515 Madison Avenue, 6th Floor, New York, NY 10022
Phone: (212) 752-6770 / Fax: (212) 754-0369

Name:_____**Date of Birth**:_____
Last First mm/dd/yyyy

Address:_____
Street City, State Zip Code

Gender (please circle one): Male Female **Marital Status**: Single Married Divorced Widowed

Home Phone:_____ **Cell Phone**:_____

Work Phone:_____ **Email Address**:_____

*We confirm all patient appointments via **email and text**. Please indicate if you do NOT want to receive these reminders.*

Primary Care Physician: _____ **Phone**:_____

How did you hear about us? Did someone refer you? Referring Physician?_____

_____

Occupation:_____

Employer's Name: _____ **Phone**:_____

Employer's Address:_____
Street City, State Zip Code

Emergency Contact:_____**Relationship**:_____ **Phone**:_____

Pharmacy & Address:_____ **Phone**:_____

Interest in medical & wellness services:

Internal Medicine	Yes	No
Nutrition/Weight Loss	Yes	No
Dermatology	Yes	No
Non-Surgical Orthopedics	Yes	No
Physical Therapy	Yes	No
Chiropractic	Yes	No
Medical Massage	Yes	No
Acupuncture	Yes	No
Stress Management /Biofeedback	Yes	No

I consent to treatment that is received in this office. I understand that my personal information is available to all medical providers at this location. I have received a copy of the office's notice of privacy practices and authorize the release of any medical or other information necessary to process a claim with my insurance. I request payment of insurance benefits either to myself or the party accepting assignment. I understand that I am responsible for any copay, deductible or expenses incurred that are not covered under my medical insurance.

Signature: _____ **Date**:_____

What are your chief health concern(s)?_____

_____

How did your problem begin? _____

Have you had this problem before? Were any diagnostic imaging (x-rays, MRIs, etc.) or other tests performed?

_____

Have you seen other doctors for this condition? ☐ Yes ☐ No

If so, please list the type of treatment received and the contact information for the other doctor(s):

_____

Please list any relevant medical history, including surgeries (type and year), injuries, hospitalizations, illnesses:

_____

_____

_____

Has anyone in your family had a similar complaint?_____

Are you currently taking any medications and supplements?

Name/Type	Dosage	Frequency	Date Started	Date Stopped

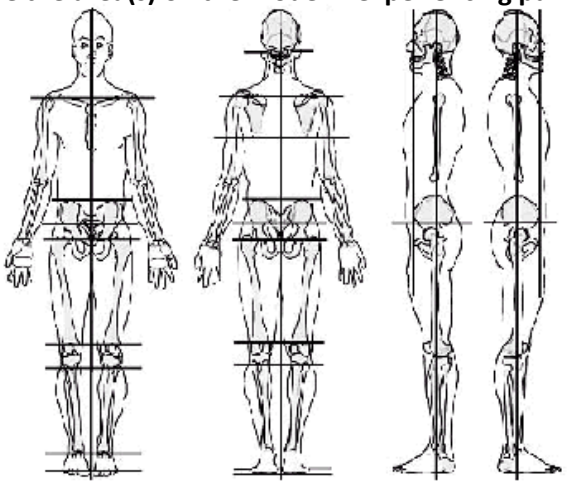
Please list any allergies (including food allergies) and type of reaction:_____

_____

Current height: _____ **Date of last measurement: _____**

Current weight: _____ **Date of last measurement: _____**

Circle the area(s) on the model if experiencing pain.



What makes the problem <u>better</u>? (select all that apply):

	Cold		Inactivity		Movement		Sitting		Walking
	Heat		Lying Down		Nothing		Standing		Other

What makes the problem <u>worse</u>? (select all that apply):

	Cold		Inactivity		Movement		Sitting		Walking
	Heat		Lying Down		Nothing		Standing		Other

How would you describe the pain? (select all that apply):

	Aches		Gripping/Constricting		Sharp/Stabbing		Tingling
	Burning		Itching		Soreness		Weakness
	Dull		Sharp/Dull		Throbbing/Gnawing		Other

How bad is your pain or problem? (please circle; 0 = no pain, 10 = unbearable) 0 1 2 3 4 5 6 7 8 9 10

