HEALTH HISTORY QUESTIONNAIRE

Welcome to our clinic! Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the **Comments** section. Thank you!

NAME:_____
ADDRESS:_____
CITY _____ STATE_____ ZIP _____
Home Phone: _____Work Phone: _____E-Mail:_____
Date of Birth:_____ Age: _____ Height: _____Weight: _____
Place of Birth:_____ Social Security Number: _____
Occupation: _____ Marital Status: _____
In Emergency Notify: _____
Referred by: _____
Family Physician/Phone Number: _____
Employers' Name & Address:_____
Insurance Carrier: _____
Policy #:_____Group#:._____
Have you tried acupuncture or Chinese herbal medicine before?
_____

MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?
_____
_____
How long has it been since you first noticed any symptoms? _____
Have you been given a diagnosis for the problem by you family physician? _____
If so, what is it? _____
What kinds of treatment or therapy have you tried? _____

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES):

☐Allergies
☐Cancer
☐Diabetes
☐Hepatitis
☐High Blood Pressure
☐Heart Disease
☐Seizures
☐Rheumatic Fever
☐Surgeries
☐Venereal Disease
☐Thyroid Disease
☐Birth Trauma (prolonged labor, forceps delivery, etc)
☐Other Significant illness (describe)_____
_____
☐Accidents or Significant Trauma (describe)_____
_____

OTHER RELEVANT MEDICAL HISTORY
_____
_____
_____
_____

FAMILY MEDICAL HISTORY

☐ Allergies	☐ Cancer	☐ Seizures
☐ Diabetes	☐ Heart Disease	☐ Stroke
☐ Asthma	☐ High blood Pressure	☐ Other

OCCUPATION : _____

Occupational stress factors (physical, psychological, chemical): _____

_____

LIFESTYLE: _____

Do you follow a regular exercise program? _____If so, please describe:_____

_____

Please describe your average daily diet? _____

_____

Please check any of the following habits that apply. How much and how often do you use them:

☐ Cigarette smoking ☐ Coffee,tea or cola ☐ Alcohol beverages

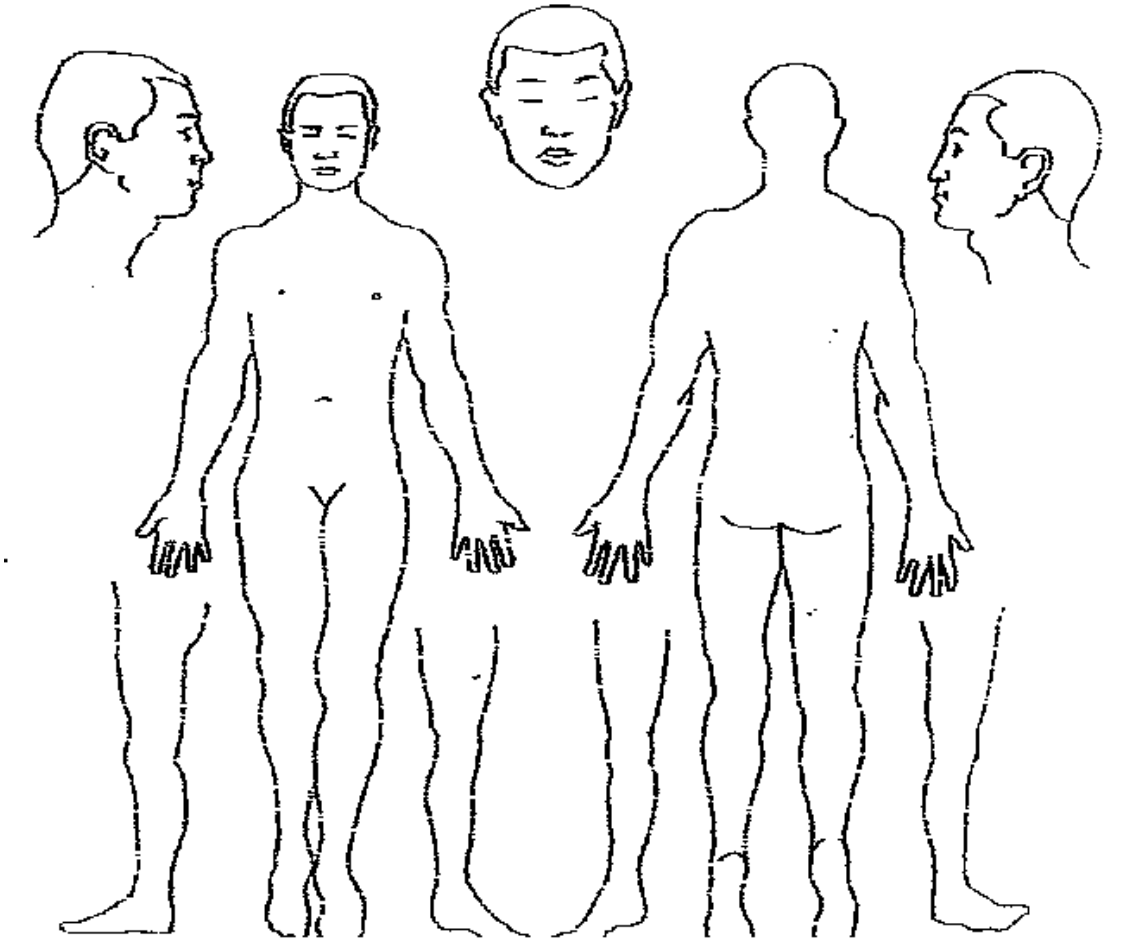
List medications taken within last two months (vitamins, drugs, herbs, etc.): _____

