Northampton Community Acupuncture

160 Main St. Suite 23 & 24, Northampton, MA • (413) 586-8251 • nohocommunityacupuncture.com

Consent to Treatment

I, ___________________________________ , hereby authorize Rachel S. Condon and Katie Oleksak, both licensed acupuncturists in the state of Massachusetts, to administer Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following:

> *Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations. These techniques are used in an attempt to treat bodily imbalances or diseases, decrease pain, and normalize the body's physiological functions. Although* ***very*** *infrequent, occasional minor local bruising, bleeding, fainting (rare), or discomfort may occur.*

I understand that I have the right to refuse any form of treatment. I have hereby been informed of the risks and possible consequences involved with this treatment, and have been given the opportunity to ask questions pertaining to the treatment.

Signature of patient: ____ **Date:**_________________

Notice of Receipt of Privacy Policies

As mandated by federal and state legal requirements, your health information must be protected. As part of these regulations, we are required to ensure that you are aware of privacy policies, legal duties, and your rights to your protected health information.

By signing below, you acknowledge that you have received and read a copy of our privacy policies information. *(This is included on this clipboard, under the health history forms, for you to read, or you may request a copy to read at the clinic if you download paperwork online.)*

Signature of patient: ____

Financial Agreement

Northampton Community Acupuncture makes every attempt to make acupuncture available to as many people as possible, at the most affordable rates. In respect for our intention to offer high quality health care at affordable prices, we ask for 24 hours notice in advance of an appointment if it is necessary to cancel or reschedule an appointment.

All appointments that are rescheduled or cancelled with less than 24 hour advanced notice, and appointments missed without notice, will be charged as if you attended, i.e., a $30 fee or one deduction from a package special. We appreciate your understanding.

Printed Name: ________________________________ **Signature:**______________________________

Patient Information

Date ____

Name ____

Address ____

Age ___________________ DOB___________________

Gender Identity __________________________________

Occupation________________Full or Part Time_______

Physician/phone _________________________________

How did you hear about us? _______________________

Contact Information

Have you had acupuncture before? Y____ N____

Have you had acupuncture for your primary concern(s)? Y____ N____

Primary phone number_____________________________

E-mail____

Emergency Contact Information:

Name____________________ Relationship____________

Primary phone number ____________________________

Health History

What are your primary concerns for treatment and approximately how long have you had them?

Primary concern: Approximately how long:

____

____

Describe how your concern(s) negatively affect you:

____

Please check the following that currently apply:

SLEEP:

(Difficulty) falling asleep____ staying asleep ________

Sleep apnea___ Racing thoughts inhibiting sleep_____

DIGESTION:

No. of bowel movements per week____ Gas______

Diarrhea___ Constipation___ (Stool) Blood___ /Mucus ___/ Loose___ Bloating___ Reflux___ Hemorrhoids____

Vomit___ Nausea___ Pain___ Lack of appetite______

Major dietary restrictions:

____

Please list medications or supplements that you are taking on a daily basis and purpose for use:

Medication/Supplement: Purpose for use:

____

____

____

Please list any serious illnesses, accidents or surgeries and estimated date(s), including childhood illnesses:

Incident: Estimated Date:

____

____

____

Please check any conditions that you currently have or have had: Hepatitis B______ HIV/AIDS______

