Christina Sluman, L. Ac.

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Traditional Chinese Medicine is based on the principle of balancing an individual's body, mind, emotions and spirit. The following confidential questionnaire is a detailed and invaluable source of information about you. It provides the practitioner with a complete sense of you as a unique individual, as opposed to a collection of symptoms.

Your appointment is scheduled for: _____

24-hour notice is required for cancellation to avoid a $40 service fee
Payment is due at time of service;
We accept cash, checks, VISA and Mastercard

Patient Information:

Name: _____

Address: _____

_____

Home #: (____)_____ Work #: (____)_____ Cell #: (____)_____

Date of Birth: _____ Sex: Male Female

Referred by: _____

Email: _____

May we use this same address for important updates and special offers? Yes No

Employer: _____

Health Insurance:

Provider: _____ Policy #: _____

Insured's Name: _____DOB:_____

Address: (if different than patient)_____

Office Information: Co-Pay_____ Notes:_____

Revised: 01/20/2019

PRESENT HEALTH CONCERNS: Please list your most important health concerns in order of their significance.

1. _____ Approx. Date of Onset: _____
   Does it interfere with your: Work Sleep Daily Routine Recreation
   Other therapies tried: Medications Surgery Chiropractic Phys. Therapy Other _____
2. _____ Approx. Date of Onset: _____
   Does it interfere with your: Work Sleep Daily Routine Recreation
   Other therapies tried: Medications Surgery Chiropractic Phys. Therapy Other _____
3. _____ Approx. Date of Onset: _____
   Does it interfere with your: Work Sleep Daily Routine Recreation
   Other therapies tried: Medications Surgery Chiropractic Phys. Therapy Other _____

Please list all **medications** that you are currently taking (or have used in the past 2 months), with dosages:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list all **vitamins, minerals, herbs or homeopathic remedies** that you are currently taking:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list allergies that you have to any of the following:

Drugs: _____ Foods: _____

Other (i.e. pollen, paint, etc.): _____

HEALTH HISTORY

Past Medical History: Please list past injuries, broken bones, surgeries and hospitalizations with approximate dates.

_____

_____

Health Care Practitioners you are under: _____

Personal Habits:

Tobacco	packs/day _____
Alcohol	drinks/week _____
Coffee/Tea/Cola	cups / day _____
Recreational drugs	times week _____
High Stress Level	Reason _____

Do you follow any diet regimens/restrictions?
Yes No
If yes, describe: _____

_____

Work Activity:

Sitting	% of time _____
Standing	% of time _____
Light labor	% of time _____
Heavy labor	% of time _____

Exercise:
Do you exercise regularly?
Yes No
If yes, describe and tell how often:

_____

_____

FAMILY INFORMATION

Do you have children: Yes No If Yes, how many? _____ Ages? _____

Are you or could you be currently pregnant? Yes No Due Date: _____

Please check if you have had in the **last three months** any of the following:

GENERAL

Poor appetite
Heavy appetite
Changes in appetite
Weight loss/gain
Cravings
Peculiar tastes
Strong thirst
Fevers/Chills
Sweat easily
Localized weakness
Bleed/bruise easily
Sudden energy drop
(time? _____)
Fatigue
Tremors
Poor sleeping
Heavy sleeping
Dream disturbed sleep
Night sweats
Dizziness

SKIN AND HAIR

Rashes/Hives
Itching
Dry Skin
Change in hair or skin texture
Other skin or hair concerns:
Ulcerations
Eczema/Psoriasis
Loss of hair
Pimples/Acne
Fungal infections
Recent moles
Dandruff

HEAD, EYES, EARS, NOSE AND THROAT

Spots in front of eyes
Glasses or contact lenses
Eye strain/pain
Red eyes
Itchy eyes
Dry eyes
Excessive tearing
Poor/blurry vision
Night blindness
Recurrent sore throats
Concussions
Earaches/Infections
Ringing in ears
Poor hearing
Sinus problems
Post nasal drip
Excessive phlegm - color _____
Nose bleeds
Swollen glands
Sores on lips/tongue
Dry Mouth
Excessive saliva
Teeth problems
Gum problems
TMJ disorder
Grinding teeth
Cataracts/Glaucoma
Headaches (location, triggers, severity) _____
Other head & neck concerns:

CARDIOVASCULAR

High blood pressure
Low blood pressure
Chest pain
Irregular heartbeat
Other heart or blood vessel concerns:
Palpitations
Fainting
Cold hands/feet
Swelling of hands
Swelling of feet
Blood clots
Phlebitis

RESPIRATORY

Cough
Coughing blood
Wheezing
Asthma
Bronchitis
Pneumonia
Pain with deep breath
Shortness of breath
Tight chest
Production of phlegm – color? _____
Is it thick or thin
Allergies – what? _____ (food, airborne, medications)
Other lung related concerns:

GASTROINTENSTINAL

Nausea
Vomiting
Diarrhea
Constipation
Hemorrhoids / Fissures
Acid Regurgitation
Belching
Bad breath
Blood in stools
Black stools
Mucus in stools
History of chronic laxative use
Abdominal pain
Itchy anus
Burning anus
Gas / Bloating
Hiccups

Other concerns with your general digestion?

