North Shore Naturopathic & Acupuncture

DATE _____

NAME: _____ **AGE:** _____ **BIRTHDATE:** _____ **SEX:** _____

ADDRESS: _____**CITY:** _____**STATE:** _____**ZIP:** _____

PHONE: (home/cell) (_____)_____(work) (____)_____ OCCUPATION:_____

PARENT OR GUARDIAN (for minor patient): _____

NAME OF EMERGENCY CONTACT: _____ **PHONE: (_____)**_____
MARITAL STATUS (Please circle): single married divorced widowed

PRESENT HEALTH CONCERNS: (Please list most important ones first and indicate when you first noticed the problem)

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

What other healthcare professionals are you seeing and their specialty:_____
_____

What diagnoses were you given?_____
_____

WHAT GOALS DO YOU HAVE FOR YOUR VISIT AT THE CLINIC TODAY?

Primary Goal: _____

Other Goals: _____

HAVE YOU EVER CONSULTED A NATUROPATH BEFORE? YES NO (Circle one)

HAVE YOU EVER CONSULTED AN ACUPUNCTURIST BEFORE? YES NO (Circle one)

DO YOU HAVE ANY QUESTIONS ABOUT NATUROPATHIC MEDICINE OR ACUPUNCTURE BEFORE WE GET STARTED?

_____

_____

Bonnie Cronin, ND, LAc.
North Shore Naturopathic & Acupuncture
402 North Main Street, Canandaigua, NY 14424
585-394-3490

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING, WITH DOSAGES: (Please include prescription and non-prescription drugs. For example, allergy medications, aspirin, Tylenol, Advil, laxatives, oral contraceptives, hormones etc.)

1)_____ 4) _____

2)_____ 5) _____

3)_____ 6)_____

7)_____ 8)_____

LIST VITAMINS, MINERALS, HERBS, HOMEOPATHIC REMEDIES PRESENTLY TAKING, WITH DOSAGES:

1)_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

7)_____ 8)_____

PLEASE LIST ANY KNOWN ALLERGIES TO THE FOLLOWING: (explain the reactions)

DRUGS: _____

_____

FOODS: _____

_____

ENVIRONMENTAL (grasses, pollens, animal dander, etc.)
_____

_____

PERSONAL HABITS:
Do you: (Please check box and circle day or week, as appropriate)

- ❑ Use tobacco _____packs per day/week How many years?_____ Date Quit:_____
- ❑ Drink coffee _____cups per day/week
- ❑ Drink black tea _____cups per day/week
- ❑ Drink water _____cups per day/week
- ❑ Drink alcohol _____glasses per day/week
- ❑ Drink sodas _____glasses per day/week
- ❑ Use artificial sweeteners _____packets per day/week
- ❑ Use margarine _____pats per day/week
- ❑ Use recreational drugs explain use_____

How many times a week do you eat in a restaurant? Breakfast_____ Lunch_____
Dinner_____
What types of restaurants?_____
Do you follow any particular diet regimens or restrictions? If yes, please describe:
_____

PAST HISTORY:
Hospitalizations: (Please indicate reasons/dates) _____
Serious Illnesses and Injuries: _____

CHILDHOOD:
How was your health as a child? (circle one) excellent good fair poor
Were there any complications with your delivery?
Explain._____
Were you breast fed?_____How long?_____
Did you have any serious emotional, mental or physical traumas as a child? Please explain._____
_____
_____
_____
Do you have siblings? (indicate age and sex)_____

IMMUNIZATIONS: (Check those that apply)
- ❑ Measles When?_____
- ❑ Mumps When?_____
- ❑ Rubella When?_____
- ❑ Small pox When?_____
- ❑ Influenza When?_____
- ❑ Tetanus When?_____
- ❑ Diphtheria When?_____
- ❑ Hepatitis B When?_____
- ❑ Other _____

BLOOD TYPE:
What is your blood type? (Circle one) A B AB O don't know

FOR WOMEN:
Age at onset of menstruation?_____Any period of time without a menstrual cycle, if so how long?_____
Any use of oral contraceptives? If so how long?_____
Number of children:_____ Number of miscarriages, c-sections, spontaneous abortions, abortions. (please explain)_____
_____
_____
Age at onset of menopause?_____Any hormone replacement therapy, if so how long?_____
Date of last Pap Smear: _____ Results Were: (circle one) Normal Abnormal Don't know
Date of last mammogram:_____ Results: (explain)_____

SOCIAL HISTORY:
Please circle those that apply: Single Married Significant Other Separated Divorced Widowed
Do you have children? _____ If so, how many? _____ Please list their names & ages:_____
_____

TEST HISTORY:
Please check box and indicate date of last procedure. Circle any tests that were abnormal and explain in space provide below.

