LIholistic
health associates

399 Deer Park Ave. Suite 1., Babylon Village, NY 11702
631.539.9733 - www.LIHOLISTIC.com

PATIENT INFORMATION

TODAY'S DATE___________

Name____Date____________________
Address____Zip_____________
Daytime P#_____________________________ Eve P#____
Cell #_________________________________ E-mail____
DOB______________ Age____ Ht____Wt______SS#___________________________ Married Single Other
Emergency contact name____
Relation__________________________P#____
Employer Name____
Contact name_______________________________________P#___________________________________
PCP Name ____P#___________________________________
Address____Zip_____________
OB-GYN Name____P#_________________________________
Address____Zip_____________
Referred by____P#_________________________________
Address____Zip_____________

Main complaint____

Date of onset (when you first noticed your problem):____

How long have you had this condition?____

Have you had this in the past? 0 Yes 0 No
When:____

Pain/Complaint : 0 Minimal 0 Slight 0 Moderate 0 Severe Scale of 1-10(10 is worse)_________________________

What makes it better?____

What makes it worse?____

Your condition is: 0 Getting worse 0 Constant 0 Comes and goes

Medications/drugs/herbs you are currently taking:____

____

List surgeries/operations you have had and dates:____

____

Family History

	Father	Mother	Sibling	Children	Self
Arthritis					
Asthma					
Cancer					
Allergies					
Heart trouble					
High blood pressure					
Stroke					
Diabetes					

Energy level	**Stress**
0 High (time of day) 0 Low (time of day)	0 None 0 Moderate 0 Severe What causes it?

Sweating & Circulation

0 Night sweats 0 Rarely Sweat 0 Excess Sweating 0 Spontaneous Sweat	Feeling of 0 Hot 0 Cold What areas?____________________________ Hands and feet get cold easily? 0 Yes 0 No

General

0 Chills 0 Low energy 0 Dizziness 0 Allergies	0 Fatigue 0 Excess thirst 0 Weight loss 0 Weight gain	0 Aversion to heat 0 Aversion to cold 0 Low back pain 0 Joint disorders

Skin

0 Dry 0 Itchy 0 Moist, clammy 0 Burning 0 Blood not clotting 0 Hives	0 Changing moles/lumps 0 Changing in cysts/tumors 0 Boils 0 Frequent rashes 0 Acne 0 Bruises easily (black & blue spots)	0 Hair loss/thinning 0 Dry scalp 0 Skin puffy/wrinkled 0 Dark circles under eyes 0 Other:

Sleep

0 Trouble falling asleep 0 Trouble staying asleep 0 Restful	0 Insomnia 0 Vivid dreams 0 Other:	How many hours do you sleep each Night ?

Head & Neck

0 Dizziness	0 Blurred vision	0 Headaches:
0 Memory loss	0 Double vision	(list area)
0 Eye pain	0 Floaters	
0 Dry eyes	0 Loss of balance	0 Other:
0 Red eyes	0 Darkness under eves	

Ears & Nose

0 Poor hearing	0 Ringing/buzzing in ears	0 Congestion/allergies
0 Earaches	0 Frequent nose bleeds	0 Frequent colds # p.y.________
	0 Sinus trouble	0 Other:
0 Ear discharge/infections		

Chest

0 Hard to breathe	0 Mucous rattles when breathing	0 Swollen ankles
0 Wheezing	0 Trouble breathing at night	0 Coughing phlegm
0 Shortness of breath	0 Persistent cough	Color
0 Pain/pressure in chest	0 Chest pain	0 Other:
0 Palpitations	0 Coughing Blood	

Genitourinary

0 Frequent urination	0 Strong smelling urine	0 Frequent infections
0 Daytime		0 Water retention
0 At night	0 Pain or burning on urination	0 Other:
0 Hard to urinate	0 Blood in urine	

Gastrointestinal (check those that apply)					
	Often	**Seldom**	**Severe**	**Mild**	**None**
Poor appetite					
Excessive appetite					
Nausea					
Vomiting					
Belchinq/Bloating after meals					
Indiqestion					
Stomach pain					
Lower abdominal pain					
Bloody Stools					
Black Stools					
Mucus in stools					
Hemorrhoids					
Lower bowel qas					
Stools have foul odor					
Colon problems					
Diarrhea					
Constipation					
Bowel movements occur ______ time/s in _______ day/s					

Neurological

0 Tremors 0 Numbness 0 Tingling	0 Pain 0 Paralysis 0 Seizures	0 Poor coordination 0 Stroke 0 Other:

Emotional & Mental

0 Nervousness 0 Depressed 0 Easily angered 0 Easily irritated 0 Frequent crying 0 Disoriented	0 Moody 0 Mind not clear 0 Manic 0 Obsessive 0 Compulsive 0 Anxiety	0 Fearful 0 Terrors 0 Difficulty expressing emotions Other:

Lifestyle Habits (please state how much, how many and how often)

Cigarettes (packs per day):____________________

Alcohol (type/per week): ____________________

Prescription drugs: ____________________

Over-the-counter drugs: ____________________

Recreational drugs: ____________________

Vitamins/Herbs:____________________

Coffee/Tea (cups):____________________

Dietary restrictions:____________________

Food cravings: ____________________

Exercise (type and frequency): ____________________

Briefly describe your diet:____________________

If you wish to provide additional information please use the space below:

____

____

____

____

____

Signature____________________**Date**____________

This office is HIPPA compliant. This and all patient information is kept strictly confidential. Your written request is required to authorize release to any other party.

WOMEN'S HEALTH HISTORY

Menstrual History

Age at which mensus began	Flow is 0 Heavy 0 Normal 0 Light
Periods are 0 regular 0 irregular	Cramping ___days prior ___days during
# of days from one to the next	Symptoms: 0 Irritable 0 Emotional 0 Headache
#of days you bleed	0 Breast tenderness 0 Fatigue 0 Loose stools
Color: 0 Lt red 0 Dk red 0 Purple 0 Brown 0 Black	0 Acne
Clots 0 Yes 0 No Size AM PM Varies	Other:
Do you spot between periods?	Date of last period:
Have you been diagnosed with:	Have your periods changed since they began? How?
0 Endometriosis	
0 Uterine Fibroids	
0 Pelvic Adhesions	Do you Ovulate on own?
0 Pelvic abnormalities	On what day of cycle?

Do you:	Have discharge from nipples 0Yes 0No
Have low sexual energy 0Yes 0No	Have facial hair 0Yes 0No
High sexual energy 0Yes 0No	Loss of head hair 0Yes 0No
Use vaginal lubricants 0Yes 0No	Oily skin 0Yes 0No
Douche regularly 0Yes 0No	Take steroids 0Yes 0No

Have you had :	
Venereal Disease 0Yes 0No	Regular yeast infections 0Yes 0No
Chlamydia Infection 0Yes 0No	Chronic Vaginal Discharge 0Yes 0No
Genital Warts/Sores 0Yes 0No	Abnormal Pap Smear 0Yes 0No Date:
Herpes Oral/Genital 0Yes 0No	Date of last Pap Smear:
Pelvic Inflammatory Disease 0Yes 0No	IUD 0Yes 0No
PID treatment 0Yes 0No	Cervical Biopsy, cauterization or conization 0Yes 0No

Number Years

How many pregnancies have you had?
How many children do you have?

How many abortions have you had?

How many miscarriages have you had?

How many times has a D&C been performed?

Have you taken any medications for

gynecological conditions other than contraceptives?

Medication Reason How long

____

____

____

____

____

Have you had fertility treatments? 0 Yes 0 No

If yes, by whom? When and where? What types?

____

____

____

____

____

____

____

____

Have you taken medication to help you ovulate? 0 Yes 0 No

When How long?

____

____

____

Have you had any tubal operations? 0 Yes 0 No

Have you had any hormone laboratory tests performed? 0 Yes 0 No

What were the results?____
____
____
____
____

How long have you been trying to conceive? __________________

Have you had a diagnosis relating to infertility? 0 Yes 0 No

What was it?____
____
____
____

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? 0 Yes 0 No

Have you been exposed to any known environmental toxins or hormones? 0 Yes 0 No

Have your fallopian tubes been evaluated medically? 0 Yes 0 No

What were the results?____
____
____
_____

Do you have a single partner with whom you have been trying to conceive? 0 Yes 0 No

How long have you been married or living together?

Has he had a fertility workup? 0 Yes 0 No

What were the results?____
____
____

Is your partner supportive of your wish to conceive? 0 Yes 0 No

Have you taken oral contraceptives? 0 Yes 0 No

When How long?
____
____
____
____

Have you ever taken DepoProvera? 0 Yes 0 No

When How long?

MEN'S HEALTH HISTORY

Have you had :	**Do you:**
Venereal Disease 0Yes 0No	Have low sexual energy 0Yes 0No
Chlamydia Infection 0Yes 0No	High sexual energy 0Yes 0No
Genital Warts/Sores 0Yes 0No	Night time seminal emission 0Yes 0No
Herpes Oral/Genital 0Yes 0No	Have difficulty getting or maintaining an erection 0Yes 0No
Vericocele 0Yes 0No	Get a headache after ejaculating 0Yes 0No
Semen analysis 0Yes 0No	Work with chemicals or hazardous material 0Yes 0No
Results?	
Any genital injury or surgery? 0Yes 0No	Have children? 0Yes 0No Age(s):
Dates;	

