

# Soho Herbs & Acupuncture

16 East 40<sup>th</sup> Street    2<sup>nd</sup> Floor    New York    NY    10016    212.945.7300

## PATIENT HEALTH HISTORY FORM

IDENTIFICATION DATA					
Name _____	Today's Date _____				
Address _____	Date of Birth _____	Age _____			
City/Zip _____	Place of Birth _____				
Home Phone _____	Business Phone _____				
Mobile Phone _____	Email Address _____				
Gender _____	Ethnicity _____				
Education _____	Occupation _____				
FAMILY HISTORY					
AILMENT	FATHER	MOTHER	SIBLING	CHILDREN	OTHER
Allergies					
Blood Disorder					
Diabetes					
Cancer/Tumors					
Seizures					
High Blood Pressure					
Kidney/Bladder					
Stomach/Intestinal					
Drug Abuse					
Heart Disorder					
Stroke					
Other					
Age of Death					
PERSONAL HEALTH HISTORY					
Allergies (Food/Drug)	Asthma	Cancer	Hepatitis (Type __)	Diabetes	Thyroid
High Blood Pressure	Stroke	Seizures	Tuberculosis	Digestive	Other
<u>Hospitalizations</u>					
Date:	Illness:			Hospital/Clinic	
Pregnancy History / Number of Children _____					
Reason for seeking treatment today _____					
REFERRAL INFORMATION					
Referred by _____					

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## PATIENT HEALTH HISTORY FORM

MEDICATIONS / SUPPLEMENTS / DIET			
HABITS	CURRENT	PAST	FREQUENCY
Cigarettes			
Alcohol			
Caffeine			
DIET	(LIST FOODS EATEN ON A TYPICAL DAY)		
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Restrictions			
Cravings			
Prescription Drugs			
PHYSICIAN INFORMATION			
Name of Doctor _____		Date of Last Physical Exam _____	
Address _____			
Phone _____			

While Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace 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 or herbal medicine treatment.

To comply with Article 160, Section 8211.1 (b) of NYS Education Law, we request that you read and sign the following statement:

I/We, the undersigned, do affirm that \_\_\_\_\_ (patient) has been advised by Frank Butler, L.Ac., and/or Jen Resnick, L.Ac., to consult a physician regarding the condition(s) for which such patient seeks acupuncture and/or herbal medicine treatment(s).

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Acupuncturist Signature)

\_\_\_\_\_  
Date

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## Informed Consent to Acupuncture and Chinese Herbal Treatment

I consent to acupuncture and herbal treatments and other procedures associated with Chinese medicine by the acupuncturist named below. I understand that methods of treatments may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal medicine, and nutritional counseling.

Acupuncture has the effect of normalizing physiological functions, modifying the perception of pain, and of treating certain diseases and imbalances of the body. Most people experience a sense of well being and relaxation during and after the treatment. I have been informed that acupuncture is a safe method of treatment, but that occasionally bruising, numbness or tingling at the site of needle insertion may occur after treatment. Bruising is also a possible side effect of cupping. Rare side effects include dizziness or fainting, especially if the patient is overdue for a meal. Burns on the skin are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects may occur.

I will notify the acupuncturist if I am or become pregnant since this will affect the treatment.

I do not expect the acupuncturist to be able to anticipate and explain all of the possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgment during the course of treatment which, based upon the facts then known, the acupuncturist believes is in my best interests.

I understand that all my records will be kept confidential and will not be released without my written consent. If cases are used for research or publishing purposes, identities, including personal and identifying information will be altered.

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.

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(Patient Name – Please Print)

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Date

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\_\_\_\_\_  
(Patient / Legal Guardian Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Acupuncturist Signature)

\_\_\_\_\_  
Date

## 24 Hour Cancellation Policy

This is to advise you of our office's 24 hour cancellation policy. Due to limited number of appointment time slots, we must schedule our day carefully and we are unable to hold an appointment time for you if you are not able to keep it. Giving us 24 hours notice or more allows us to fill your cancellation from the waiting list of patients in need of an appointment.

If you need to cancel your scheduled appointment, please notify us as soon as possible, at the very last, 24 hours before your scheduled appointment. If you cancel an appointment with less than 24 hours notice you will be charged the full fee for the visit.

I have read the above statement and I fully understand the cancellation policy as described above, and authorize Soho Herbs and Acupuncture to charge my credit card the full fee for the missed appointment.

\_\_\_\_\_  
(Authorizing Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Credit Card Number, Expiration Date, Billing Zip Code)

\_\_\_\_\_  
Date