BLUE PHOENIX WELLNESS
Daniel Reinaldo Bernstein, L. Ac., C.H.

DANIEL REINALDO BERNSTEIN, L.AC.
212-777-7191
www.bluephoenixwellness.com

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you.
If you have questions, please ask.
Thank you.

PERSONAL INFORMATION:

Name _____ Date _____

Home Address _____

City _____ State _____ Zip_____

Home Phone _____ Work Phone _____

Email _____

Occupation _____ Person Responsible for your account_____

Insurance Carrier_____ Insurance ID #_____

Who should we thank for referring you to this office? _____

Sex: ☐ Female ☐ Male Height _____ Weight _____ Birth date _____ Age ___

MARITAL STATUS:

☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Widowed

Have you received acupuncture therapy before? ☐ Yes ☐ No

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date		You	Your Relative	Approx. Date
Cancer	☐	☐	_____	Heart Disease	☐	☐	_____

Diabetes	☐	☐	_____	High Blood Pressure	☐	☐	_____
Hepatitis B/C	☐	☐	_____	Psychiatric Disorders	☐	☐	_____

SEXUALLY TRANSMITTED DISEASES:

☐ Gonorrhoea ☐ Syphilis ☐ AIDS ☐ HPV ☐ Chlamydia ☐ Herpes ☐ Date _____

Please indicate if any of the following pertain to you:

☐ Low Blood Pressure	☐ Pregnancy	☐ Strep Infection
☐ Faint	☐ Latex Allergy	☐ Lymph nodes removed
☐ Seizures	☐ Other Allergies: To What?	☐ Alcoholism
☐ Pacemaker	☐ Asthma	☐ Birth Trauma
☐ Blood -Thinning Meds	☐ MS	☐ Lyme disease

OTHER MAJOR ILLNESSES, INJURIES, SURGERIES, COSMETIC WORK:

Please provide details: _____

When? (Dates) _____

List any medications and supplements you are currently taking: (Continue on back if necessary)

Medicine	Dosage	Reason	Length	Prescribed by	Date of last checkup

DIET:

Breakfast	Lunch	Diner	Snacks

Food cravings: _____

Food intolerance: _____

How much do you consume (servings per day/week)

Meat _____ Sugar/Sweets _____ Dairy/Cheese/Milk _____

Are you always thirsty? ☐ Yes ☐ No Do you prefer ☐ Hot or ☐ Cold drinks?

Taste Preference: ☐ Salty ☐ Sour ☐ Bitter ☐ Sweet ☐ Spicy

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much		Yes	No	How Much
Coffee/Black Tea	☐	☐		Tobacco	☐	☐		Water Intake	☐	☐	
No-medical drugs	☐	☐		Alcohol	☐	☐		Soda pop	☐	☐	

SYMPTOM SURVEY (FOR EVERYONE)

GENERAL

___Recurrent Infections
___ Night Sweats
___Sweat easily
___ Bleed or bruise easily
___Thirst but no desire to drink
___Fatigue
___Sudden energy drops
Time of day_____
___Poor Sleep
___Tremors
___Poor Balance
___Edema

SKIN

___ Rashes
___Itching
___Eczema
___Oozing
___Pimples
___Dry skin / scalp
___Recent moles

CARDIOVASCULAR

___Chest discomfort/pain
___Heart Palpitations
___Cold hands or feet
___Swelling of hands or feet
___Blood Clots
___Spider veins
___Fainting
Other _____

RESPIRATORY

___Difficulty breathing
___Pain with breathing
___Shallow breathing
___Shortness of breath
___Production of phlegm
color _____
___Recurrent cough
___Bronchitis
___Pneumonia
___Asthma/Wheezing
Other _____

DIGESTION

___Bad breath
___Change in appetite
___Nausea
___Vomiting
___Heartburn
___Indigestion
___Belching
___Abdominal pain or cramps
___Weight gain
___Weight loss
___Loose stools / Diarrhea
___Strong smelling stools
___Bloody stools
___Pale stools
___Green stools
___Black stools
___Constipation
(not daily, or difficult)
___Pain with passing stools
___Gas
___Rectal pain
___Hemorrhoids
___Anorexia nervosa
___Bulimia
Other _____

HEAD/EYES/EARS/ NOSE/THROAT

___Headache
Where _____
When _____
___Migraines
___Dizziness
___Discharge from ear
___Poor hearing
___Ringing in ears
___Blurry vision
___Night blindness
___Color blindness
___Spots in front of eyes
___Eye pain
___Excessive tearing
___Glasses
___Sore eyes

