

Drugs (prescription and over-the-counter, that you are now taking):

Name of drug	Reason for drug	Dose (mg/etc)	For how long	Prescribing doctor
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Allergies [drugs, food, environmental (grass/pollen, etc.) Please **circle any, which are life-threatening**]:

Medical / Health History:

Primary Care Doctor/Provider (if any): _____ Date last seen: _____

Reason for seeing: _____

Clinic Name: _____ Doctor's phone:() _____ Fax:() _____

Doctors full address: _____

Other <u>Current</u> Health Provider(s):	Type:	Phone:	Fax:
_____	_____	() _____	() _____
_____	_____	() _____	() _____
_____	_____	() _____	() _____

Date of last full physical exam: _____, Results: normal other(_____)

Date of last urine test: _____, Results: normal other(_____)

Date of last blood work: _____, Results: normal other(_____)

Date of last prostate exam (males): _____, Results: _____

Date of last PAP/ pelvic exam (females): _____, Results: _____

Are you pregnant (females)? _____ If so, how far along are you (females)? _____

When was your last menstrual period (females)? _____ How long are your cycles (females)? _____

Outpatient Procedures / Hospitalizations (surgeries/ special diagnostic studies):

Type (of surgery/study)	Date	Reason for procedure/ admission	Outcome / Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Major Illnesses/emotional or physical trauma/ accidents (not already listed):

Type:	Date:	Treatment received:	Outcome:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History (Using the following key, designate which family members have had the following. List type where parentheses are present):

M=Mother F=Father B=Brother S=Sister G=Grandparent C=Child

condition	who	condition	who	condition	who
Allergies		Diabetes		Kidney disease	
Alcoholism		Cancer ()		Mental disorder ()	
Anemia		Cancer ()		Obesity	
Arthritis(Rheumatoid)		Epilepsy		Stroke	
Arthritis(Osteo)		Heart Disease		Thyroid (low/ high)	
Auto Immune disease		High Blood Pressure		Other: ()	
Bleeding tendency		High Cholesterol		Other: ()	

Social History (please circle, or complete if applicable):

Parents: Married Separated Divorced

Mother's Occupation: _____ Full Time: _____ Part Time: _____

Father's Occupation: _____ Full Time: _____ Part Time: _____

Guardian: _____ Relationship: _____

Siblings:	Name	Age	Health Problems
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Personal Habits (check or describe in the following boxes):

	Tobacco	Alcohol	Caffeine	Recreational drugs
Currently use:				
Previously used:				
Never used:				
How much/many: (per day/week/ month/ etc.)				
Specify type: (filtered/not; beer/ wine/mixed drinks; tea/coffee/espresso)				
For how long (months/years)				
Date quit				

Diet history (include any liquid tea, coffee, etc., in description.):

What was breakfast yesterday? _____

What was lunch yesterday? _____

What was dinner yesterday? _____

List snacks you had yesterday: _____

How many glasses of **plain water** per day? _____ filtered tap distilled well water

Do you practice any special diet restrictions? _____

Review of Systems (Health History) please check:

Past	Now	Past	Now
___	___ Acne	___	___ Eczema
___	___ Allergies	___	___ Epilepsy/Seizure
___	___ Anemia	___	___ Fatigue
___	___ Asthma	___	___ Frequent Infections
___	___ Bed Wetting	___	___ Headaches
___	___ Birth Defects	___	___ Heart Murmur
___	___ Colic	___	___ High Fever
___	___ Croup	___	___ Hyperactivity
___	___ Constipation	___	___ Insomnia
___	___ Cough/Wheeze	___	___ Jaundice
___	___ Cradle Cap	___	___ Learning Disorder
___	___ Depression	___	___ Moodiness
___	___ Diarrhea	___	___ Stuffy Nose
___	___ Dizzy Spells	___	___ Thrush
___	___ Earaches	___	___ Vomiting Spells

Eliminations (please complete):

Bowel movement habits		Urine habits	
Frequency: (how often) Twice/ day, every week...		Frequency: (how often per 24hour period)	
Color: (black, brown, yellow, green, white)		Color: (dark yellow, light yellow, green, colorless)	
Consistency: (hard, formed, soft, watery)		Character: (clear, cloudy, concentrated, dilute)	
Any mucus or blood on stool? (which)		Any blood or sediment? (which)	
Does stool pass easily?		Any pain, incontinence, other urinary symptoms?	

Digestion: Any stomach upset, bloating, burping, flatulence (gas), nausea, or rectal itching after food?
(circle or specify):

Anything else you want us to know? _____

Sam Schikowitz, ND LAc
INFORMED CONSENT FOR THERAPY FORM

This form is your authorization that allows Dr. Sam Schikowitz to perform specific procedures as necessary to facilitate your evaluation and therapy:

Procedures

General Evaluation Procedures - General physical inspection, including tongue examination, pulse taking, and other physical assessments.