_____

Please describe any drug use for non-medical purposes: _____

_____

Please mark painful or distressed areas on the chart below



PLEASE PUT A CHECK NEXT TO ANY CONDITION YOU'VE EXPERIENCED IN THE LAST THREE MONTHS, CIRCLE THOSE YOU'VE EXPERIENCED IN THE PAST. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.

GENERAL

- ☐ Poor appetite
- ☐ Insomnia
- ☐ Disturbed sleep
- ☐ Localized weakness
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Changes in appetite
- ☐ Sweating easily
- ☐ Tremors
- ☐ Bleeding or bruising easily
- ☐ Night Sweats
- ☐ Fever
- ☐ Chills
- ☐ Sudden energy drop ____(time of day)

Other unusual or abnormal conditions you have noticed in your general sense of health

_____

_____

SKIN & HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair loss
- ☐ Recent moles
- ☐ Changes in texture of hair or skin

Any other hair or skin problems_____

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Eye strain
- ☐ Sinus problems
- ☐ Recurrent sore throats
- ☐ Nose bleeds
- ☐ Grinding teeth
- ☐ Sores on lips or tongue
- ☐ Facial pain
- ☐ Teeth problems
- ☐ Headaches (where? when?)
- ☐ Jaw clicks

Any other head or neck problems _____

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Difficulty in breathing
- ☐ Phlebitis

Any other heart or blood vessel problems_____

RESPIRATORY

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pain with deep inhalation
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Excessive phlegm (color?)

Any other lung problems_____

GASTROINTESTINAL

☐ Nausea	☐ Belching	☐ Rectal Pain
☐ Vomiting	☐ Black stools	☐ Hemorrhoids
☐ Diarrhea	☐ Blood in stools	☐ Abdominal pain or cramps
☐ Constipation	☐ Indigestion	☐ Chronic laxative use
☐ Gas	☐ Bad breath	

Any other problems with stomach or intestines: _____

GENITOURINARY

☐ Pain while urinating	☐ Urgency to urinate	☐ Decrease in flow
☐ Frequent urination	☐ Unable to hold urine	☐ Impotence
☐ Blood in urine	☐ Kidney stones	☐ Sores on genitals

Do you wake up at night to urinate? _____ If so, how often? _____

Any particular color to your urine? _____

Any other genital or urinary problems? _____

REPRODUCTIVE AND GYNECOLOGIC

☐ Premenstrual changes	☐ Heavy menstrual flow	☐ Premature births
☐ Menstrual clots	☐ Light menstrual flow	☐ Miscarriages
☐ Painful menses	☐ Irregular menses	☐ Abortions
☐ Unusual menses	☐ Other problems	

Age at first menses _____ Age at menopause _____ Number of pregnancies _____

Time between cycles _____ Duration of bleeding _____ First day of last menses _____

Do you practice birth control? _____ If so, what type? _____ For how long? _____

Any other gynecologic problems? _____

MUSCULOSKELETAL

☐ Neck pain	☐ Back pain	☐ Hand/wrist pain
☐ Muscle pains	☐ Muscle weakness	☐ Shoulder pains
☐ Knee pain	☐ Foot/ankle pains	☐ Hip pain

Any other joint or bone problems? _____

NEUROPSYCHOLOGICAL

☐ Seizures	☐ Poor memory	☐ Anxiety
☐ Dizziness	☐ Lack of coordination	☐ Bad temper
☐ Loss of balance	☐ Concussion	☐ Easily susceptible to stress
☐ Areas of numbness	☐ Depression	

Have you ever been treated for emotional problems?

