Jackie Payne Acupuncture
Confidential Health History

Welcome! Please take the time to fill out this questionnaire fully. Your answers are strictly confidential. If you have any questions, please feel free to ask.

Today's Date _____

Name _____ Age _____ Date of Birth _____

Address_____City _____

State _____ Zip _____ E-mail _____

Tel: Home _____ Cell_____ Work _____

Ok for me to send you appointment reminders via text message and/or email? ❑ Y ❑ N

Height _____ Weight _____ Gender: _____

Occupation_____ Who referred you? _____

Name & Tel # of Physician _____

OK for me to contact? ❑ Y ❑ N

Emergency Contact Name & Tel# _____

Relationship _____

Insurance Information:

Name of Primary Insurance_____

Subscriber's Name_____

Subscriber ID /Member Number_____

Subscriber's Birthday_____ Patient's Relationship to Subscriber_____

Telephone Number of Insurance_____

Name of Secondary Insurance_____

Subscriber's Name_____

Subscriber ID/ Member Number_____

Subscriber's Birthday_____ Patient's Relationship to Subscriber_____

Telephone Number of Insurance_____

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Are you currently pregnant? _____ Are you presently trying to become pregnant? _____

Have you received acupuncture before?_____ If so, for what condition?_____

What was the outcome?_____

What would you like treated by acupuncture? _____

_____

How long have you had this condition? _____ The onset was ❑ Sudden or ❑ Gradual?

What were the circumstances? _____

What medical diagnosis have you received, if any? _____

What kinds of treatment or therapy have you tried? _____

How has this condition affected your daily activities? _____

What makes this condition better?_____ worse? _____

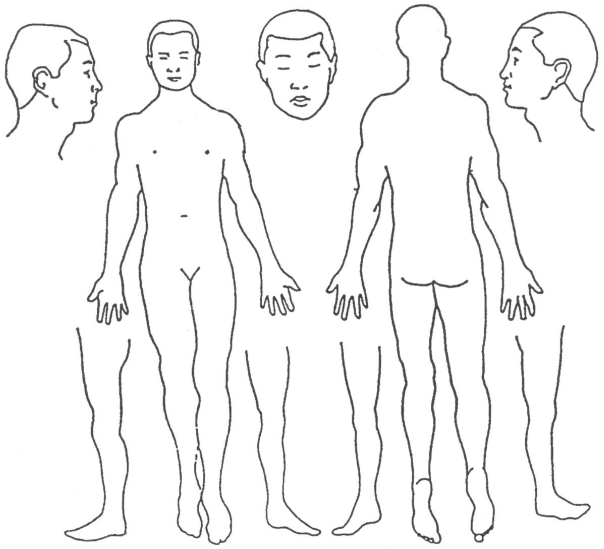
Rate the intensity of the physical discomfort of this condition:

(None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

How emotionally distressed are you by this condition?

(Not at all) 0 1 2 3 4 5 6 7 8 9 10 (Extremely)

Please shade any areas of pain or distress on the diagram below:



Medical History Please check off any current or former conditions and include dates as well as any relevant information.

❑ AIDS/HIV _____ any neuropathies? _____
❑ Alcoholism/ Drug Abuse _____
❑ Allergies _____ ❑ Anemia _____
❑ Asthma/ Bronchitis _____ ❑ difficulty inhaling ❑ difficulty exhaling
❑ Bell's Palsy _____ ❑Blood clotting disorder _____
❑ Bipolar disorder _____ ❑Cancer/Tumor_____
❑ Chron's Disease & / or colitis _____
❑ Chronic Fatigue Syndrome (CFIDS)_____ ❑Depression (Major)_____
❑ Diabetes-Type_____ any neuropathies?_____