Test	Date	Test	Date	Test	Date
❑ Chest X-ray		❑ Cholesterol		❑ PSA	
❑ Spine X-ray		❑ Chemistry Panel		❑ Complete Physical Exam	
❑ Blood Tests		❑ Pap Smear		❑ DEXA	
❑ EKG		❑ Mammogram		❑ Others (Please list)	
❑ MRI		❑ Sigmoidoscopy			
❑ CAT Scan		❑ Colonoscopy			
❑ Cardiac Stress Test		❑ Rectal exam			

_____
_____
_____

FAMILY HISTORY:
Please check the ñyesò box next to each condition that applies to you or one of your family members. Please note whether condition applied to family member in the past or currently by denoting a ñPò for past or ñCò for current. Indicate the relationship or the word ñselfò in the ñRELATIONò column when appropriate.

	YES	RELATION	COMMENTS		YES	RELATION	COMMENTS
Alcoholism				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Diabetes				Stroke			
Eczema				Tuberculosis			
Epilepsy				Other			

OTHER QUESTIONS

What are your <u>favorite</u> foods? _____
Do you crave sweets?_____ Any particular time of the day? _____
Do you salt your food at the table? _____
What foods do you <u>really</u> dislike? _____
Would you like to increase or decrease your weight? If so, by how much?_____
When did you last have a significant weight change (more than 10 pounds)? _____
What exercise do you do and how often? _____
How many hours of sleep do you get each night? _____Do you wake rested?_____
Are you presently sexually active? _____Any difficulties?_____
Method of birth control?_____
Rate your current stress level from 1-10 (10= most stress)_____How much does this affect you? _____
What are the major stress factors in your life now?_____
Please rate your current emotional health? (please circle) Excellent Good Fair Poor Unstable Crisis
Are you currently in psychotherapy?_____ Do you have a good support network?_____
Does your home environment have a supportive effect on your health?_____
How many hours of <u>relaxation</u> (not including sleep) do you give yourself during the work week?_____
During the weekends?_____

How many vacations do you take per year?_____
What are your favorite recreational activities? _____
When was your last eye exam? _____Do you wear contacts? _____Hard or Soft?_____
Do you have any visual impairments, if so, what are they?_____
Do you drink purified or bottle water? _____If so, what brand do you use?_____
Do you have amalgam (silver fillings)?_____How many? _____Any other dental problems?_____
Do you make an effort to eat organic foods? _____If so, what percentage of your diet?_____
Are you on a restricted diet due to religious or other beliefs? Please explain. _____
_____
Are you considering any elective surgery or medical procedure in the near future?_____
Are you or have you ever been exposed to any toxic chemicals?_____
If yes, which ones?_____

HEALTH AND LIFESTYLE OVERVIEW

Please tell me what is bothering you. If this involves a specific health condition or illness, please tell me about it in as much detail as possible. List the very first time that you noticed the condition and describe carefully any factor that you think may have played a role in its onset and progression. Please attach a sheet if more space is required.

Is your health currently getting better, worse, or staying the same. How do you know?

What have you tried to do to improve your state of health (ex. other doctors, treatments, supplements, etc.)?

Please list the 5 most significant stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

a.

b.

c.

d.

e.

Please list any other health concerns/conditions, even if you think they may not be important.

Why did you choose this office?

For our time together to be a <u>true win</u> for you, what do you want to take place over the course of your care here?

How long do you feel this will take?

Do you think the pain and/or symptoms that you are experiencing could be purposeful? That is, could they be your bodyôs wisdom saying, ñ I need some helpé letôs change some things here!ò Please share your thoughts.

Do you feel your pain and/or illness is a reflection of a <u>short-term superficial circumstance</u> or <u>longer term potentially deeper-seated challenges</u>? Please share your thoughts.

What areas of your lifestyle are likely involved with your condition and you would like to improve:
(prioritize #1.2,3 etc)

___My level of anxiety ___Not enough time spent in nature

___My pace of living
___Not enough quiet time and rest
___My diet and nutrition program
___My exercise program
___Other.Explain_____

___My creative expression
___My feelings around career
___My social and family life
___My communication skills

Please list any self-destructive lifestyle habits (example: smoking, lack of exercise, addictions, etc.)

What might it cost you if you don't significantly improve your lifestyle and underlying contributing factors to compromised health? (For example, vitality, longevity, joy, happiness, peace of mind, future physical independence, current and/or future relationships, career effectiveness, etc.)

What is your present level of commitment to change the underlying causes of problem(s) which relate to your lifestyle? (Rate from 1-10 with 10 being 100% committed)

List your 3 highest priorities in life which come to mind and speak to your heart. Where does your health and vitality factor in?

a)

b)

c)

What obstacles could prevent you from changing those lifestyle factors undermining your health?

