PATIENT INFORMATION

Please answer questions to the best of your knowledge.

*Name*_____*Date*_____

*Address*_____

*City*_____*State*_____*Zip*_____

*Home Phone*_____*Other*_____*Phone*_____

*Fax*_____ *Email*_____

*Sex: male ( ) female ( ) Height*_____ *Weight*_____ *Birthdate*_____/_____/_____*Age*_____

*Emergency Contact: Name*_____*Phone*_____

*Referred by*_____*Have you received acupuncture before? Yes ( ) No ( )*

Your primary biomedical doctor's contact information:

*Name*_____

*Address*_____

*Phone*_____*Fax*_____

Please indicate any significant illness you or a blood relative have had:

	You	Relative	When		You	Relative	When
Cancer	( )	( )	_____	*High cholesterol*	( )	( )	_____
Hepatitis	( )	( )	_____	*Seizures*	( )	( )	_____
High blood pressure	( )	( )	_____	*Emotional disorders*	( )	( )	_____
Infectious diseases	( )	( )	_____	*Tuberculosis*	( )	( )	_____
Diabetes	( )	( )	_____	*HIV/AIDS*	( )	( )	_____

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

Medicine	*Dosage*	*Reason*	*How long*	*Prescribed by*	*Last check up*

Please check if any of the following statements are true for you.

( ) I have known allergies ( ) I am taking anticoagulants ( ) I have a pacemaker ( ) I am pregnant

Please indicate the use and frequency of the following:

	yes	*no*	*how much*		*yes*	*no*	*how much*		*yes*	*no*	*how much*
Coffee/Black tea	( )	( )	_____	*Water intake*	( )	( )	_____	*Soda pop*	( )	( )	_____
Non-medical drugs	( )	( )	_____	*Alcohol*	( )	( )	_____	*Tobacco*	( )	( )	_____

How do you FEEL about the following areas of your life:

	Good	*Average*	*Poor*	*Your comments:*
Significant other	( )	( )	( )	_____
Family	( )	( )	( )	_____
Diet	( )	( )	( )	_____
Sex	( )	( )	( )	_____
Self	( )	( )	( )	_____
Work	( )	( )	( )	_____
Exercise	( )	( )	( )	_____
Spirituality	( )	( )	( )	_____

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

_____

What other forms of treatment have you sought?

_____

Please list any other health problems you now have:

_____

Please list any allergies or food sensitivities you may have:

_____

Please list any accidents, surgeries or hospitalizations (including date):

_____

Please list any special considerations or circumstances you would like your practitioner to be aware of:

_____

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FOR MEN

Date of last prostate checkup_____/_____/_____ PSA results_____

Manual prostate exam results_____

Frequency of urination: Daytime ____Night time____Color of urine: Clear ( ). Cloudy ( ). Red ( ). Odor ( )

Symptoms related to prostate:

Delayed stream ( ). Dribbling ( ). Incontinence ( ). Retention of urine ( ).

Rectal dysfunction ( ). Increased libido ( ). Decreased libido ( ). Premature ejaculation ( ).

Impotence ( ). Groin pain ( ). Testicular pain ( ). Back pain ( ).

Other: ( ):

_____

_____

FOR WOMEN

Age of first period (menarche)_____

Age of last period (menopause)_____

Number of days between periods_____

Number of days of flow_____

Number of pads/tampons on heaviest day_____

Are you pregnant? yes ( ). no ( )

Number of pregnancies_____

Number of live births_____

Number of abortions_____

Number of miscarriages_____

Color of flow: Red ( ). Purple ( ). Dark ( ). Brown ( ).

Clots: yes ( ) no ( )

Date of last: Gynecological exam_____Pap smear_____Mammogram_____

Results:_____

_____

Have you been diagnosed with: Fibroids( ). Fibrocystic breasts ( ). Endometriosis ( ). PID ( ).

Ovarian cysts ( ). Other ( ):_____

Symptoms associated with menses:

Pain ( ). Nature of pain: Cramping ( ). Stabbing ( ). Burning ( ). Aching/dull ( ). Constant ( ).

Intermittent ( ). Bearing down sensation ( ).

Discharge ( ). Nature of discharge: Clear ( ). White ( ). Yellow ( ). Other color ( ). _____

Thick ( ). Thin ( ). Scanty ( ). Copious ( ).

Headache ( ). Swollen breasts ( ). Increased libido ( ). Constipation ( ). Ravenous appetite ( ).

Mood swings ( ). Irritability ( ). Nausea ( ) Vaginal Dryness ( ). Poor appetite ( ).

Decreased libido ( ). Hot flashes ( ). Diarrhea ( ). Night sweats ( ). Insomnia ( ).

Other: ( ):

_____

_____

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GENERAL SYMPTOM SURVEY (FOR EVERYONE)

Please check the symptoms you have experienced recently:

( ) Poor appetite
( ) Excessive appetite
( ) Digestive problems
( ) Loose stools/diarrhea
( ) Nausea
( ) Vomit
( ) Belching/burping
( ) Heartburn/reflux
( ) Food sitting in stomach
( ) Gas or bloating
( ) Constipation
( ) Tired after meals
( ) Easily bruised
( ) Sudden weight loss
( ) Hemorrhoids
( ) Colitis or Diverticulitis
( ) Blood in stool
( ) Pasty taste in mouth
_____

( ) Depression
( ) Worrying a lot
( ) Anxiety
( ) Easily frightened
( ) Difficulty in making decisions
( ) Often sad
( ) Often angry
( ) Often crying
( ) Thinking a lot