❑ Eczema _____ ❑ Emphysema _____
❑ Endometriosis _____ ❑Fibroids_____
❑ Fibromyalgia_____ ❑Gallstones_____
❑ Heart Disease_____
❑ Hepatitis A/B/C - please specify _____
❑ Hernia _____❑ Herpes - Type _____
❑ Hypertension _____❑Hypoglycemia_____
❑ Irritable Bowel Syndrome (IBS)_____
❑ Joint Replacement_____❑Kidney Stones and /or Disease_____
❑ Lupus_____ ❑Lyme disease _____
❑ Lymph Nodes removed - where? _____ can you have injections on that side? _____
❑ Mitral Valve Prolapse_____❑Mood Disorder_____
❑ Multiple Sclerosis _____ ❑Organ Transplant/ Removed _____
❑ Osteoarthritis _____❑Osteoporosis_____
❑ Pacemaker _____
❑ Parkinson's Disease_____❑Pelvic Inflammatory Disease_____
❑ Polio _____spinal segments involved_____
❑ Psoriasis_____❑PTSD (Post-Traumatic Stress Disorder)_____
❑ Reflux Esophagistis (GERD)_____ ❑Rheumatic or Scarlet Fever _____
❑ Rheumatoid Arthritis _____❑ Seizures and/or Epilepsy _____
❑ Shingles_____ ❑Stroke_____
❑ Schizophrenia_____❑Thyroid disease _____
❑ Tuberculosis _____ ❑Trigeminal Neuralgia_____
❑ Other _____

Vaccination History: Any reaction that you remember? Any unusual vaccinations?

_____

Please describe any significant accidents, injuries, trauma, illnesses, and surgeries:

Birth complications/trauma (your own), if any_____

Age _____

Age _____

Age _____

Age _____

Age _____

Age _____

Scars from injury/surgery (even minor): _____

_____

Medications Please list all medications (including over-the counter), herbs, vitamins and minerals you are taking and their indications._____

_____

_____

Family Medical history

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, hepatitis, high cholesterol, cancer, etc.

Mother_____
Father_____
Siblings_____
Maternal Grandparents_____
Paternal Grandparents_____

Diet and Lifestyle

How is your appetite? ❑ Good ❑ Poor ❑ No appetite ❑ Hungry all the time
Any food cravings? _____
Any food intolerances? _____
Are you vegetarian? _____ How many years? _____
How do you feel emotionally around food? _____
Any history of an eating disorder? _____

Thirst: ❑ Always thirsty ❑ Never thirsty ❑ Thirsty, but no desire to drink ❑ Dry mouth ❑ Bitter taste
Do you prefer ❑ Hot or ❑ Cold drinks? Do you more often feel ❑ Hot or ❑ Cold?

How much and how often do you have the following:
Meat _____day/wk, Sugar/Sweets _____day/wk, Caffeine (Coffee, Tea, Soda)_____day/wk,
Dairy (milk, cheese, yogurt, ice cream)_____day/wk, Water _____day/wk,
Alcoholic beverages _____day/wk

How is your energy? _____ What time of day is it highest? _____ lowest? _____
Are you a ❑ Morning person? ❑ Night owl?
What kind of exercise do you do? _____
How often? _____ Does exercise: ❑ give you energy or ❑ make you tired?
Any unusual sweating? _____ Dizziness?_____

How do you feel emotionally? _____
Do you have: ❑ depression ❑ anxiety ❑ panic attacks ❑ insomnia ❑ irritability/short temper
❑ poor memory ❑ difficult concentration ❑feeling overwhelmed ❑ extreme mood swings
❑ extreme lack of emotion ❑ other_____
❑ Single, ❑ Stable relationship, ❑ Married, ❑ Divorced/ Separated, ❑ Widowed
How do you feel about your relationship? _____
How is your sexual energy? _____
How do you feel about your work? _____
What aspect of your life do you find most stressful?_____
How / where do you hold stress? _____
How do you relax? _____
How many hours do you generally sleep per night? _____ Do you have night sweats? _____
Do you have trouble ❑ falling asleep ❑ staying asleep ❑ dream disturbed sleep
Do you wake at the same time every night? What time_____

Do you use prescription or recreational drugs to help you relax or sleep? _____

Please **circle** any condition you have now, and **underline** any condition you have had in the past:

Musculoskeletal: Muscle pain/ tightness/ cramping. Spasms. Weakness. Repetitive strain. Tendonitis. Arthritis/Joint pain. Joint clicking. Limitation of movement. Rheumatism. Swollen joints. Bone pain. Where? _____

Pain is: Sharp. Burning. Dull/Aching. Deep. Superficial. Shooting. Tingling. Numb. Better with heat. Better with cold. Better with rest. Better with movement or massage. Worse in AM/ PM.

