Rebecca Krauss, L.Ac. MSAOM, MQP, Chloe Weber, L.Ac, MSOM
TEL. (516) 770-6280 • Beccakrauss@gmail.com, Chloe.Weber@gmail.com

Initials: _____

PATIENT INFORMATION

DATE _____/_____/20_____

LAST NAME _____ FIRST NAME _____ MIDDLE _____

DATE OF BIRTH _____/_____/_____ GENDER _____ PREFERRED PRONOUN_____

MARITAL STATUS : M S D W

EMAIL _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME/CELL PHONE _____

EMPLOYER _____ OCCUPATION_____

WORK ADDRESS _____

EMERGENCY CONTACT _____ RELATION _____

HOME ADDRESS _____ PHONE _____

REFERRED PHYSICIAN _____ PHONE _____

PAYMENT METHOD (CIRCLE ONE): _ INSURANCE PPO _ CASH

FOR INSURANCE BILLING ONLY:

INSURANCE NAME _____ EFFECTIVE DATE _____/_____/20_____

ADDRESS _____ PHONE _____

CERT # _____ GROUP # _____

SUBSCRIBER _____ DOB _____/_____/_____

RELATION: SELF / OTHER _____

AGREEMENT & AUTHORIZATION TO PAY MEDICAL BENEFITS DIRECTLY TO ATTENDING PROVIDER:

I HEREBY AUTHORIZE MY INSURANCE _____ TO MAKE PAYMENTS DIRECTLY TO REBECCA KRAUSS, Lac/ CHLOE WEBER/YANG EARTH PLLC FOR ALL MEDICAL EXPENSE BENEFITS OTHERWISE PAYABLE TO ME FOR THIS PERIOD OF TREATMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE BENEFITS. IN THE CASE OF INSURANCE PAYMENTS ISSUED DIRECTLY TO ME, I AGREE TO SIGN OVER SUCH PAYMENTS/CHECKS DIRECTLY TO REBECCA KRAUSS/ CHLOE WEBER, LAc/YANG EARTH PLLC. I ALSO AUTHORIZE RELEASE OF MY RECORDS TO THE INSURANCE COMPANY FOR BILLING PURPOSES.

_____

PATIENT / PARENT / GUARDIAN / INSURED

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Dear Valued Customer,
Please complete this questionnaire before arriving at the clinic for your first treatment. All the information will be held confidential unless otherwise required by law or you agree this information may be shared for insurance or healthcare reasons. If you have questions, please ask. Thank You,

Rebecca Krauss, L.Ac/Chloe Weber

How did you hear about us? _____

HEALTH INFORMATION

Please identify your health concerns listed in order of importance below:

Condition & Date Began Diagnosis & Past Treatment

1. _____

Details: _____

_____

_____

_____

2. _____

Details: _____

_____

_____

_____

Personal Medical History (Include Dates):

Major Surgeries or Accidents: _____

Major Illnesses: _____

Known Allergies (food or drug): _____

Current Medications & Supplements: _____

_____

Lifestyle:

a. Occupation: _____ Hours/Week: _____

b. How many hours per night do you sleep? _____ Do you wake rested? Y / N

c. Diet: List any dietary specifics including avoided foods: _____

_____

Cravings: _____

Meals per day? _____ Water per day (8 oz glasses)? _____

d. Nicotine/Alcohol/Caffeine Use (give a number per day for each if applicable):

_____Coffee _____Black Tea _____Soft Drinks _____Cigarettes _____Alcohol

e. Exercise routine: _____

f. Interests and hobbies: _____

g. Activities you do for relaxation: _____

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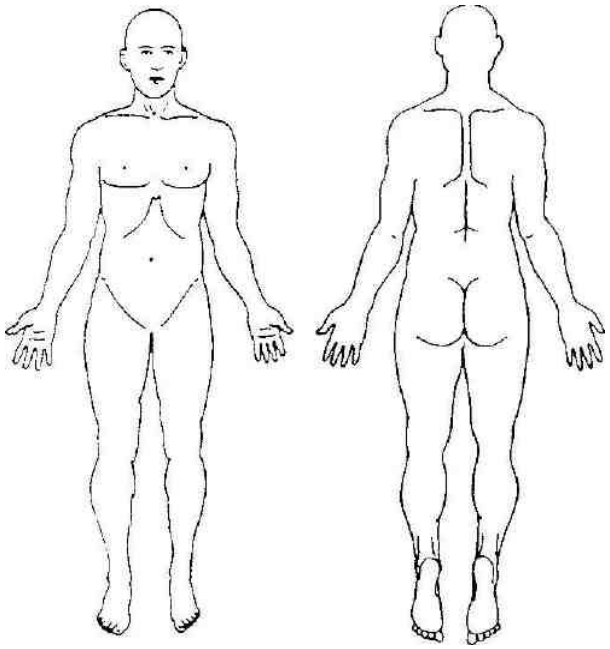
Body Pain:



How did your pain begin: _ Gradually? _ Suddenly?