_____

Have you ever considered or attempted suicide?

_____

Any other neurological or psychological problems?

_____

COMMENTS

Please list any other problems you would like to discuss:

_____

_____

_____

Acupuncture Associates, PC
Joan Boccino L.A.c NYS License # 00923 - Jeanette Busch L. Ac. NYS License # 00939
200 East 15th St, Suite A
New York, NY 10003
Office: 212-777-3909 Fax: 212-777-3228
email: joan@herbsandhealing.com

PAYMENT AUTHORIZTION FOR:

(1) PAYMENT OF MEDICAL BENEFITS AND
(2) RELEASE OF MEDICAL INFORMATION

I authorize payment of medical benefits to , Jeanette Busch or Acupuncture Associates, PC for acupuncture services rendered to me. Furthermore, I authorize the release of any medical information necessary to process my insurance claims, to the insuring company or agency.

(PRINT NAME)

SIGNATURE ON FILE

DATE

ADVICE TO CONSULT A PHYSICIAN

While Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Article 160. Section 8211.1(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 _____ L. Ac. to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

_____ _____ ` ☐

Patient signature Date Declined copy (initial)

_____ _____

Licensed Acupuncturist Signature Dale

INFORMED CONSENT

I hereby request and consent to Oriental Medicine diagnosis and treatment by the above named Practitioner. I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, tui na massage and Chinese or Western herbal medicine and nutritional counseling.

I have had the opportunity to discuss the nature and purpose of treatment with the Practitioner. I have been informed that acupuncture is a safe method of treatment. but that it may have side effects including bruising, numbness or tingling near the needling sites that may last a few days and dizziness and fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, Including lung puncture (pneumothorax). Infection is another possible risk. Though we use sterile disposable needles for each patient. Bums and/or scarring are a potential risk of moxibustion, l understand that while this document describes the main risks, other side effects and risks may occur. I also understand that the herbs and nutritional supplements that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I also understand that they come from plant, animal and mineral sources and that some herbs may be inappropriate during pregnancy.

I do not expect the Practitioner to be able to anticipate and explain all risks and complications. I wish to rely on the Practitioner to exercise judgment during the course of the treatment that the Practitioner feels is correct at the time, based upon the facts then known, is in my best interests.

I understand that my records will be kept confidential and will not be released without my written consent. I will inform the Practitioner if I should become pregnant

It have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above mentioned procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name (print) _____

Patient's Signature _____

Date Signed _____

ACKNOLDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOLDGEMENT

I, _____, have received a copy of this office's Notice of Privacy Practices and I consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)

  _____
  _____

ACUPUNCTURE ASSOCIATES, PC
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 READ IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to s in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may se and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include acupuncture, cupping, tui na, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance plan for your treatment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected information when we are required to do so by federal, state or local law. We may disclose your PROTECTED-HEALTH INFORMATION to public health authorities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding,, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of he request or to obtain an

order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ,, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below.

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMAITON.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201

877-696-6775 (Toll Free)

Acupuncture Associates PC
Insurance Policies

We participate in a number of insurance plans for the convenience of our patients and because of our interest in having acupuncture accessible to as many people as possible.

Patients who remit payment to us through insurance plans, however, should be advised of the following.

Missed appointments without 24 hrs notice or prior arrangement are the responsibility of the patient. We cannot bill your insurance company for payment. You will be responsible for the regular visit fee.

You should also be aware that even though we bill your insurance company, you are responsible for payment in the event that payment is refused. You are also responsible for payment if the insurance company at a later date decides that they paid for your treatment in error.

It is your responsibility to know the terms/conditions of your policy and to advise us of them and any changes in them. This may include, but is not limited to, things like: covered diagnosis, limitations in the number of visits, pre-authorizations, referrals and participation in affinity or similar programs. Participation in affinity or discount programs will start after we receive documentation of participation and will not be retroactive.

Patient acknowledgement:

I have read, understand and agree to the above described policies. I understand that I am responsible for any and all charges not covered by my insurance carrier due to the lack of such benefits within my plan or due to my lack of coverage for any reason. I also understand that I am responsible for any co-insurance, deductibles and co- payments. I hereby authorize , Jeannette Busch, and/or Acupuncture Associates to bill my credit card for any of these charges without further authorization.

_____ _____
Patient Signature and date Credit Card Number

_____
Exp. Date vcode

_____
Printed Name _____

_____ _____
Billing Name Billing Address