Gastro-intestinal: How often do you move your bowels? _____
Difficult or painful bowel movement. Constipation. Diarrhea/Loose stool. Alternating constipation/diarrhea. Hard stool. Burning. Undigested food in stool. Abdominal pain. Distention/Bloating. Gas. Nausea. Vomiting. Vomiting with blood. Foul breath. Belching. Acid reflux. Lack of stomach acid. Heartburn. Indigestion. Blood in stool. Black stool. Hemorrhoids. Chronic laxative use. Feel bloated/ tired after eating. Ulcer.
Other_____

Respiratory, Eyes, Ears, Nose, Throat, & Head:
Do you smoke cigarettes? _____day/wk, for _____years
Chronic cough. Coughing blood. Coughing mucus. Asthma/Wheezing. Shortness of breath on exertion/at rest. Difficulty breathing lying down. Excessive phlegm. Frequent colds. Nose bleeds. Chronic runny nose. Chronic stuffy nose. Post-nasal drip. Sinus Infections. Yellow mucus.
Painful/Red eyes. Poor vision. See spots/Floaters. Night blindness. Blurry vision. Problems with balance (vertigo). Ear pain/infections. Poor hearing. Ringing in ears. Sore throat. Streptococci infections. Bleeding gums.Sores on lips or tongue. Gum problems. Dental abscess. Facial pain. TMJ /Jaw pain.
Other _____
Frequent headaches/migraines describe _____

Cardiovascular: Have you been diagnosed with any heart trouble? _____
What is your blood pressure? _____ Fast pulse >100 bpm. Slow pulse <60 bpm. Chest pressure or pain. Shortness of breath. Palpitations/Arrhythmia. High blood pressure. Low blood pressure. Flushed face. Dizziness/Vertigo.Fainting. Diabetic neuropathy. Varicose veins. Cold hands and feet. Cold sweats. Poor circulation. Blood clots. Bruise easily. Swelling of the ankles or legs. Edema. Other heart or blood vessel problems_____

Skin, Hair, Nails: Dry skin. Rashes. Itching. Hives. Acne. Red face. Face flushes. Dry hair. Dandruff. Hair loss. Premature graying. Brittle nails. Fungal infections. Sweaty hands/ feet/ everywhere. No sweat. Night sweating.
Other _____

Misc: Fatigue/Exhaustion. Motion sickness. Tremors/Tics. Dizziness. Poor balance. Fever. Chills. Headache with nausea. Hormone Imbalance. Thyroid imbalance. Hypoglycemia. Autoimmune disease. Emotional problem. Difficulty waking up in morning. Energetic all evening. Confusion. Changes in consciousness. Car/Sea/Air sickness. Teeth grinding.
Other _____

Urinary: Frequent urination. Painful urination. Burning urination. Blood in urine. Trouble starting stream. Urgency to urinate. Incontinence. Urinary tract infections. Pale urine. Dark yellow urine.
Do you wake at night to urinate? _____ other _____

Women: ❑ Currently using birth control medication. ❑ Used in past. For how many years?_____
What type?_____
Age of onset of menses _____ days between cycles _____ duration of flow _____
Color/quality of blood_____
Irregular menstruation. Long/ Short cycle. Pain before/During/ After menses.
Heavy/ Light/ No bleeding. Spotting between periods. Clots.
Number of pregnancies _____ deliveries _____ abortions/miscarriages _____ age at menopause _____
Pregnancy complications _____
Vaginal discharge: amount _____ color _____ quality _____ frequency _____.
Vaginal itching/burning/ Discharge/ Pain. Yeast infection.
PMS symptoms: Emotional. Irritability. Breast tenderness. Breast lumps. Cramps. Related Headache. Low back pain. Other_____
Uterine Fibroids. Uterine Cysts. Hysterectomy. Tubal Ligation. Discharge from breasts.
Infertility. Menopausal symptoms. Reduced sexual energy. Genital sores. Genital pain. Abnormal vaginal bleeding. Pelvic pain.
Other _____

Men: Prostatitis. Impotence. Premature ejaculation. Seminal emission. Reduced sexual energy. Genital sores. Genital pain. Blood/mucus discharge. Vasectomy. Low sperm count/ motility.
Other _____.
Type of contraception used?_____.
Have you ever had a prostate examination? _____.