How is your lifestyle being affected due to the pain? _____

What time is the pain most severe? _____ **Least severe**?_____

FAMILY MEDICAL HISTORY

	Yes	No	
			Write relationship of relative(s) with the below conditions with age of onset/diagnosis if known:
Allergies			
Arthritis			
Asthma			
Breast Cancer			
Colon Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Melanoma/Skin Cancer			
Prostate Cancer			
Seizures			
Skin Disorders/Diseases (specify)			
Stroke			
Uterine/Ovarian Cancer			
Other Diseases/ Conditions			

PERSONAL MEDICAL HISTORY (check all that apply):

Preventative Test History

	Month/Year of Last Test	Test Results
Blood Sugar		
Bone Density		
Cholesterol		
Colonoscopy		
Dentist		
EKG		
Eye Exam		
Mammogram		
OBGYN Exam		
Prostate Screening		
Stress Tests		

Additional information:_____

Immunizations

Tetanus/Diptheria/Pertussis (Tdep)	Yes (Date_____)	No
Hepatitis A	Yes (Date_____)	No
Hepatitis B	Yes (Date_____)	No
Influenza	Yes (Date_____)	No
Pneumonia	Yes (Date_____)	No
Polio	Yes (Date_____)	No
Shingles	Yes (Date_____)	No
Typhoid	Yes (Date_____)	No
Yellow Fever	Yes (Date_____)	No
Others	Type_____	Date_____

General

	Allergies		Cravings		Headaches		Loss of Sleep		Pain in Hands
	Bleed/Bruise Easily		Dental/Gum Issues		Hepatitis (specify)		Lyme Disease		Pain in Legs
	Cancer (Specify)		Diabetes (Specify)		Hypo/Hyperglycemia				Swollen Glands
	Chills		Dizziness		Iron Deficiency		Numbness		Thyroid Disease
	Chronic Fatigue		Fatigue		Liver Disease		Organ Transplant/ Immunosupression		Weight Gain
	Convulsions		Fevers		Localized Weakness		Pain in Arms		Weight Loss

Additional information:_____

Cardiovascular

	Artificial Valve		High Blood Pressure				
	Blood Clotting		Low Blood Pressure		Poor Circulation		Shortness of Breath
	Chest Pain/Pressure		Pacemaker		Previous Heart Attack		Slow Heart Beat
	Cold Hands/Feet		Pain over Heart		Previous Heart Stroke		Sweat Easily
	Fainting		Paralytic Stroke		Rapid Heart Beat		Swelling of Ankles
	Hardening of Arteries		Phlebitis		Raynaud's Syndrome		Varicose Veins

Additional information:_____

Gastrointestinal

	Bad Breath		Colon Trouble		Diverticulitis		Hepatitis/Liver Disease		Poor Appetite
	Black Stools		Constipation		Excessive Hunger		Hernia		Stomach Ulcers
	Bloating		Crohn's Disease		Gall Bladder Trouble		Intestinal Worms		Strong Thirst
	Blood in Stool		Diarrhea		Gas		Irritable Bowel Syndrome		Vomiting
	Changes in Appetite		Difficult Digestion		Gastro-Esophageal Reflux		Nausea		
	Colitis		Distention of Abdomen		Hemorrhoids		Pain over Stomach		

Additional information:_____

Genitourinary

	Bed Wetting		Impotence		Lumps in Breast
	Blood in Urine		Inability to Control/ Incontinence		Menopausal Symptoms
	Cramps or Backache		Infertility Problems		Painful Menstrual Periods
	Frequent Urination		Kidney Infection		Painful Urination
	Heavy Flow		Kidney Stones		Prostate Problems

Additional information: _____

Head, Eyes, Ears, Nose and Throat

	Blurred Vision		Facial Pain		Peculiar Tastes/Smells
	Difficulty Swallowing		Grinding Teeth		Poor Vision
	Earaches		Jaw Clicks/Locks		Ringing in Ears
	Eye Strain or Pain		Night Blindness		Sinus Problems
	Face Flushing		Nose Bleeds		Spots in Front of Eyes

Additional information: _____

Infectious Diseases

	Herpes	
	TB	
	Other/STD (Specify)	

