Patient Information

Patient
Last Name: _____ First Name: _____

Gender: Male Female DOB: ___/___/___ Age: _____

Marital Status: _____ No. Of Children: _____ _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home No.: _____ Cell No.: _____ Work No.: _____
Email Address: _____
Employer Name: _____ Occupation: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

****

Emergency Contact
Last Name: _____ First Name: _____
Home No.:_____ Cell No.:_____ Work No._____
___Relationship to patient: _____

****

Insurance Information
Insurance Company: _____
Insured's Name: _____ Ins. Co. Tel. No._____
Insurance Co. Address:_____
Group No.: _____ Policy No.:_____
Secondary Insurance Company: _____
Insured's Name: _____
Group No.: _____ Policy No.: _____

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Responsible Party: (Complete this section if you are not the patient, but are responsible for the bill.)
Responsible Party: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home No.:_____ Cell No.:_____ Work No.:_____

Chief complaint you would like help with:

_____

_____

How long ago did this problem begin?

_____

What kinds of treatment have you tried?

_____

Have they helped alleviate the problem?

_____

Are you currently receiving any treatment for your problem? _____
If so, what?

_____

Past Illnesses: Dates:

_____ _____

_____ _____

_____ _____

Past Surgeries: Dates:

_____ _____

_____ _____

_____ _____

Significant Traumas (ex. car accidents, falls,....) Dates:

_____ _____

_____ _____

Medications: (include prescription, over the counter, vitamins, herbs, etc., taken within the past 3 months)

_____ _____

_____ _____

_____ _____

_____ _____

Average Blood Pressure _____/_____ Average Pulse Rate_____

Allergies:

_____

Family Medical History (general health):
Mother's side: _____
Father's side: _____
Siblings: _____
If any of the above are deceased, what was the cause?

_____

_____

Current emotional health:_____

Current quality of life:_____

Occupation:_____ Do you like your job? _____

Stress Level:_____

Have you had any unusual stresses recently?:_____

Your favorite time of year:_____ Worst time of year:_____

Hobbies and recreational habits:_____

Do you exercise regularly?:_____ If so, please describe: _____

Do you smoke cigarettes?: _____ If so, for how long and how many per day?:_____

Do you drink alcohol?: _____ If so, how many times per week?:_____

Please check how many times you use the following:

	Never	1-3 times/ month	1 time/ week	2-4 times/week	Everyday
Sugar:	_____	_____	_____	_____	_____
Caffeine:	_____	_____	_____	_____	_____
Fried Foods:	_____	_____	_____	_____	_____
Raw Foods:	_____	_____	_____	_____	_____
Spicy Foods:	_____	_____	_____	_____	_____
Soda:	_____	_____	_____	_____	_____
Fast Food:	_____	_____	_____	_____	_____
White Flour:	_____	_____	_____	_____	_____

Please check any conditions you have experienced within the past 3 months to 1 year:

Cardiovascular

❑ Blood Clots	❑ Dizziness	❑ Cold Hands/Feet	❑ Shortness of Breath
❑ Fainting	❑ Irregular Heartbeat	❑ Varicose Veins	❑ Difficulty Breathing
❑ Chest Pain	❑ High Blood Pressure	❑ Swelling of Hands	❑ Palpitations
❑ Cold Sweats	❑ Low Blood Pressure	❑ Swelling of Feet	

Gastrointestinal

- ❑ Bad Breath
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Black Stools
- ❑ Belching
- ❑ Gastric Ulcers
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Acid Reflux
- ❑ Intestinal Gas
- ❑ Abdominal Pain
- ❑ Blood in Stools
- ❑ Nausea
- ❑ Bloating

Genito-Urinary

- ❑ Painful Urination
- ❑ Incontinence
- ❑ Discolored or Dark Yellow Urine
- ❑ STD's
- ❑ Frequent Urination
- ❑ UTI's
- ❑ Blood in Urine
- ❑ Erectile Dysfunction
- ❑ Urgent Urination
- ❑ Scanty Urination
- ❑ Kidney Stones