Is there anything else you wish to bring to our attention?

Please describe your goals, hopes and expectations for acupuncture treatments:

THANK YOU for your honesty, as it will help us better understand your current state and allow us to move more accurately toward your improved health.

**All patients are advised under New York State Law to consult a physician regarding the condition or conditions for which they are seeking acupuncture treatment. In addition, patients are responsible for seeking the advice and treatment of a physician should their symptoms change for the worse, or should a new condition arise.

Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

I authorize my insurance benefits to be directly paid to the acupuncturist. I understand that I am financially responsible for any balance. If my insurance carrier sends payment to me for services incurred in this office, I agree to send or bring those payments to this office upon receipt. I authorize Jackie Payne Acupuncture or the insurance company to release any information required to process my claims. I agree that I will pay the reduced fee of $170 for an initial treatment and $130 for each follow-up treatment due to financial difficulties if my insurance does not cover acupuncture treatments.

Signature of Patient or Patient Representative **Date**

Practitioner Signature

Cancellation Policy

I understand that there is a 24-hour cancellation policy. I agree to pay the full price of a session if I cancel less than 24 hours within the scheduled appointment time.

Signature of Patient or Patient Representative **Date**

Informed Consent

I consent to acupuncture treatments and related procedures, associated with Oriental Medicine, by Jacqueline A. Payne, L.Ac. I have discussed the nature and purpose of my treatment with her and I understand that the methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, gua sha, and electrical stimulation.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, tingling, numbness or mild pain near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and gua sha. An unusual risk of acupuncture includes spontaneous miscarriage, nerve damage, and organ puncture. Infection is another possible risk, although this office uses only sterile, disposable needles while maintaining a clean and safe environment. Burns and scarring are potential risks of using moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgments during the course of treatment, and decide what she thinks is in my best interest, based upon the facts that are known at the time.

Since everyone responds to acupuncture differently, outcome of the treatment cannot be guaranteed. Some individuals may experience total or partial relief of their pain or symptoms after the first few treatments, while others may notice a steady, gradual improvement. In some cases, no relief may be felt at all until after several days go by. Some people may notice that their pain actually seems to be worse before it gets better.

I will notify the acupuncturist, who is caring for me, if I become pregnant.

By voluntarily signing below, I show that I have read or have had read to me, this consent to treatment. I have been told about the risks and benefits of acupuncture and other procedures and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for both the present condition and for any future conditions for which I seek treatment(s).

_____ _____

Signature of patient or patient representative **Date**

Notice of HIPAA Privacy Practice

I have received the HIPAA privacy notice of Jackie Payne Acupuncture
(posted on www.jackiepayneacupuncture.com and available upon request).

_____ _____

Signature of patient or patient representative **Date**

Jackie Payne Acupuncture

917.450.2754
jackiepayne3@gmail.com

Location:

- 80 Fifth Avenue, Suite 1205
  (b/w 13th and 14th Streets)

Preparation for Treatment:

- Please have eaten a light meal prior to treatment.

Payment:

- Cash, Check, Venmo, or Credit Card.

Insurance:

- Insurance accepted if covered under your health care plan. My office can call and verify your benefits for you.

Initial Visit: $170.00

- A thorough history and evaluation is followed by a full treatment. The plan of treatment will be determined at this time. Please allow one hour and 30 minutes.

Follow Up Visits: $130.00

- Acupuncture's effects are cumulative. Acute conditions generally take a shorter course of treatment: 5 to 6 consecutive weekly treatments. Chronic conditions usually require more consecutive treatments over a longer period of time.

Cancellation Policy:

- Out of respect for my time and the time of other patients, there is a 24-hour cancellation policy. The session will be charged if cancelled less than 24 hours before the scheduled time.