



STEPHEN F. COHEN, DAC (RI), MSOM, LAC
AXIOM ACUPUNCTURE ®
AXIOM WELLBEING ®

49 WEST 24TH STREET, 8TH FLOOR
NEW YORK, NEW YORK 10010

MURRELLS INLET, SOUTH CAROLINA 29675

Name: _____	Date: _____		
Address: _____			
City: _____	State: _____	Zip: _____	
Home Phone: _____	Work Phone: _____		
Mobile Phone: _____	E-Mail: _____		
Date of Birth: _____	Age: _____	Marital Status: _____	
Referred by: _____	Occupation: _____		
Physician: _____	Phone: _____		
Address: _____	City: _____	State: _____	Zip: _____
In Emergency Notify: _____	Phone: _____		

Main Complaint (symptoms, diagnosis, duration, etc.)

Significant Trauma (physical or emotional)

Birth History (prolonged labor, forceps delivery, complications, etc.)

Surgeries (please include date of procedure)

Allergies (chemical, environmental, food, drugs, etc.)

Medications (names & dosages) please attach an additional page if necessary.

Vitamins/Supplements/Herbs

Exercise

Days per week Length of workout Type of Activity

Diet

Meals per day Snacks Caffeinated Drinks Alcohol per week

What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

What makes your condition worse? (Stress, fatigue, hunger, heat, certain foods, damp days etc.)

Personal History Please check any conditions or symptoms you have now.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Elevated Blood Cholesterol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> Diverticulitis/IBS |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Raynaud's Disease |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Imbalance | <input type="checkbox"/> Respiratory Allergies |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Chronic Pain Condition | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Gastritis/Pancreatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Infertility | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> HIV/AIDS | | | |
| <input type="checkbox"/> Other _____ | | | |

Family Medical History Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Asthma _____ |
| <input type="checkbox"/> Other _____ | | | |
-
-

Please **check** if you have had any of these items listed below in the last **year**
Put a **star** on the box if you had this in the past but do not any longer.

General

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sweats Easily | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Bleed/Bruise easily | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Peculiar tastes/smells | <input type="checkbox"/> Dental/gum problems |
| <input type="checkbox"/> Muscle weakness/fatigue | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Strong thirst (hot or cold drinks) | |
| <input type="checkbox"/> Other _____ | | | |

Skin and Hair

- | | | | |
|---|--------------------------------------|--|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Face flushing |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Warts | <input type="checkbox"/> Fungal Infection | <input type="checkbox"/> Weak or ridged nails |
| <input type="checkbox"/> Other _____ | | | |

Head, Eyes, Ears, Nose and Throat

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Migraines | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night Blindness |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Jaw clicks/locks | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Other _____ | | | |

Cardiovascular

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Varicose/spider veins | <input type="checkbox"/> Pressure in chest | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Spontaneous sweating | <input type="checkbox"/> Dizziness | |
| <input type="checkbox"/> Other _____ | | | |

Respiratory

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight sensation in chest | <input type="checkbox"/> Difficult inhale/exhale |
| <input type="checkbox"/> Difficulty breathing when lying down | | <input type="checkbox"/> Production of phlegm... what color? _____ | |
| <input type="checkbox"/> Other _____ | | | |

Gastrointestinal

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bloating/Edema | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Loose stools (>2 per day) | <input type="checkbox"/> Abdominal pain/cramps |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid reflux/GERD | <input type="checkbox"/> Hernia | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Significant thirst | <input type="checkbox"/> IBS/Crohn's Disease | |
| <input type="checkbox"/> Other _____ | | | |

Genito-Urinary

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Scanty flow | <input type="checkbox"/> Copious flow |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Sores on genitals | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Burning urination |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Pain in testicles | <input type="checkbox"/> Herpes | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Night urination... What time? _____ How often? _____ | | | <input type="checkbox"/> Excessive libido |
| <input type="checkbox"/> Other _____ | | | |

Gynecological/Reproductive

- | | | |
|--|---|--|
| <input type="checkbox"/> Difficult/Painful intercourse | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Age of first menses _____ |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Date of last menses _____ |
| <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Date of last PAP/Pelvic _____ |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Fibrocystic breast tissue | <input type="checkbox"/> Number of pregnancies _____ |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Polycystic Ovarian Disease | <input type="checkbox"/> Number of ectopic pregnancies _____ |
| <input type="checkbox"/> Irregular menstruation | <input type="checkbox"/> PMS | <input type="checkbox"/> Number of live births _____ |
| <input type="checkbox"/> Painful menstruation | <input type="checkbox"/> Number of miscarriages _____ | <input type="checkbox"/> Number of abortions _____ |
| <input type="checkbox"/> Other _____ | | |

Do you use birth control? _____

If yes, what type? _____ How long? _____

Musculoskeletal

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Back pain Low___ Middle___ Upper___ | <input type="checkbox"/> Bursitis | | <input type="checkbox"/> Rotator Cuff |
| <input type="checkbox"/> Soreness/weakness in lower body (back, knee, hip, ankle, foot) | | | |
| <input type="checkbox"/> Other _____ | | | |

Neuropsychological

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety/Panic attacks | <input type="checkbox"/> Bad temper/irritable | <input type="checkbox"/> Easily susceptible to stress | <input type="checkbox"/> Seasonal Affective Disorder |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Manic Depression | |
| <input type="checkbox"/> Other _____ | | | |

Have you ever been treated for emotional problems? Yes No

Have you ever considered or attempted suicide? Yes No

Have you ever been treated for substance abuse? Yes No

Comments Please inform me of any other problems you would like to discuss.

Acupuncture Consent for Purposes of Treatment, Payment and Healthcare Operations

Pursuant to State Law and healthcare best practices, you should consult a physician regarding the condition or conditions for which you are seeking an acupuncture treatment. We, the undersigned, do affirm that the patient has been advised by, Stephen F. Cohen, a Licensed Acupuncturist, to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

Patient's Signature

Date

Stephen F. Cohen, DAc (RI), MSOM, LAc

Stephen F. Cohen, DAc (RI), MSOM, LAc

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by Stephen F. Cohen, DAc (RI), MSOM, LAc.

I understand I have a right to review AXIOM Acupuncture's Notice of Privacy Practices prior to signing this document. AXIOM Acupuncture's Notice of Privacy Practices is available to me at www.axiomacupuncture.com or is available upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of AXIOM Acupuncture. The Notice of Privacy Practices for AXIOM Acupuncture is also provided at the location of the licensed acupuncturist and in this document. This Notice of Privacy Practices also describes my rights and AXIOM Acupuncture's duties with respect to my protected health information.

AXIOM Acupuncture reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, and nutritional counseling. 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 needle sight, which may last a few days. An unusual risk of acupuncture includes spontaneous miscarriage, nerve damage and organ puncture. Infection is another possible risk, however since this office uses only sterilized, disposable needles while maintaining a clean and safe environment, this is unlikely. Burns and scarring are potential risks of using moxibustion.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately*.

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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. _____

initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _____

initials

I agree to pay the full charge for any missed or forgotten appointments without 48-hour notice of cancellation. _____

initials

From time to time, I understand I may receive emails, updates and contact information from AXIOM Acupuncture and or AXIOM Wellbeing. _____

initials

Are you Pregnant?

Is it possible you may be Pregnant?

Patient's Name

Patient's Signature

Date Signed

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.

Name of Patient _____

Patient's Representative _____

Relationship or Authority of Patient _____

Witness _____