*Males over 40 years of age: Have you had your prostate examined along with a PSA test? _____
If so, what were the results? _____

Gynecology & Pregnancy

- ❑ Irregular Periods
- ❑ Prolonged Flow
- ❑ Vaginal Discharge
- ❑ Cysts
- ❑ Painful Periods
- ❑ PMS
- ❑ Fibroids
- ❑ Clots
- ❑ Light Flow
- ❑ Heavy Flow
- ❑ Difficult Births
- ❑ Fertility Problems

Age of First Menses: _____ Date of Last Menses: _____
# of Pregnancies: _____ # of Births: _____ # of C-Sections: _____
# of Miscarriages: _____ # of Abortions: _____ # of Premature Births

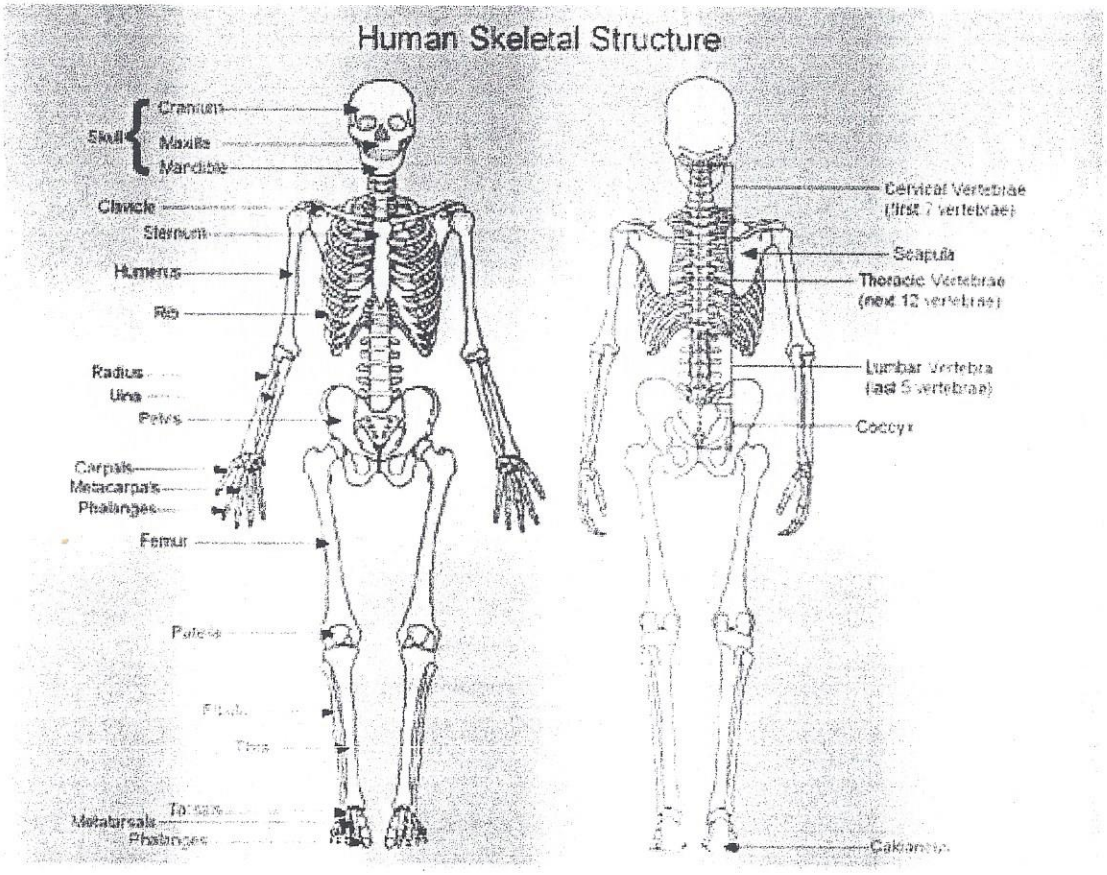
Neuro-Psychological

- ❑ Depression
- ❑ Headaches
- ❑ Dizziness
- ❑ Anxiety
- ❑ Migraines
- ❑ Seizures
- ❑ Tinnitus
- ❑ Irritability
- ❑ Head Injuries
- ❑ Loss of Balance
- ❑ Easily Angered
- ❑ Poor Memory
- ❑ Mood Swings
- ❑ Disorientation
- ❑ Areas of Numbness
- ❑ Visual Disturbances
- ❑ Weak Extremities
- ❑ Lack of Coordination

Musculoskeletal

❑ Neck Pain	❑ Wrist/Hand Pain	❑ Joint Pain	❑ Muscle Weakness	❑ Back Pain
❑ Hip Pain	❑ Weak Joints	❑ Muscle Spasms	❑ Scoliosis	❑ Knee Pain
❑ Arthritis	❑ Muscle Cramping	❑ Shoulder Pain	❑ Ankle/Foot Pain	❑ Recent Sprains
❑ Muscle Soreness	❑ Elbow Pain			

Please circle areas of pain or injury.



Have you ever received psychiatric treatment? _____
If so, for what and did you get relief? _____

Have you ever considered or attempted suicide? _____
If so, have you received counseling or have you been prescribed any medication from a psychiatrist? _____

Do you have any nervous habits? _____

Do you have any other problems you would like us to be aware of? _____

Informed Consent to Acupuncture Treatment

I consent to acupuncture treatments and other procedures associated with the practice of Traditional Oriental Medicine by the licensed acupuncturist. I have discussed the nature and purpose of the treatment with the licensed acupuncturist named below.

I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, and bodywork therapies.

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. 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, although this Practice uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal and mineral sources), which may be recommended, are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives and tingling of the tongue.

I understand that herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant taste or smell.

I will immediately notify the licensed acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the licensed acupuncturist who is caring for me if I am or become pregnant.