Lifestyle Counseling, and Exercise Prescription.

Herbs/Natural Medicines – Prescription of various therapeutic substances including plants, minerals, and animal materials. Substances may be given in the form of tea, pills, powders, tinctures which may contain alcohol, topical creams, pastes, plasters, washes, suppositories, or other forms. Homeopathic remedies often highly dilute quantities of naturally occurring substances may also be used.

Dietary Advice and Therapeutic Nutrition – The use of foods, diet plans, or nutritional supplements for therapies

Soft Tissue and Osseous Techniques – The use of bodywork, traction, neuro-muscular techniques, muscle manipulation, craniosacral therapy, tui-na, and movement of spine and extremities.

Electromagnetic and Thermal Therapies – Includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, infrared and ultraviolet therapies, and hydrotherapies.

Acupuncture – Insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body to adjust the flow of energy through meridian systems

Traditional Oriental Techniques: Cupping – a technique used to relieve symptoms in which cups made of glass, plastic, or bamboo are placed on the skin with a vacuum created by heat or other device, **Gua Sha** - rubbing on an area of the body with blunt, round instrument, **Moxa** – indirect or direct burning on acupoint using stick or ball of moxa to relieve symptoms, **Bleeding** – insertion of sterilized needles to acupoints to relieve symptoms.

Potential Risks and Benefits

Potential risks: Discomfort, pain, infection, discoloration, or burns from needle insertions, topical procedures, heat or frictional therapies, electromagnetic and hydrotherapy; allergic reactions, nausea, loose bowel movements, and abdominal cramping from prescribed herbs or supplements or dietary advice; and soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progress.

Notice to Pregnant Woman: All female patients must alert the practitioner if they know or suspect that they are pregnant or are trying to become pregnant. Some of the therapies could present a risk to the pregnancy. We do not use labor-stimulating acupuncture points or any labor-inducing substances unless the therapy is specifically for the induction of labor. A therapy intended to induce labor requires a letter from a primary care provider authorizing or recommending such a therapy.

I recognize the potential risks and benefits of these procedures as described above, and I understand that I may ask questions regarding my therapy before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures realizing that no guarantees have been given to me by the clinic or any of its personnel regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

Patient's Name (Print) _____ Signature _____ Date _____

Guardian/Representative's Name (Print) _____ Signature _____ Date _____

Dr. Sam Schikowitz, ND LAc

Information about the services provided by Sam Schikowitz, ND LAc.

Sam Schikowitz, ND LAc, is licensed as a Naturopathic Physician in Connecticut State and a Licensed Acupuncturist in New York State. He received Bachelor's Degrees in Biology and Pre-Medicine from UC Santa Cruz. He received a 3 ½-year Masters of Science in Acupuncture and Oriental Medicine degree and a 5-year doctorate degree as a Doctor of Naturopathic Medicine from a fully accredited Naturopathic Medical and Acupuncture School, Bastyr University, in Seattle Washington.

New York State does not yet license Naturopathic Physicians to practice medicine. The practice of the profession of medicine is defined as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition. Sam Schikowitz, ND LAc does not practice medicine in the state of New York. He functions solely as a licensed acupuncturist and health consultant and focuses his practice of the enhancement of health. I understand that nothing that is said or done in his office, or in any other setting is meant for the diagnosis and/or treatment of any medical condition(s) or disease, and that he uses his education and experience to give suggestions. I agree to the physical contact necessary for assessment of your case and that I make decisions that are right for you about whether to use Dr. Schikowitz's suggestions. Furthermore, his services are not meant to replace or to be a substitute for those of a licensed medical practitioner. He advises that you seek the concurrent care of a health care provider licensed in New York State.

We may discuss substances that have not been subject to double blind clinical studies or FDA approval or regulation. You assume the responsibility for the decision to take any natural remedy. If you feel you are having any adverse reaction then stop taking all supplements immediately. If you are pregnant or nursing, confirm the safety of any supplements with your obstetrician or pediatrician. Recognize that, as an effect of the suggestions provided by Sam Schikowitz, ND LAc, the signs and symptoms of your medical condition(s) may diminish or disappear.

I have read and understand the information provided. I agree to the services provided by Sam Schikowitz, ND LAc, and attest that I am not requesting an appointment for the purpose of collecting information on methods of practice at his clinic.

Full Name Printed _____

Full Name Signed _____ Date _____

Parent/Guardian Signature _____ Date _____