( ) Insomnia/difficult sleeping
( ) Heart palpitations
( ) Cold hands & feet
( ) Nightmares
( ) Mentally restless
( ) Frequently laughing
( ) Chest pains
_____

( ) Cough
( ) Asthma
( ) Hay fever
( ) Frequently catching colds
( ) Shortness of breath
( ) Intolerant to weather changes
( ) Bronchitis
( ) Allergies
( ) Nasal problems
( ) Skin problems
( ) Frequent yawning
( ) Recent use of antibiotics

_____

( ) Fatigue
( ) Often too cold
( ) Often too hot
( ) Very thirsty
( ) Bitter taste in mouth

( ) Abdominal pain
( ) Chest pain
( ) Sciatic pain
( ) Headaches
_____

( ) Low back pain
( ) Knee problems
( ) Hearing impairment
( ) Ear ringing
( ) Kidney stones
( ) Bone spurs
( ) Decreased sex drive
( ) Infertility
( ) Sexual dysfunction
( ) Hair loss
( ) Urinary problems
( ) Edema
( ) Decreased sense of smell

( ) Eye problems
( ) Jaundice
( ) Difficult to digest oily foods
( ) Gall stones
( ) Soft brittle nails
( ) Easily irritated
( ) Easy to faint
( ) Tendonitis
( ) Muscles spasms or twitches
( ) Dry skin
( ) Dizziness
( ) Poor concentration
( ) Frequent sighing

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INFORMED CONSENT TO ACUPUNCTURE TREATMENT

This signed form indicates that the patient named below has been informed of and has consented to acupuncture treatment and other associated and complimentary procedures.

The methods of treatment include but are not limited to Acupuncture, moxibustion, cupping, guasha,
Electro-acupuncture, laser stimulation, Tui Na (Chinese massage), Shiatsu (Japanese massage), essential oil application, Reiki, herbal medicine and nutritional counselling.

The patient has been informed that acupuncture is a safe method of treatment and side effects are generally uncommon. Potential side effects of acupuncture include bruising, numbness or tingling near the needling site that may last a few days. Occasionally dizziness or fainting may occur. The patient is encouraged to actively and openly communicate with the practitioner about their treatment experience so as to allow adjustments to be made which aim to maximize patient comfort. Single-use, sterile and disposable needles are used to avoid infection. When moxibustion is applied to acupoints, some burning and/or scarring may occur, depending on the technique used. This form lists the most common risks of acupuncture, but each person may experience different effects.

The herbs and nutritional supplements (derived from plant, animal and mineral sources) which may be recommended are traditionally considered safe, although some may be toxic at high doses. Some herbs are inappropriate for pregnant women. Some possible side effects of herbs include nausea, gas, stomach ache, vomiting, diarrhea, rashes, hives or tingling of the tongue. Please inform the practitioner if these or any other side effects are experienced after taking herbs so that appropriate modifications can be made to the formula. These side effects can generally be avoided when herbs are administered by a properly trained herbalist.

The patient has also been advised to inform the practitioner if she becomes pregnant.

PATIENT ADVISORY TO CONSULT A PHYSICIAN

In order to gain the best of both worlds, the patient named below has been advised that for whatever medical conditions they are seeking treatment for by acupuncture and other alternative modalities, they have been advised to check in and consult with their biomedical doctor(s).

In compliance with Article 160, Section 8211.1 (b) of NYS Education Law…..

_____

Print Patient Name

has been advised by ***Paul Kempisty L.Ac.*** *to consult a physician regarding the condition(s) for which they are seeking acupuncture treatment.*

_____

Patient Signature *Date*

_____

L.Ac Signature *Date*

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The privacy of your medical information is important to us. You may be aware that U.S. government regulations established under HIPAA (Health Information Portability and Accountability Act) govern the protection of health information. This notice describes how it may be used, as well as certain rights you have as a patient.

Use And Disclosure Of Protected Information

All information regarding patients, their treatments, diagnosis and appointments is kept strictly confidential. Patient chart and financial data will be seen only by the practitioner. There is no electronic transfer of your medical data. For treatment purposes, private information will be provided to another practitioner only after your written consent is given.

Your medical information may be used, without further notice to you, or specific authorization by you, where required by law:

- for public health purposes;
- to report child abuse;
- in judicial or administrative proceedings;
- by a health oversight agency for oversight activities authorized by law;
- under law enforcement purposes;
- by a coroner or medical examiner;
- to avert serious threat to health or safety;
- under military authorites if you are a member of the armed forces of the United States.

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or telephone, at your residence, to remind you of appointment(s). No reference to medical service will be made. Occasionally, we may call to give instructions or to notify you that herbs or supplements are in the office. If you wish for us to make use of alternative methods of communicating with you, please provide that information on the signature sheet.

Rights That You Have

You have the right to inspect and obtain copies of your medical information. A reasonable fee will be charged for copying. You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for the requested amendment. If we disagree with requested amendment, we will notify you of such disagreement, and we will further notify you of your rights. You have the right of request an accounting of any disclosures we make of your medical information, except for:

disclosures we make directly to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or for emergency or notification purposes.

Obligations That We Have

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it currently is in effect.

Please sign the attached acknowledgement of receipt as we are required under law to show that we gave you this information.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have read and understand the Notice of Privacy Practices and have therefore been advised of how medical information may be used and disclosed in the office, and have also been informed of how I may gain access to and control this medical information.

_____

Signature of Patient or Personal Representative

_____

Print name of Patient or Personal Representative

_____

Relationship of Personal Representative to Patient

_____

Date

If you wish for us to make use of alternative methods of communicating with you, please provide that information below: