereby consent to acupuncture. _____ (patient's initials)

**CANCELLATION POLICY-- Please sign in acknowledgement.**

You will be charged for your appointment when cancelling with less than 24 hours notice or not cancelling or forgetting. You can leave a voice or text message at the above listed phone number or email address. I do not overbook. I reserve your appointment for you. Thank you!

PRINT Name _____

Signature _____

**CONSENT FOR TREATMENT OF MINOR CHILD**

Child's Last Name _____ First Name _____ Initial _____

Parent/Guardian Signature _____ Today's Date _____

Witness _____ Today's Date _____

**Becky J Hinman, Licensed Acupuncturist**
**Master of Science in Oriental Medicine**
**New York State License #1598**
**Professional Esogetic Colorpuncture Certification**

**Acupuncture Wellness Center**
**301 W Broad St, Horseheads,**
**(607) 734-8849 voice or text**
**BeckyAWC@hotmail.com**

Today's Date _____

Last Name _____ First Name _____ Initial _____

Mailing Address _____

City/State/Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Date of Birth _____

Email Address_____ Place of Birth _____

Emergency Contact _____ Phone# _____ Relationship _____

Who may I thank for referring you to me? _____

Current (or most recent) Occupation_____ Employer _____

Hours per week _____ Disabled____ Retired____ Student____ Other_____

Single____ Married____ Divorced____ Widowed____ Partner or Significant Other____

Live with: Spouse____ Partner____ Parents____ Children____ Friends____ Alone____

Ages of Children_____

Blood Type_____ Height_____ Weight_____ Ideal Weight_____

Who is your primary care provider?_____

Do you receive other health care? _____ If yes, from whom and for what? _____

_____

Have you ever had acupuncture?_____ From whom and when?_____

| Conditions or Goals (in order of importance) | Onset (Month &Year) | Frequency (per day or week) | Severity (mild/moderate/severe) |
|---|---|---|---|
| **Example: Headaches** | **June 1998** | **4 times per wk** | **severe** |
| 1._____ | _____ | _____ | _____ |
| 2._____ | _____ | _____ | _____ |
| 3._____ | _____ | _____ | _____ |
| 4._____ | _____ | _____ | _____ |

How does your condition(s) affect you? _____

_____

What do you think is happening? _____

_____

What do you feel needs to happen for you to get better? _____

_____

What other kinds of treatments have you tried? _____

_____

Do you have any contagious diseases now?_____ If yes, what?_____

Are you allergic or hypersensitive to medicines, herbs, foods, animals or anything else?

| Substance | Reaction |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Current Medications (over-the-counter and prescription) & Vitamins, Minerals, Supplements

| Name | Reason | For how long |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please check all the childhood illnesses you have had

| | | | |
|---|---|---|---|
| ☐ Chicken Pox | ☐ Rheumatic Fever | ☐ Mononucleosis | ☐ _____ |
| ☐ Mumps | ☐ Measles | ☐ Polio | ☐ _____ |

When is your **energy level** the highest? _____ lowest? _____

What is your spiritual or religious practice? _____

Accidents, Injuries, ER Visits, Hospitalizations and Surgeries (include year) _____

_____

_____

_____

Please describe your typical food intake

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

How many meals per week do you **eat out** of the house? _____ Have been diagnosed or suspected of having an eating disorder? _____ Are you on a special diet? _____ If so, please describe _____

What foods or flavors, do you crave? _____

How many **(8 oz) cups per day** do you drink of .... ? Water ____ Coffee ____ Soda _____

Diet soda _____ Green/Herbal tea ____ Black tea _____ Other beverages _____

Do you **smoke**? ___ # of cigs/cigars per day _____ How long?_____ Quit when ?_____

Do you use **recreational drugs**? _____

Have you been treated for **addiction** (alcoholism, drugs, sex, food) ? _____

Do you have a history of abuse (physical, sexual, emotional)? _____

Do you have difficulty falling asleep? _____ Do you have difficulty staying asleep? _____

Do you awake rested? _____ Do you exercise? _____

Main interests and hobbies are _____

Check all that apply to **you and your family** and note who.

| | | | | | |
|---|---|---|---|---|---|
| | Alcoholism | | | Glaucoma/Cataracts | |
| | Allergies | | | Headaches / Migraines | |
| | Arthritis | | | Heart disease | |
| | Autoimmune diseases | | | Hepatitis | |
| | Anorexia/Bulimia | | | High/Low blood pressure | |
| | Anxiety | | | Joint problems | |
| | Asthma | | | Kidney disease | |
| | Breast lumps | | | Liver disease | |
| | Cancer | | | Mental-Emotional illness | |
| | Candida | | | Mononucleosis | |
| | Chronic infections | | | Obesity | |
| | Colitis or IBS | | | Osteoporosis/Osteopenia | |
| | Depression | | | Pneumonia | |
| | Diabetes | | | Polio | |
| | Ear infections | | | Shingles | |
| | Eczema | | | Stroke | |
| | Epilepsy or seizures | | | TB | |
| | Fibromyalgia | | | Thyroid condition | |
| | GERD | | | Weight changes | |

Are you willing to take Chinese Herbs or change your diet if recommended?_____

What do you do to relax? _____

_____

Describe your support system? (family, friends, religion, spirituality, community/groups, pets)

_____

_____

**Pain**

Where _____

When _____

Feels like _____

Please check any of the following that pertain to your pain:

| Pain is Better With | | Pain is Worse with |
|---|---|---|
| | **Pressure** | |
| | **Heat** | |
| | **Cold** | |
| | **Barometric pressure changes** | |
| | **Rain or snow or humidity** | |

Please check any of the following that you **are currently experiencing or in last 6 months**.