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INSURANCE INFORMATION

If Insured information is different from patient information please complete the following:
Name of Insured____Sex__________
Address of insured____
City________________________Zip_________Tel:____________________________________
Insured'sD.O.B.________________Insured's Soc. Sec. #________________________________
Relationship to patient SPOUSE__CHILD__OTHER__
Insured's Employer____
Address____
____**Tel:**_____________

Primary Insurance
Name______________________________
Policy#_____________________________
Group#_____________________________
Address____________________________
____
Tel:_______________________________
Do you have a deductable?___________
If yes, has your deductable been met?___________
Do you have a co-payment?______ Amount $______

Secondary Insurance
Name________________________________
Policy#______________________________
Group#______________________________
Address_____________________________
____
Tel:________________________________

I request that payment of authorized medical benefits be assigned on my behalf to L I Holistic Health Associates/Andrea Huggler LAc. LLC., for services furnished to me by her or under her supervision. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits payable for related services.
To avoid misunderstandings regarding acupuncture and insurance we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees unless other arrangements are made in advance. We will prepare necessary forms to obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all of our fees. Should your account be tendered to a collection agency for non-payment, regardless of reason, you will be assessed and charged the exact collection fee charged to us to collect your account.

I have read the above statement and fully understand its meaning and signify by my signature below.

Signature_______________________________________**Date**_________________

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PATIENT ADVISORY TO CONSULT A PHYSICIAN

L I Holistic Health Associates/ ANDREA E. HUGGLER LIC.AC. LLC., are committed to your health and well-being. We believe that while Oriental medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through blomedica! 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 821 I.I (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 LIHHA STAFF (licensed acupuncturist) TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with the practice of traditional Oriental medicine provided by L I Holistic Health Associates/ANDREA E HUGGLER LIC.AC., LLC. I have discussed the nature and purpose of my treatment with the member of the clinical staff named below.

I understand that methods of treatment may include but are not Ilmited to: acupuncture, moxibustion, cupping, electrical stimulation, AMMA Therapy* and Tui Na (Chinese Massage).
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 or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this site uses sterile, disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.
I will notify the clinical staff member who is caring for me if I am pregnant.
I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgement during the course of treatment which the clinical staff thinks at the time, based upon the facts known to them, is in my best interests.
By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risk and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I have read this form and freely give permission to receive acupuncture.

Date:______________________ Name of Clinical Staff :

Signature of Patient or Representative____

Print Name of Patient Representative (if applicable)____

This office is HIPAA Compliant. This and all patient information is kept confidential and cannot be released without your written consent.

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PRIVACY STATEMENT AND PATIENT AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

L I Holistic Health Associates/ Andrea Huggler LAc., LLC., have informed me by this document that certain policies are in effect in their office, to insure my right of privacy to confidentiality of my personal health information. The doctor has informed me that this letter will cover the elements required in the HIPP A (Health Information Privacy Protection Act of 1996) regulations that go into effect April 14, 2003. My signature below signifies that I have received this document and understand the intent and content of it. That it protects my rights to privacy, my ability to inspect and change any conditions of health information disclosure at any time by requesting an addendum to the chart, but not the removal of any part of the chart. The addendum is to be completed in the presence of the doctor or of designated office personnel.

The doctors are providers of record and are responsible for maintaining my health record and confidentiality at all times. Their office staff, including administrative and ancillary medical attendants have been counseled and trained in regards the confidentiality of my medical record, and will not discuss my care, nor have access to confidential information that is not required for them to perform their duties. Their duties require filing of reports within the chart, maintaining records, securing records, communication with insurance companies and governmental agencies. They are to be discrete and avoid incidental disclosure as best as physically possible within the confines of the office.

My signature below further authorizes the doctors and their staff to release pertinent health information for routine purposes such as treatment, communication with consultants and other health care providers necessary to adequately provide for my complete health care, and payment by third party payers. This applies to all forms of communication, either paper or electronic. "Minimal disclosure" of information will be permitted sufficient to comply with results from employers and to process workmen's compensation claims. Governmental agencies including the health department may be notified in reporting disease conditions required by state law.

On proper signing of an authorization to release information, I consent to have the doctor release to me or any individual agency I designate, or to my next of kin, if am mentally or physically incapacitated to give my permission, a copy of my medical record in part or whole. I acknowledge that there will be a charge for such copying of the chart as proscribed by law and that the copy will be available within 10 working days.

I have had the opportunity to ask questions. I acknowledge that at any time I may change any and all restrictions herein about sharing my health information. I give the doctors and their staff permission to utilize my protected information as described above in order to conduct their business and provide for my necessary medical care. This document shall remain in effect unless I direct otherwise.

Patient Name:____

Signed: ____

Date: ______________________