The Acupuncture Office
Patient Health History Intake DATE_____

NAME:_____ Email _____

Address: _____ City/State_____ Zip_____

Phone: Home: (_____)_____ Cell:(_____)_____ Work: (_____)_____

Emergency Contact /relationship _____Phone: (____)_____

Date of Birth: _____ Sex M / F Ht_____ Wt ____ Profession_____

Marital status: S M D W Health of spouse: Exc /Good/Fair /Poor # of children, if any ____

Name of Child	Age	Sex M/F	Any health concerns?	Name of Child	Age	Sex M/F	Any health concern?
_____	___		_____	_____	___		_____
_____	___	M/F	_____	_____	___	M/F	_____

Referred by_____ internet phonebook

Overall health (circle one): Excellent / Good / Fair / Poor / Other _____

Chief Complaints (reason you are here) _____
_____

When did it start? _____ Sudden or gradual onset (circle)
If you were given a Western diagnosis, please list _____
What makes it better?_____ What makes it worse?_____

If you've tried other treatments, list and indicate effectiveness
_____ _____
_____ _____

Other current complaints	Current Medications	Vitamins/Supplements
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgeries (list with dates) _____ _____
_____ _____

Trauma: Falls/injuries/accidents, etc. (list with dates)
_____ _____
_____ _____

List any scars you have from surgeries or cuts:_____

Emotional status in general? Happy Depressed Worried Angry Afraid Stressed
Other_____
My social, family and personal relationships are :
Very Fulfilling Usually Fulfilling Rarely Fulfilling Horrible Indifferent

Family history of serious illness: (circle)
Cancer Diabetes Heart Other: _____

Do you have any religion based dietary restrictions? (i.e. Vegetarian, Kosher, etc)_____
Do you have any food allergy or sensitivity based diet restrictions? _____
What does your typical diet include? (Please circle all)
Meat fish eggs dairy vegetables fruit breads starches cakes/cookies sweets
How many meals per day? _____ Snacks? _____ Any sugar sub?_____
Intake per day: Water _____ Coffee_____ Soda _____ Diet soda_____
If you smoke or drink alcohol or caffeine, please indicate how much.
Cigarettes _____ Alcohol_____ Caffeine _____
Are you currently using any recreational drugs? (marijuana, etc)_____

Rest/Activity
How many hours of sleep do you get a night? _____ (see General Feelings area)
Do you get regular exercise? Yes No Type_____ Frequency_____
_____ _____

Past & Present Condition

___AIDS/HIV	___Diabetes	___High Blood Pressure	___Rheumatic Fever
___Alcoholism	___Emphysema	___Measles	___Scarlet Fever
___Allergies	___Epilepsy	___Multiple Sclerosis	___Seizures
___Appendicitis	___ Goiter	___Mumps	___Stroke
___Arteriosclerosis	___Gout	___ Pacemaker	___Thyroid disorder
___Asthma	___Heart disease	___Pleurisy	___Ulcer
___Cancer	___Hepatitis	___Pneumonia	___Venereal Disease
___Chicken Pox	___Herpes	___Polio	___Whooping cough

General Feelings

___Fatigue	___Recurrent Fever	___Trouble falling asleep	___Swelling
___Cold hands/feet	___Bleed / bruise easily	___Waking at night	____Heavy feeling
___Chills	___Weight gain / loss	___Night sweats	
___Hot feeling	___Muscle cramps	___Dream-disturbed sleep	
___Sweat easily	___Dizzy / Vertigo	___Numbness / tingling / tremors	

Digestion / Appetite

___Nausea	___Gas	___Heartburn	___Anal itch / burning / fissure
___Bloating	___Diarrhea	___Indigestion	___Bowel movements:_____/day
___Vomiting	___Constipation	___Stomach pain	___Stools: soft / hard / black / blood
___Excessive appetite	___No appetite	___Cravings: sweets / salt / carbs	

Cardiovascular

___High blood pressure	___Irregular heartbeat	___Fainting	___Phlebitis
___Low blood pressure	___Palpitations	___Chest pain	___Blood clots

Respiratory

___Shortness of breath	___Bronchitis	Cough: ___Dry ___Wet	___Coughing blood
___Tightness in chest	___Wheezing	Mucus: ___Thin ___Thick	

Head ___Eye pain ___Facial pain ___Lip / tongue sores ___Poor hearing
___Red / Itchy eyes ___TMJ ___Excess saliva ___Ringing in ears
___Dry eyes ___Grind teeth ___Sore throat ___Concussion
___Blurred vision ___Gum problem ___Swollen glands ___Lump in throat
___Glaucoma / Cataract ___Dry mouth ___Sinus problem ___Headache / Migraine

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Skin & Hair
___Acne ___Ulcerations ___Itching ___Rash ___Hair loss
___Hives ___Psoriasis ___Eczema ___Fungal infection ____Dandruff

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Emotional
___Phobias ___Irritable ___Work stress ___Seeing a therapist
___Poor memory ___Easily stressed ___Relationship stress ___Physical abuse victim
___Anxiety ___Easily angered ___Family stress ___Sexual abuse victim

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Urinary-Genital
___Painful urination ___Bedwetting ___Urination frequency: _____x day
___Urgent urination ___Unable to hold urine ___ Volume of urine: scant / regular / high
___Incomplete urination ___Blood in urine ___Wake to urinate _____ x night
___Increased libido ___Decreased libido ___Kidney stones

FEMALE ___Uterine Fibroids ___Ovarian cysts
Date last period began: _____ Age menses began_____ Typical # days ____