**Qi**

- ○ Fatigue
- ○ Low energy
- ○ General weakness
- ○ Lack of desire to speak
- ○ Prolapse of any organ
- ○ Hemorrhoids
- ○ Bloody nose
- ○ Dull achy pain
- ○ Sore & distending pain
- ○ Frustration

**Xue**

- ○ See floaters
- ○ Dry skin or mouth
- ○ Difficulty falling asleep
- ○ Numbness or tingling
- ○ Dizziness
- ○ Hair loss
- ○ Scanty irregular menstruation
- ○ Cysts, lumps, or swellings
- ○ Sharp, stabbing, fixed pain

**Yin**

- ○ Wake up repeatedly during sleep
- ○ Afternoon flushes
- ○ Night sweats
- ○ Heat in hands, feet & chest
- ○ Feel hot at night
- ○ Dry mouth

- Restlessness
- Recurrent inflammation “-itis”

**Yang**

- Feel cold
- Cold hands
- Cold feet
- Dislike cold

**Shen**

- Muddled/foggy thinking
- Lack of joy or vitality
- Irritability
- Dream disturbed sleep
- Incessant talking

**Jing**

- Weak bones
- Hearing problems
- Teeth problems
- Developmental delays
- Early forgetfulness

**Damp**

- Limbs or head feels heavy
- Movable cysts
- Foggy thinking
- Lack of taste
- Everything tastes sweet
- Lack of desire to drink
- Acid reflux
- Swollen limbs or joints
- Eczema or psoriasis

**Wind**

- Tremors
- Itchy skin without rash
- Symptoms move around
- Stiff tongue
- Stiff neck
- Seizures
- Paralysis

**Respiratory**

- Shortness of breath
- Asthma
- Copious thin clear phlegm
- Dry unproductive cough
- Scant dry sticky phlegm
- Dry itchy throat
- Sore tongue or lips
- Sore throat
- Sinus congestion
- Sinus infections
- Nose bleeds
- Bronchitis
- Pneumonia
- Copious saliva

**Digestive**

- Low or no appetite
- Always hungry
- Bloating or gas pains
- Belching
- Diarrhea
- Constipation (not daily BM)
- Alternating constipation & diarrhea
- Nausea or vomiting
- Fatigue after eating
- Hypoglycemia

- Heartburn
- Dry lips
- Drinking in small sips
- Bad breath
- Painful or bleeding gums
- Canker sores
- Bowel obstruction
- Excessive thirst
- Difficulty swallowing
- Feels like something stuck in throat
- Metallic taste in mouth
- Bitter taste in mouth
- Pain after eating fatty food
- Gallstones

**Urinary**

- Urinary incontinence
- Bladder or kidney infections
- Kidney stones
- Night urination 2 or more
- Lack of bladder control

**Skin / Immune**

- Easily catch colds
- Easily bruised
- Varicose veins
- Frequent antibiotic use
- Recurrent yeast infections
- Low blood pressure
- Sleep best 7 am to 9 am
- Generally feel cold
- Generally feel hot
- Brittle nails
- Easily perspire
- Anemia
- Rashes
- Itching

**Eyes / Ears**

- Blurry vision
- Dry eyes
- Eyes easily tear
- Poor hearing or loss
- High-pitched ringing
- Low-pitched ringing

**Mental / Emotional**

- Oppressive sadness
- Sighing
- Worrier
- Easily frightened
- Strained personal relationship(s)
- Mental confusion
- Depression
- Moodiness
- Anger easily
- Difficulty making decisions
- Nervousness
- Fearful
- Easily stressed

**Heart / Circulation**

- Heart palpitations
- High blood pressure
- Blood clots
- Swelling in ankles
- High cholesterol

**Muscle / Bones**

- Muscle weakness

- ○ Muscle spasms / cramps
- ○ Bones ache
- ○ Easily broken bones

**WOMEN ONLY**

Age menses began _____ Age of menopause _____

Average days of flow _____ Average number of days between cycles _____

Number of live births _____ Number of miscarriages _____ Number of abortions _____

Menstrual Flow

- ○ Clotting
- ○ Brownish
- ○ Dark purplish
- ○ Bright red
- ○ Pale red
- ○ Watery, thin
- ○ Heavy flow
- ○ Starts & stops
- ○ Cramping
- ○ Pain
- ○ Headaches

PMS

- ○ Nausea
- ○ Food cravings
- ○ Depression
- ○ Vomiting
- ○ Headaches
- ○ Irritability
- ○ Water retention
- ○ Migraines
- ○ Breast tenderness
- ○ Abdominal pain
- ○ Back pain

General

- ○ Difficulty conceiving
- ○ Birth control pills
- ○ Breast cancer
- ○ Ovarian cysts
- ○ Uterine fibroids
- ○ Vaginal sores
- ○ Vaginal discharge
- ○ Vaginal odor
- ○ Herpes
- ○ Human Papilloma Virus positive
- ○ STD (chlamydia, PID, syphilis, etc.)
- ○ Fibrocystic breasts
- ○ PCOS
- ○ Pain at ovulation
- ○ Hysterectomy
- ○ Bleeding between cycles
- ○ No period / skipped cycles
- ○ Irregular cycle

**MEN ONLY**

- ○ Impotence
- ○ Erectile dysfunction
- ○ Enlarged prostate
- ○ Prostate cancer
- ○ Testicular pain
- ○ Herpes
- ○ STD (chlamydia, PID, syphilis, etc.)