___Facial pain
___Nose bleeds
___Nasal discharge
___Blocked nose
___Snoring
___Grinding teeth
___Teeth problems
___Recurrent sore throat
___Hoarseness
___Tonsillitis
___Swollen glands
___Sores on lips/mouth
Other _____

GENITO-URINARY

___Pain on urination
___Urgency with urination
___Frequent urination
___Blood in urine
___Decrease in urinary flow
___Unable to hold urine
___Incontinence at night
___Dribbling urination
___Kidney stones
___Prostate problems
___Impotency
___Changes in sexual drive
___Rashes
___Do you wake at night to urinate?
How many times?
_____
Other _____

MUSCULOSKELETAL

___Neck ache/pain
___Back ache/pain
___Knee ache/pain
___Shoulder pain
___Elbow/Forearm pain
___Hand/Wrist pain
___Foot/Ankle pain
___Joint/Bone problems
___Torn tissues
___Prostheses
___Muscle pain/weakness
___Hernia
Other _____

NEUROLOGICAL

___Seizures
___Nerve damage
___Paralysis
___Stroke
___Sleep disorder
___Concussion
___Vertigo
___Lack of coordination
___Loss of balance
___Poor memory
___Difficulty in concentrating
Other _____

BEHAVIOURAL

___Vacant
___Moody
___Easily susceptible to stress
___Aggressive/Bad temper
___Lose control of emotions
___Anxiety
___Panic Attacks
___Depression
___Fear

FOR WOMEN

What are the main health problems for which you are seeking treatment?

_____

_____

What other forms of treatment have you sought?

_____

_____

HOW DO YOU FEEL ABOUT THE FOLLOWING AREAS OF YOUR LIFE?

Please check the appropriate boxes and indicate any problems you may be experiencing:

	Great	Good	Fair	Poor	Bad	Your Comments
Significant Other						_____
Family						_____
Diet						_____
Self						_____
Work						_____
Exercise						_____
Spirituality						_____

# of pregnancies____ # births ____ # premature births ____ # miscarriages ____ # abortions ____

Age of 1st menses____ # days between menses ____ Duration of menses ____

Age of menopause ____

___Painful periods ___Irregular periods ___Light periods ___Heavy periods

OTHER SYMPTOMS RELATED TO MENSES:

___ Discharge ___ Headache ___ Nausea ___ Constipation ___ Diarrhea

___ Swollen Breasts ___ Mood Swings ___ Increased Appetite ___ Decreased Appetite ___ Insomnia

FOR MEN

Date of last prostate check up _____ PSA results _____

Manual prostate exam results _____

Lab results

_____

Frequency of Urination: Daytime _____ Nighttime _____

Color of urine: ___ clear ___ murky odor: _____

Symptoms related to prostate

__Prostate problems __Delayed stream __Dribbling __Incontinence __Retention of urine

__Rectal dysfunction __Increase libido __Decreased libido __Premature ejaculation _Impotence

__Back pain __Groin pain __Testicular pain Other _____

PAIN PATIENTS

Please note the severity of your problem right now:

No Problem Worst Imaginable

Please note the greatest degree of severity of your problem within the last week

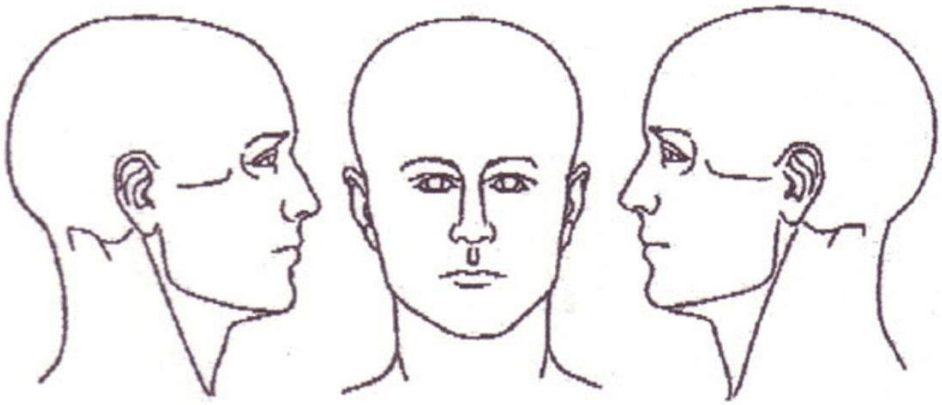
No Problem Worst Imaginable

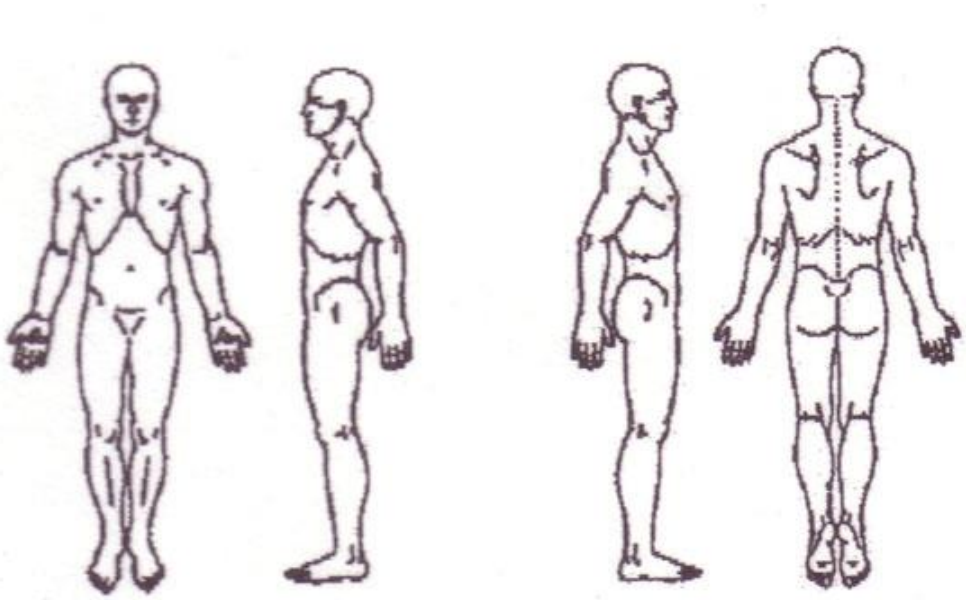
Please indicate areas of pain or distress:

COMMENTS: _____ _____

_____

_____





Disclosure Statement

CONFIDENTIALITY

Matters regarding your sessions will be kept confidential except in the following circumstances: You grant me specific permission to release information to a specific individual or agency; child abuse; you are an imminent danger to self or others; or in the case of the subpoena of records. Any information shared is kept confidential.

CANCELLATIONS

Since I have reserved our appointment time for you, it is my policy to charge for cancellations received less than 24 hours' notice unless we are able to reschedule the appointment within the same week.

I AGREE TO ALL THE TERMS LISTED ABOVE:

CLIENT'S SIGNATURE

_____

Date_____

Guardian's signature (if client is a minor)

_____

Date_____

Acceptance of Terms

I, the undersigned, understand all questions and verify that all information is complete and accurate to the best of my knowledge. I also understand that the hypnotic methods used by Hypnotist(s) of Blue Phoenix Wellness are not a substitute for medical or psychiatric treatment. I understand these methods to be a conditioning process, whereby an individual is taught to use their own abilities for their benefit and wellbeing. With this understanding, I hereby grant Daniel Bernstein permission to hypnotize me or the minor child whose name appears at the top of this form. I (we) further grant permission for the sessions to be recorded/taped as needed.

I know my progress is dependent upon my efforts and that there are no guarantees as to the result or progress to be made. I understand that the success of the treatment will be in direct proportion to my commitment to the end result.

I (we) agree to pay for services rendered to the above-named client as the charge is incurred. Although I do not diagnose nor prescribe or tell people what to do, in the course of our treatment sessions, I suggest, educate, motivate and inspire people to get well. I do not provide physical or mental therapy, although if agreed upon between you and me, I may perform acupuncture within the session.

I am not a doctor or psychological counselor. Any suggestions or advice are general and should not be interpreted as a substitute for consulting with medical or mental health professionals. Accordingly, I take no responsibility for the consequences of any actions you might decide to take based on any comments or opinions I may express in the course of your visit.

Confidentiality: I will not release any information to anyone without a written authorization from you, except as provided for by law.

Packages purchased at a discounted rate are non-refundable.

By signing this document, I am confirming that all information is true to the best of my knowledge, and I agree to all the terms listed above:

CLIENT'S SIGNATURE

_____

Date_____

Guardian's signature (if client is a minor)

_____

Date_____