# CARING HANDS ACUPUNCTURE PLLC

3089 38th Street
Astoria, NY 11103
(718) 762-7300
caringhandsacupuncture@gmail.com

This is a confidential questionnaire that will help us determine the optimal treatment plan specific to your needs. If you have any questions or concerns, please do not hesitate to ask us. Thank you.

## NEW PATIENT INTAKE FORM

Today's Date: _____ / _____ /_____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Email: _____ Date of Birth: ___ /___ /____ Age: _____

Occupation: _____ Employer: _____

Gender: ☐ Male ☐ Female Height: _____ Weight: _____

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Emergency Contact: _____ Phone #: _____ Relationship: _____

How did you hear about us? _____

Have you had Acupuncture before? ☐ Yes ☐ No For what condition? _____

How was your experience with Acupuncture? ☐ Good ☐ Very Good ☐ No change

Are you presently under a physician's care? ☐ Yes ☐ No For what condition? _____

Physician's Name: _____ Phone #: _____

Address: _____

Did your primary care physician refer you to us? ☐ Yes ☐ No

Can we contact these providers to ensure coordination of your care? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No Metal implants? ☐ Yes ☐ No Where? _____

Are you taking blood thinners? ☐ Yes ☐ No

## HEALTH INFORMATION

Reason for seeking care at our office? _____

_____

Have you received a medical diagnosis? ☐ Yes ☐ No

Please list: _____

Are you experiencing pain right now? ☐ Yes ☐ No

Describe your pain? ☐Dull ☐Sharp ☐Stabbing ☐Shooting ☐Burning ☐Other: _____

What was the initial cause? _____

How long have you had this problem? _____

What makes your symptoms improve? _____

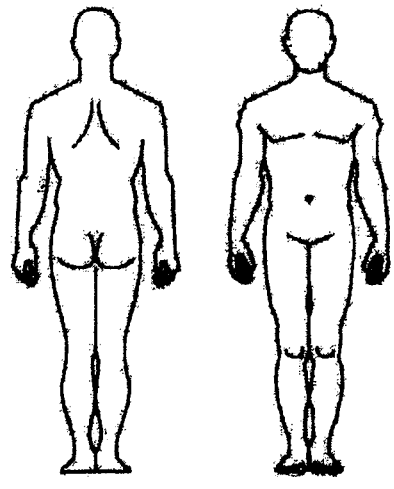
What makes your symptoms worse? _____

List any other providers you have seen for your condition:

_____

Other Comments: _____

**On the diagram below, please circle areas where you feel symptoms associated with your complaints.**



## LIFESTYLE

Do you smoke tobacco? ☐ Yes ☐ No How many per day? _____ Age started? ____ Age quit? _____

Do you smoke e-cigarette? ☐ Yes ☐ No How many per day? _____ Age started? ____ Age quit? ____

Do you drink alcohol? ☐ Yes ☐ No How many per week? _____

Do you use recreational drugs? ☐ Yes ☐ No Type? _____ Frequency? _____

Do you exercise regularly? ☐ Yes ☐ No Please describe: _____

## MEDICAL HISTORY

Check those that apply to your past medical history

| | | |
|---|---|---|
| ☐ Alcoholism / Substance Abuse | ☐ High/Low blood pressure | ☐ Hepatitis / Liver disease |
| ☐ Allergies | ☐ HIV/AIDS | ☐ Multiple sclerosis |
| ☐ Autoimmune disorder | ☐ Kidney disorder | ☐ Obesity |
| ☐ Arthritis / Rheumatism | ☐ Emphysema | ☐ Pneumonia |
| ☐ Asthma | ☐ Fibromyalgia | ☐ Sinus infections |
| ☐ Bleeding/Blood disorder | ☐ GERD / Ulcer | ☐ Skin disorders |
| ☐ Cancer / Tumor | ☐ Lyme's disease | ☐ Stroke |
| ☐ Diabetes | ☐ Lupus | ☐ Thyroid disorder |
| ☐ Eating disorder | ☐ Mental illness | ☐ Tuberculosis |
| ☐ Epilepsy / Seizures | ☐ Meningitis | ☐ Trauma (fall, car accident, etc.) |
| ☐ Headaches / Migraine | ☐ Mononucleosis | ☐ Venereal disease / STD |
| ☐ Heart attack/disease | ☐ Mumps | ☐ Other: _____ |