Are you pregnant? Y___ N___ Due Date (if known)____

Do you get regular medical exams? Y___ N___

Estimated date of last exam________________________

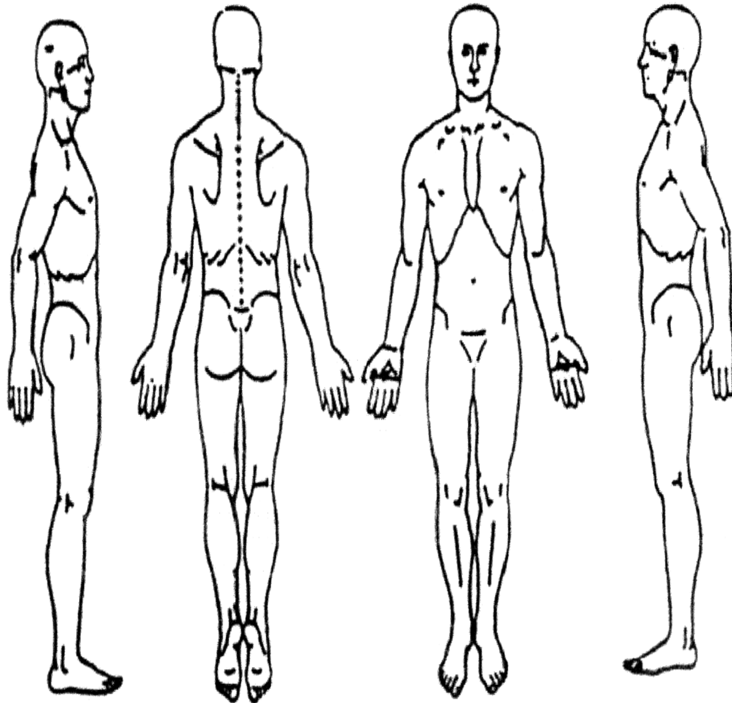
PAIN CONDITIONS:

Please clearly circle any areas of pain that you are currently experiencing/ related to your primary concern(s):

List your pain conditions here:

1. ____

2. ____



Please check the following traits that apply to the area of pain that is circled:

The following applies to pain condition #1:

Sharp___ Burning___ Aching___ Dull___ Crampy___

Fixed in one location? Y___ N___ Moving to various locations? Y___ N___

Does the pain feel *better* with the following: Pressure___ Cold__ Heat__ Excercise__ Other____________________

Approximately how long have you been experiencing this pain?____

Is this a flare-up of a chronic condition? Y____ N______

The following applies to pain condition #2:

Sharp___ Burning___ Aching___ Dull___ Crampy____

Fixed in one location? Y___ N___ Moving to various locations? Y___ N___

Does the pain feel *better* with the following: Pressure___ Cold__ Heat__ Excercise__ Other____________________

Approximately how long have you been experiencing this pain?____

Is this a flare-up of a chronic condition? Y____ N______

Do you have arthritis? Y___ N___

Do you have swelling/weakness/achiness anywhere in the body, and if so, where? _________________________

Do you experience cramping or tremors anywhere in your body, and if so, where?________________________

The following information may or may not seem related to your primary concerns for acupuncture, however, the information is important in helping your practitioner gain an overall picture of your current health and well-being to best treat you.

Please check the following that currently apply:

BODY TEMPERATURE:

Tendency to feel (overall): Hot___ Cold___

Hands/Feet: Sweaty___ Cold___ Hot Flashes___

Night Sweats___ Dry/itchy skin___ Skin rashes___

ENERGY:

Shortness of breath___

General muscle weakness___

Poor Immunity___ General fatigue___ Tires easily___

MOOD:

Sadness___ Low motivation___ Depression___

Anxiety___ Mental confusion___ Foggy-thinking___

Excessive worry___ Excessive anger___ Irritability___

URINATION:

Burning___ Pain___ Blood___ Cloudy/dark___

Discharge___ Frequency___ Incontinence___

CARDIOVASCULAR:

Chest Pain__ Blood pressure: High___ Low_____

Poor circulation___ Swelling in hands/feet___

Rapid/irregular heartbeat___ History of heart attack___

EAR/NOSE/THROAT/EYE/RESPIRATORY:

(Ears) Achiness___ Loss of hearing___ Ringing___

(Sinuses) Congestion___ Pressure___

Dry mouth___

(Vision) Blurry___ Eye floaters___ Dry eyes___

(Cough) Dry___ Productive___

Difficulty breathing___ Asthma___

Do you smoke cigarettes Y___ N___ Have you smoked in the past? Y___ N___

Tension headaches ___ Migraines ___

(Do migraines include):Nausea___One-sided: R___L___

Light/sound sensitivity___

REPRODUCTIVE HEALTH:

WOMEN:

(Libido) Regular___ High___ Low___

Regular menstrual cycle: Y___ N___ Estimated age of first period___ Estimated age of menopause___

Average number of days in cycle___ Average number of days bleeding___

Estimated first day of last period_________

Blood clotting___ Spotting___ PMS___

Fertility issues___ Previous miscarriage___

Approximate date(s) ________________________________

MEN:

Erectile difficulties___ Prostate issues___

Low libido___

Testicular pain___ Fertility issues___

Signature

This information is correct to the best of my knowledge.

Signature:____ **Date:**_______________________