Menstrual: Flow: heavy / light Color: light red/dark red/ brown
___Painful ___Fatigue ___Headache ___Back pain ___ PMS ___Spotting
Pregnancies:
# of children____ Miscarriages___ Abortions___ Caesarean___ Excess blood loss___
Menopause: Began at what age? _____
___Hot flashes ___Insomnia ___Night sweats ___Mood swings ___Dryness

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MALE
___Prostate problems ___Erectile dysfunction ___Premature ejaculation

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Musculoskeletal
Please mark on the diagram areas of discomfort

Sharp Pain
☐ Dull Pain
☐ Constant Pain
☐ Shooting Pain

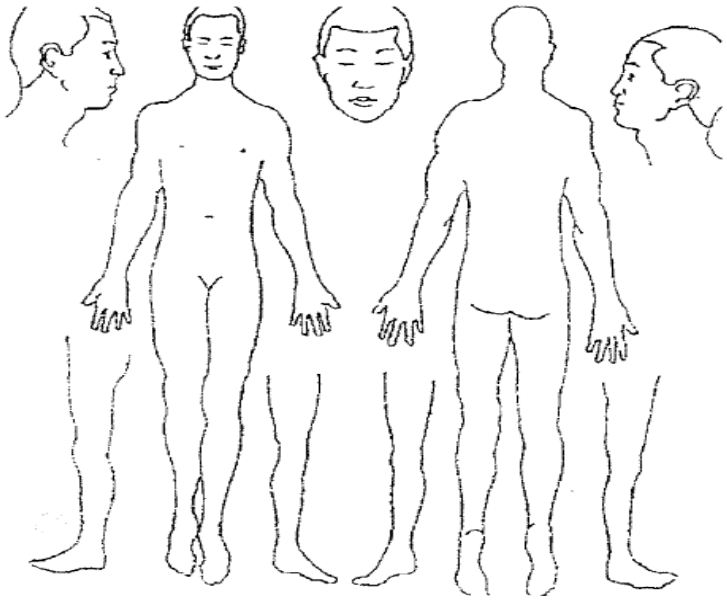
Please rate the pain intensity
on a scale of 1 → 10 (10 is highest)

*can also indicate # on diagram

What decreases the pain?

What causes the pain to increase?

OTHER:
☐ Tingling
☐ Itching
☐ Numbness
☐ Neuropathy
☐ Tension/Tightness
☐ Limited Range of Motion
☐ Limited Use



The Acupuncture Office

15-B Century Hill Drive
Latham, NY 12110
heal@TheAcupunctureOffice.net

Phone 518-785-8999
www.TheAcupunctureOffice.net

Consent to Treatment

To comply with Article 160, Section 82111.1(b) of NYS Education Law, we request that you read and sign the following statement:

We, the undersigned, do affirm that _____ (patient) has been advised by The Acupuncture Office to consult a physician regarding the condition(s) for which each patient seeks acupuncture treatment.

The patient has also been informed of the following considerations regarding acupuncture and related therapies:

Methods of treatment used in this practice may include, but are not limited to, acupuncture, herbal therapy, Tuina (Chinese massage), Qi Gong (energy work) and nutritional counseling.

Acupuncture is a safe method of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. *Unusual* risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol, hand sanitizer and sterile disposable needles and maintains a safe and clean environment. There is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

If pregnant, or in the process of trying to get pregnant, the acupuncturist will be notified in order to avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

If pregnant, or in the process of trying to get pregnant, the acupuncturist will be notified in order to avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

Herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken *without* my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.
If any discomfort or adverse reactions are experienced, the patient should notify the acupuncturist as soon as possible,

Practitioners of The Acupuncture Office may review medical records and lab reports, but all records are kept confidential. If it becomes necessary to share health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided and acknowledged.

Risks and benefits may be discussed further with the practitioner before signing. However, it is not expected to be able to anticipate and explain all possible risks and complications of treatment. The practitioner will exercise his or her judgment in the best interest of the patient during the course of treatment, based upon the facts then known.

Appointment times are scheduled specifically for the patient, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee may be charged for sessions missed without such advance notification.

In signing this form, the patient acknowledges any inherent risks, and gives his/her consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

_____ _____
Patient (Representative) Signature Date

_____ _____
Licensed Acupuncturist Date

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Financial Policy

Payment is required at the time of service. We accept cash, personal checks, debit cards and Mastercard, Visa, and Discover.

We are not providers with any health insurance plan, nor do we participate in no-fault or worker's compensation. We can provide a superbill receipt for you to submit to your insurance carrier if your plan covers acupuncture. Please remember it is your responsibility to check with your insurance provider regarding your eligibility.

Acupuncture **IS** considered a qualified medical expense for Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA). Herbs, vitamins and nutritional supplements **ARE NOT** considered qualified medical expenses.

Important 24-hour Appointment Cancellation Policy

It is extremely important for you to remember that when you make an appointment with us that time is reserved exclusively for you.

If you need to cancel or re-schedule an appointment, kindly provide at least 24 hours notice so that we can give the appointment to someone else and our time is not wasted.

You will be asked to pay in full for appointments cancelled or missed without 24 hour notice.

Patients who repeatedly cancel or miss appointments without 24 hours notice will be asked to leave the practice.

I have read and understand the above financial and appointment cancellation policies.

Signature: _____ Date: _____

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PRIVACY SUMMARY

This notice summarizes how health data about you may be used and shared and how you can get access to this data.

IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:

a) Treatment - To give you medical treatment or other types of health services.
b) Payment - To bill you or a third party for payment for services provided to you.
c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

_____

Signature of patient or representative Date

_____

Print patient name Patient Birth Date