Additional information:_____

Musculoskeletal

	Arthritis		Fibromyalgia		Muscle Pain		Sciatica
	Artificial/Joint Problems (specify below with date)		Foot/Ankle Pain		Neck Pain		Shoulder Pain
	Back Pain		Hand/Wrist Pain		Osteoporosis		Sprains/Strains
	Bursitis		Hip Pain		Rheumatoid Arthritis		Stiff Neck
	Carpal Tunnel		Knee Pain		Rotator Cuff		Tendonitis

Additional information:_____

Neuropsychological

	ADD/ADHD		Depression		Poor Concentration
	Alcoholism		Insomnia		Poor Memory
	Anorexia or Bulimia		Lack of Coordination		Psychiatric/Emotional Illness
	Anxiety/Excessive Stress		Numbness		Seizure Disorder
	Bad Temper/Irritable		Panic Attacks		Sexual/Libido Problems
	Concussion		Poor Balance		Vertigo

Additional Information: _____

OBGYN

Date of Last menstrual period _____
Age of onset of Menses _____
Menopause Yes No
Number of pregnancies _____
Number of births/children _____
Currently pregnant Yes No
Currently Breat Feeding Yes No
Previous C-Sections Yes No
Do you use contraception Yes (type_____) No

Additional Information _____

Respiratory

	Asthma		Difficulty Breathing		Phlegm
	Bronchitis		Emphysema		Pneumonia
	Coughing/Wheezing		Lung/Breathing Problems		Recurrent Sinus Infections
	Cystic Fibrosis		Pain with Deep Inhalation		Tight Sensation in Chest

Additional information:_____

Dermatology

	Acne		Loss of Hair		Sunburns (blistering)
	Change in Skin/Hair		Moles (new/recent)		Sores on Lips/Tongue
	Dandruff		Poor wound healing/skin ulcers/ Keloid scarring		Warts
	Fungal Infection		Psoriasis/Eczema		Weak/Ridged Nails
	Hives		Rashes		
	Itching		Skin Discoloration		

Additional information:_____

Would You like a Total Body Skin Exam? Yes No
Would you like to meet with an aesthetician for a complimentary skin assessment? Yes No
Do you have to take antibiotics prior to dental procedures or surgery? Yes No
Do you have a growth or rash you have concerns about? Yes No
If yes,
When did the growth/rash first appear?
Where is the location of the growth/rash?
What are the symptoms of the growth/rash (pain, itching, bleeding, etc.)?
Have you had any previous biopsies/treatments for the growth/rash before?
If a previous biopsy was done, what was the result?

Social history (please circle all that apply):

Overall health	Excellent	Good	Fair	Poor
Physical fitness level	Excellent	Good	Fair	Poor
Under a lot of stress	Yes	No		
Difficulty dealing with stress	Yes	No		
Fatigued all the time	Yes	No		
Often sad or blue	Yes	No		
Practice meditation	Yes	No		

Exercise Habits

Do You Exercise	Never	Routinely	Occasionally
I exercise	# Hours/Week _____		
Type of Exercise (check all that apply)	Jog	Walk	Run/Treadmill
	Stretching	Weight Lifting	Yoga
	Other (Specify)_____		

Dietary Habits

Do you try to eat a healthy diet	Yes	No	
Special dietary habits	Avoid Red Meat	Gluten Free	Minimize Fat
	Avoid Dairy/Cheese	Minimize Carbs	Vegetarian
Emphasize fruits, grains, veggies	Yes	No	
Commonly eat fast food	Yes	No	
Commonly consume	Candy	Chocolate	Diet Soda
	Chips/Junk Food	Coffee	Regular Soda
Have you met with a dietitian before?	Yes	No	

If yes, for what reason(s)?

_____

What is one goal you'd like to accomplish by meeting with a registered dietitian?

_____

What, if any, worries and/or concerns do you have about nutritional counseling?

_____

Tobacco use

Do you smoke?	Yes	No		
I smoke	Cigarettes	Cigars	Pipes	E-cigarettes
	#/Per Day_____	# Years_____		
I quit smoking (mo/yr)	_____			
Do you chew tobacco?	Yes	No		
I chew	# of times/Per Day_____	# Years_____		
I quit chewing (mo/yr)	_____			

Additional Information:_____

Alcohol consumption

Do you drink alcohol of any kind	Yes	No	
I regularly consume	_____drinks/week		
I typically drink	Beer	Wine	Other (specify)_____

Additional Information:_____

Signature*:* _____ **Date:** _____