What might stop you from following the therapeutic protocols that I may prescribe for you?

Who would be willing to support you in your health goals?

Please list your special interests and passions:

DIET SURVEY

Please list everything you eat and drink for 2-3 days

Day	Breakfast	Snack	Lunch	Snack	Dinner	Snack
1						
2						

3						

Informed Consent for Acupuncture

1. I hereby authorize Bonnie Cronin, Licensed Acupuncturist, to perform acupuncture and/or other procedures associated with oriental medicine upon me or the named patient. I understand that acupuncture is a technique used to relieve pain in a specific area of the body.
2. I am aware that methods of treatment may include, but not be limited to acupuncture, moxibustion (use of heated mugwort near certain acupuncture points), cupping (use of warm air in glass jars on areas of the body), massage, electrical stimulation, nutritional counseling and herbal medicine.
3. Some acupuncture points and herbal medications should not be used during pregnancy. Therefore, I agree to notify Bonnie Cronin, ND, LAc if I believe I may be pregnant.
4. I further agree to notify Bonnie Cronin, ND, LAc if I am diabetic, since the decreased sensation that is frequently associated with diabetes may increase the likelihood of burns, blisters or other injury from moxibustion, cupping or insertion of acupuncture needles.
5. Bonnie Cronin, ND, LAc has explained the purpose of acupuncture and informed me of expected benefits, discomforts and risks that may arise (see below), as well as possible alternatives to the proposed treatment. The risks discussed include, but are not limited to: allergic reaction to herbal medications and/or mugwort; bruising, numbness, achy sensation and tingling at the sites where acupuncture needles are inserted; burns and blisters from moxibustion, and bruises or non-permanent skin marks from cupping. I agree to notify Bonnie Cronin, ND, LAc if I experience any unpleasant or unanticipated side effects from my acupuncture treatment.
6. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
7. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from acupuncture.
8. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above that do not pertain to me.

_____	_____	_____
Patient/Relative/Guardian* *include relationship to patient	Print Name	Date
_____	_____	_____
Witness	Print Name	Date

Patient Advisory to Consult Physician

As an acupuncturist, I believe strongly in and am committed to oriental medicine. However, I recommend that you consult with your physician regarding any condition or conditions you have prior to seeking acupuncture treatment.

State law requires that you read and sign the following statement:

We, the undersigned, do affirm that _____ has been advised by Bonnie Cronin, ND, LAc, to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

_____	_____	_____
Patient's Signature	Acupuncturist's Signature	Date

Bonnie Cronin, ND, LAc
North Shore Naturopathic & Acupuncture
402 N Main St, Canandaigua, NY 14424
2349 Monroe Ave, Rochester, NY 14618
Ph: 585-394-3490 fax: 585-394-3567

Informed Consent for Naturopathic Consultation

I, _____, consent to receive naturopathic consultation services from Bonnie Cronin, ND, LAc, and North Shore Naturopathic & Acupuncture.

I understand that although Bonnie Cronin, N.D., LAc. holds a doctorate in naturopathic medicine from Bastyr University in Seattle, Washington and is a licensed naturopathic physician in the State of Washington, the State of New York does not recognize naturopathy as a form of medicine nor is Dr. Cronin licensed as a physician in the State of New York.

I understand that the consulting services provided are not meant to be used in the place of allopathic medical care. I agree that it is in my best interest, and my sole responsibility to retain an allopathic primary care practitioner (M.D.) to assess my health care needs and appropriate treatment. Bonnie Cronin, ND, LAc and North Shore Naturopathic & Acupuncture provide expert knowledge in naturopathic care. We do not diagnose illness or proclaim to treat, prevent, or cure illness.

I understand services provided by Bonnie Cronin, ND, LAc, North Shore Naturopathic & Acupuncture may include dietary recommendations, vitamin recommendations, herbal or homeopathic remedies, lifestyle recommendations, hydrotherapy (applications of hot and/or cold water), thermal therapy (applications of hot and/or cold), Tuina (Traditional Chinese Massage), craniosacral, and other forms of therapeutic bodywork. These treatments are generally considered safe, but may have side effects. The risks and benefits of each recommendation will be discussed prior to implementation.

I agree to inform my practitioner immediately if:

- I am pregnant, as many modalities are contraindicated during pregnancy
- if I experience any side effects
- if I have any major changes in my health or prescriptive medications

My signature below confirms that I have read, or have had read to me, this consent to naturopathic consultation; understand the nature of and purpose of naturopathic consultation, understand the risks and benefits of recommended modalities, and have had an opportunity to ask questions.

_____

Client Signature

_____

Date

Bonnie Cronin, ND, LAc

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