## FAMILY MEDICAL HISTORY

Check those that apply to your past family medical history

| | | |
|---|---|---|
| ☐ Allergies | ☐ Diabetes | ☐ Liver disease |
| ☐ Autoimmune disorder | ☐ Epilepsy/Seizures | ☐ Mental illness |
| ☐ Arthritis / Rheumatism | ☐ Heart attack/disease | ☐ Skin disorders |
| ☐ Asthma | ☐ High/Low blood pressure | ☐ Stroke |
| ☐ Cancer | ☐ Kidney disease | ☐ Other: _____ |

| List any serious diseases, illnesses, injuries, surgeries or hospitalizations you have had (include date): | List any allergies or adverse reactions, especially to food or drugs: |
|---|---|
| | |
| | |
| | |
| | |
| | |

**List current Medications, Vitamins, Herbs, Supplements (including over the counter medications)**

| Name | Reason | Dosage | How Long |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Check all SIGNS/SYMPTOMS that you are CURRENTLY experiencing AND/OR experience FREQUENTLY**

## GENERAL

| | | |
|---|---|---|
| ☐ Poor appetite | ☐ Insomnia | ☐ Sudden energy loss |
| ☐ Change in appetite | ☐ Localized weakness | ☐ Low energy/Fatigue |
| ☐ Chills | ☐ Poor balance | ☐ Peculiar taste/smells |
| ☐ Fevers | ☐ Night sweats | ☐ Weight loss/gain |
| ☐ Bleed/Bruise Easily | ☐ Strong thirst (cold/hot drinks) | |

## SKIN & HAIR

| | | |
|---|---|---|
| ☐ Rashes | ☐ Dandruff | ☐ Moles |
| ☐ Hives/Allergic dermatitis | ☐ Change in skin/hair texture | ☐ Dry skin |
| ☐ Eczema / Psoriasis | ☐ Itching | ☐ Acne |
| ☐ Hair loss | ☐ Skin discolorations | ☐ Other: _____ |

## HEAD, EARS, NOSE, THROAT

| | | |
|---|---|---|
| ☐ Dizziness | ☐ Eye pain | ☐ Dental/Gum problems |
| ☐ Eye Strain | ☐ Poor vision | ☐ Recurrent sore throat/Colds |
| ☐ Color Blindness | ☐ Blurred vision | ☐ Sinus problems |
| ☐ Ringing in Ears | ☐ Teeth grinding | ☐ Facial pain |
| ☐ Nosebleeds | ☐ Jaw clicks/locks | ☐ Facial flushing |
| ☐ Headache / Migraines | ☐ Poor hearing | ☐ Sores on lips/tongue |
| ☐ Difficulty swallowing | ☐ Earaches | ☐ Other: _____ |

## CARDIOVASCULAR

| | | |
|---|---|---|
| ☐ Chest pain | ☐ Irregular heartbeat | ☐ Fainting |
| ☐ Cold hands/feet | ☐ Swelling of hands/feet | ☐ Varicose / spider veins |
| ☐ Pressure in chest | ☐ Palpitations | ☐ Other: _____ |

## RESPIRATORY

| | | |
|---|---|---|
| ☐ Cough | ☐ Phlegm production | ☐ Wheezing |
| ☐ Difficult to inhale/exhale | ☐ Chest tightness | ☐ Pain with deep inhalation |
| ☐ Coughing blood | ☐ Shortness of breath | ☐ Other: _____ |

## GASTROINTESTINAL

| | | |
|---|---|---|
| ☐ Nausea | ☐ Bloating | ☐ Constipation / Diarrhea |
| ☐ Belching / Gas | ☐ Changes in appetite | ☐ Black Stools |
| ☐ Gas | ☐ Abdominal Pain/cramps | ☐ Blood in stools |
| ☐ Indigestion | ☐ Acid reflux | ☐ Other: _____ |

## UROGENITAL

| | | |
|---|---|---|
| ☐ Pain on urination | ☐ Frequent / Urgent urination | ☐ Burning urination |
| ☐ Unable to hold urine | ☐ Kidney stones | ☐ Blood in urine |
| ☐ Dribbling after urination | ☐ Urinary tract infections | ☐ Other: _____ |

## NEUROPSYCHOLOGICAL

| | | |
|---|---|---|
| ☐ Seizures / Tremors | ☐ Confusion | ☐ Difficulty Concentrating |
| ☐ Lack of coordination | ☐ Loss of balance | ☐ Bad temper / Irritable |
| ☐ Anxiety/ panic attacks | ☐ Paralysis | ☐ Emotional changes |
| ☐ Depression / PTSD | ☐ Poor memory | ☐ Easily susceptible to stress |
| ☐ Vertigo | ☐ Area of numbness | ☐ Other: _____ |