GENITO-URINARY

Pain on urination
Frequent urination
Blood in urine
Urgency to urinate
Frequent urinary tract infections
Chronic yeast infection
Erectile dysfunction
Bedwetting
Kidney Stones
Impotency
Increased libido
Unable to hold urine
Prostate problems
Premature ejaculation
Nocturnal emissions
Sores on genitals
Decreased libido
Decrease in flow
Low sperm count

Other concerns with genitals or urinary system:

MUSCULOSKELETAL

Neck pain
Upper back pain
Lower back pain
Hand/wrist pains
Joint with limited range of motion _____
Muscle weakness
Cramps/spasms
General joint pain/stiffness
Shoulder pain
Knee pain
Foot/ankle pain
Hip pain
Muscle pains

Other muscle, joint or bone concerns:

NEUROPSYCHOLOGICAL

Seizures
Easily susceptible to stress
Depression
History of emotional/physical abuse
Memory Loss
Areas of numbness
Tics
Lack of coordination
Loss of balance
Concussion
Anxiety
Irritability

Have you ever been treated for emotional problems:

Have you ever considered or attempted suicide:

Other neurological or psychological concerns?

GYNECOLOGY

Age of first menses _____ If no longer menstruating, approximate date ceased _____

First day of last menses _____ Length between menses _____days Duration of period _____ days

Unusual flow (heavy or light)
Vaginal discharge – color _____
Irregular periods
Breast lumps/soreness
Clots in flow
Painful periods
Hot flashes
Hormone replacement
Vaginal dryness
Vaginal sores
Vaginal odor

Changes in body or psyche prior to menstruation ("PMS"):

GYNECOLOGY, continued

Date of last PAP: _____ Results were: Normal Abnormal Unsure

If you use birth control, what type and for how long?

Have you ever used hormonal methods for contraception or period regulation?
(i.e. the pill, Depo-Prevera, etc.)

Other gynecological concerns:

PREGNANCY HISTORY

Number of pregnancies: _____ Births _____ Miscarriages _____ Abortions _____

Were your births relatively normal? Explain:

Other related concerns:

DIET

Current weight _____ Weight last year? _____ Highest weight? _____

Describe your typical diet:

COMMENTS

Please let us know of any other concerns you would like to address:

FAMILY HISTORY: Please fill in the boxes for each condition that applies to one of your family members.

	Yes	Who	Comments
Addiction (alcohol/drugs)			
Cancer			
Cardiac disorders (heart disease, high blood pressure, stroke)			
Diabetes			
Digestive/Gastro-intestinal disorders			
Immune disorders (hepatitis, HIV, etc.)			
Mental illness			
Respiratory disorders (asthma, allergies, etc.)			
Skin disorders (eczema, psoriasis, etc.)			
Seizure disorders			

Disclosure, Agreements and Acknowledgements

Please read carefully, the following disclosure statements as well as the accompanying HIPPA Privacy Policy. Your signature will indicate your acknowledgement.

Consent for Treatment---

I, _____, voluntarily consent to receive Acupuncture and Chinese Herbal Medicine Treatment administered by the practitioner **Christina Sluman, L. Ac.,** who is certified by the State of New York and is certified by the National Certification Commission of Acupuncture and Oriental Medicine to practice Acupuncture and Chinese Herbology. I understand her training is in Acupuncture and Oriental Medicine and that she is not, nor claims to be, a medical doctor. I understand that the evaluation, diagnosis and treatment I receive are not a replacement for allopathic (Western) medical care.

I have provided a full and accurate medical history and understand the ongoing need to communicate my complete medical status with my provider. I understand that no guarantee has been made concerning the effects of Acupuncture and I may cease my treatment at any time.

I understand that treatment consists of the insertion of fine, sterile needles, with or without electro-stimulation, through the skin, and/or the application of heat therapy to the skin. I acknowledge that, although rare, certain side effects may result, including, but not limited to, minor bruising, minor pain at the needle site, dizziness or faintness.

I am choosing Acupuncture and/or Chinese Herbal Medicine treatment as an exercise of my right to freedom of choice in the healing arts.

_____ _____

Signature of Patient (or Guardian) Date

Insurance Agreement---

I understand and agree that health insurance policies are an arrangement between the insurance carrier and the individual patient. Furthermore, I understand that the Acupuncturist's office will prepare any necessary claims and forms to make collections from the insurance company on my behalf. However, I clearly understand that all services rendered me are charged accordingly and that I am personally responsible for payment should insurance coverage fail to pay for any reason. I also understand that if I suspend or terminate my insurance policy any fees due will be payable immediately.

_____ _____

Signature Date

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is available at our office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. (www.hhs.gov)

We have adopted the following policies:
1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the health care provider.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.