I do not expect the licensed acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the licensed acupuncturist to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts known to them, is in my best interest.

Both the patient and the licensed acupuncturist understand sexual intimacy is never appropriate and should be reported to the NYS Education Department at The New York State Office of Professions, Cultural Education Center, Room 3007, Albany, New York, 12230.

All of our records will be kept confidential and will not be released to any party without my written consent, unless reasons fall under the exceptions in the HIPAA privacy policy.

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 risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

_____	X _____
Date Consent Completed	Print Name of Patient
Nancie Forrest, L.Ac.	Y _____
Print Name of Licensed Acupuncturist	Patient or Representative Signature
_____	_____
Licensed Acupuncturist Signature	Print Name of Patient Representative (if applicable)

X
Email: _____

Would you like to receive correspondence from me in future? Please circle yes or no. Y N

Cancelled and Missed Acupuncture Appointments

Provider: Nancie Forrest, M.S., Licensed Acupuncturist
Address: 15 Bellemeade Ave, Suite 11, Smithtown, NY
Phone: 631-724-4325

Please understand that your time commitment begins at the moment you reserve an acupuncture treatment. In order to make it fair for everyone, please consider your schedule carefully and do not commit to a time that you feel may be questionable. There are times when a cancellation is, of course, necessary; but please give advance notice whenever possible.

Missed or cancelled appointments (medical emergencies excluded) without a minimum of five (5) hours notice will be considered your responsibility and a fee of $35.00 will be expected from your acupuncturist at your next visit. This fee reflects your financial commitment.

Your time slot is taken very seriously by your practitioner and represents time reserved out of his/her patient schedule. It also represents a financial loss for your practitioner if you do not show up or do not give sufficient notice.

As a highly regarded member of this practice, your respect and financial commitment is requested.

I have read, understand and agree to the above request:

Signature of Patient:_____

Date:_____

HIPAA 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 REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient/ Representative	Date
Printed Name	Witness

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Smithtown, NY 11787
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