Please describe when and how it began: _____

_____

_____

Do you have pain: _ All the time? _ Sometimes?

How painful is your condition on a scale from 1-10: _____

(1 = Slight Pain, 10 = Extreme Pain)

Is your pain worse when you:

□ Sit □ Bend □ Walk □ Lift □ Push □ Pull □ Other: _____

Does your pain interfere with: □ Work? □ Sleep? □ Daily routine?

Do you feel your present condition is:

□ Temporary? □ Permanent? □ Don't know

Please mark areas of pain on the figure to the right using the codes:

Burning: **+++** Sharp: --- Dull: **000** Worse with Cold: **CCC**

Symptoms Checklist:

Indicate with **One** check any condition that you sometimes experience;

use **Two** checks for those that occur often, use **Three** checks for symptoms that are a major concern.

_____ fatigue _____flatulence _____weak appetite _____low body weight

_____indigestion _____abdominal bloating _____food allergy _____diarrhea

_____shallow breathing _____sinus congestion _____asthma _____perspire easily

_____dry scalp _____weak nails _____skin eruptions _____spots in vision

_____blurry vision _____anemia _____dizzy on standing _____light menstruation

_____palpitations _____racing heartbeat _____numbness in limbs _____dry skin/hair

_____lower back ache _____hearing loss _____ringing in the ears _____premature aging

_____hair thinning _____frequent urination _____weak legs/knees _____diabetes

_____inability to focus _____loose teeth _____dizziness _____darkness under eyes

_____infertility _____developmental disorder

_____cold limbs _____frequent colds _____difficult to warm up _____impotence

_____dislike of cold _____early morning diarrhea _____chronic loose stools _____frequent clear urination

_____night sweats _____insomnia _____feel warm in afternoon _____facial flush

_____nervousness _____emotional instability _____dry stools _____high thirst

_____premature ejaculation _____excess dreaming _____mouth sores _____poor memory

_____aversion to heat _____dry mouth/throat _____tired and restless _____dry cough

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Symptoms Checklist (continued):

_____irritability _____headaches _____tight neck / shoulders _____indecisive

_____depression _____fullness below ribs _____lump in throat _____PMS

_____bitter taste in mouth _____sore breasts _____sinus allergies _____varicose veins

_____bleeding issues _____menstrual cramps _____pain in fixed location _____pelvic inflam. disease

_____ovarian cysts _____masses or tumors _____hepatitis

_____body aches _____loss of appetite _____feels like sack over head _____yeast infection

_____vomiting _____muddled thinking _____heavy feeling _____edema

_____nausea _____thirst, no desire to drink _____pain/fullness in abdomen

_____sore throat/tonsillitis _____nose bleed _____dark urine _____herpes simplex

_____hemorrhoids _____eye infections _____nasal infections _____heartburn

_____painful/burning urination _____tendonitis _____stomach ache/ulcer _____prostatitis

_____ear infections _____gum problems _____dark diarrhea _____constipation

_____bad breath _____strong body odor _____vaginal infection _____genital herpes

Have you been treated for emotional problems? Y / N

Have you ever considered or attempted suicide? Y / N

Any other problems you would like to discuss? _____
The information given here is true to the best of my knowledge:

Signature: _____ Date: ____/____/20_____

IF APPLICABLE – please check if you have any of the following:

Past Current	Past Current
___ ___ Abnormal PAP smear	___ ___ Hot flashes
___ ___ Pain with menstruation	___ ___ Menopause
___ ___ Birth control pill use	___ ___ IUD use
___ ___ Bleeding between periods	___ ___ Infertility
___ ___ Bleeding during/after sex	___ ___ Clots in flow
___ ___ Bloating before periods	___ ___ Endometriosis
___ ___ Irregular periods	___ ___ PMS
___ ___ Breast lumps	___ ___ Scanty bleeding with period
___ ___ Sickness/weakness	___ ___ Vaginal discharge/sores
___ ___ Vaginal dryness/itching	
___ ___ Heavy bleeding with period	___ ___ Breast swelling or pain

Interval between periods: _____ Duration of menstrual periods: _____ Date of last period: ____/____/20_____

Number of pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____

Are you pregnant? Y / N

Method of birth control if applicable: _____