## MUSCULOSKELETAL

| | | |
|---|---|---|
| ☐ Neck pain | ☐ Tendonitis | ☐ Muscle weakness/pain |
| ☐ Shoulder pain | ☐ Hand / Wrist pain | ☐ Muscle spasms/cramps |
| ☐ Knee pain | ☐ Foot / Ankle pain | ☐ Muscle stiffness |
| ☐ Back Pain | ☐ Bursitis | ☐ Sciatica |
| ☐ Joint pain | ☐ Sprains / Strains | ☐ Other: _____ |

## FOR MEN ONLY

| | | |
|---|---|---|
| ☐ Infertility | ☐ Sexual dysfunction | ☐ Hernia |
| ☐ Premature ejaculation | ☐ Testicular masses | ☐ Genital sores |
| ☐ Prostate disorders | ☐ Testicular pain | ☐ Other: _____ |
| ☐ Low sperm count/motility | ☐ Unusual discharge | |

## FOR WOMEN ONLY

| | | |
|---|---|---|
| ☐ Painful menses | ☐ Vaginal discharge | ☐ Fibrocystic breast |
| ☐ Irregular menstruation | ☐ Vaginal dryness | ☐ Fibroid tumors |
| ☐ Ovarian cysts | ☐ Painful intercourse | ☐ Infertility |
| ☐ Vaginal sores | ☐ Breast lumps | ☐ Other: _____ |

- Are you currently pregnant? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No
- # of pregnancies: _____ # of births: _____ # of miscarriages: _____ # of premature births: _____
- Age of first menses: _____ Date of last menses: _____
- Abdominal cramping? ☐ Yes ☐ No If yes, ☐ Before menses ☐ During menses ☐ After menses
- Length of cycle (days): _____ Same day of cycle each month? ☐ Yes ☐ No Length of period (days)? ____
- Color: ☐ Light ☐ Normal ☐ Dark
- Amount: ☐ Heavy menstrual flow ☐ Normal ☐ light, scanty flow
- Consistency: ☐ Thick ☐ Normal ☐ Thin
- Clots? ☐ Yes ☐ No
- Vaginal discharge between periods? ☐ Yes ☐ No If yes, ☐ white ☐ yellow ☐ other: _____
- Do you practice birth control? ☐ Yes ☐ No What type? _____ How long? _____

# ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic 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. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above 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 agree with the current or future recommendations for care. 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.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)

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## PATIENT ADVISORY TO CONSULT A PHYSICIAN

Caring Hands Acupuncture PLLC is committed to your health and well-being. While Traditional Medicine modalities, such as Acupuncture and Herbal Medicine, have a great deal to offer as a health care system, it cannot entirely replace the services available from biomedical practitioners. Therefore, it is recommended that you consult a physician regarding any condition(s) for which you are seeking acupuncture or herbal treatment.

To comply with Article 160, Section 8211.1 (b) of New York State Education law, please read and sign the following statement:

I, _____ (print name) do affirm that I have been advised by Caring Hands Acupuncture PLLC and their licensed acupuncturists, to consult a physician regarding the condition or conditions for which I seek acupuncture treatment.

Patient Signature: X _____ Date: _____

## FINANCIAL POLICY

I, _____ (print name) do affirm that I am financially responsible for payment of all medical services received at this office, and that full payment for all services and products is required at the time of service. There will also be a **$35.00** fee charged for any returned checks.
I also understand that all scheduled appointments are my responsibility and I will give the courtesy of at least **24 hours** prior notice for cancellation. Otherwise, I am responsible for any fees associated with any missed appointments.

Patient Signature: X _____ Date: _____

## HIPAA NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent.
I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I, _____ (print name) do affirm that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I also have read and understand your Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Signature: X _____ Date: _____

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## FINANCIAL AGREEMENT HEALTH INSURANCE

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

**Explanation of Insurance Coverage:**
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 patent, 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.

**Payment Arrangements**
We require that you pay $_____ towards today's charges and $_____ on each visit. Your full portion of the bill is expected to be when payment is received from your insurance carrier. Any unpaid balances Will be considered past due 30 days following insurance reimbursement Past due balances may have an interest charge of 1.5 % applied per month.

**Assignment of Benefits**
By signing this form you are authorizing payment of medical benefits will be made directly to this office. if your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. However if you pay for your visits in full the assignment will not be reported by this provider and any payment will be sent directly to you.

**Release of Information**
By signing this form you are also authorizing this office upon request from your insurance carrier the release of any medical or other information necessary to process the claim. You also acknowledge and request payment of government benefits either to myself or to the party who accepts assignment, namely this office.

**Voluntary Termination of Care**
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

Patient Signature: x_____ Date: _____