This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you.If you have questions, please ask. Thank you.

PERSONAL INFORMATION

NAME: _____ SEX: __ MALE __ FEMALE

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____ S.S.N. _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PRIMARY PHONE: _____ CELL/WORK PHONE: _____

I would like to receive confirmation calls for my appointment at: ( )_____

EMAIL: _____ OCCUPATION: _____

EMERGENCY CONTACT: (NAME)_____(PHONE)_____

MARITAL STATUS: __MARRIED __SINGLE __DIVORCED __WIDOWED NUMBER OF CHILDREN __

HAVE YOU RECEIVED ACUPUNCTURE THERAPY BEFORE? _YES (When_____) __No

WHO SHOULD WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

INSURANCE INFORMATION

INSURANCE COMPANY: _____ ID #: _____

INSURED'S NAME (IF DIFFERENT FROM PATIENT): _____

Relationship to Insured (Self/Spouse/Child) / PRIMARY HOLDER'S D.O.B: _____

SECONDARY INSURANCE: _____ ID#: _____

SECONDARY INSURED'S NAME (IF DIFFERENT FROM PATIENT): _____

Relationship to Insured (Self/Spouse/Child)/ SECONDARY HOLDER'S D.O.B: _____

MEDICAL HISTORY

Please indicate any significant illnesses you or a blood relative (grandparent, parent or sibling) have had:

Illness	**You**	**Relative**	**Approx. date**	**Illness**	**You**	**Relative**	**Approx. date**
Cancer	___	_____	_____	Diabetes	___	_____	_____
Hepatitis	___	_____	_____	Heart Disease	___	_____	_____
Rheumatic	___	_____	_____	Seizures	____	_____	_____
High Blood Pressure	___	_____	_____	Emotional Disorders	___	_____	_____
Infectious Diseases	___	_____	_____	Tuberculosis	_____	_____	_____

Sexually Transmitted Diseases: ___Syphilis___HIV___HPV____Chlamydia____Herpes DATE: _____

List any medications and supplements you are currently taking: (Continue on back if necessary)

Medicine	Dosage	Reason	How long	Prescribed by	Date of last check up
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Check the box if any of the following statements are true:

___ I have known allergies

___ I am taking Coumadin/ Warfarin

____ I have a pacemaker

___ I am taking Lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Please indicate the use and frequency of the following:

	Yes	No	How much		Yes	No	How much		Yes	No	How much
Coffee/black tea	__	__	_____	Tobacco	__	__	_____	Water Intake	___	___	_____
Non-medical drugs	__	__	_____	Alcohol	___	__	_____	Soda pop	____	____	_____

What are the main health problems for which you are seeking treatment?

_____

What other forms of treatment have you sought?_____

List any other health problems you now may have: _____

_____

List any allergies, food sensitivities or food cravings that you have_____

_____

List any accidents, surgeries or hospitalizations (include date):_____

_____

Lab results: (please include copies) _____

_____

How do you feel about the following areas of your life?

Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your comments
Other	___	____	___	____	____	_____
Family	____	_____	___	____	____	_____
Diet	____	_____	___	____	____	_____
Sex	____	_____	____	____		_____
Self	____	_____	____	____		_____
Work	____	_____	____	____		_____
Exercise	____	_____	____	____		_____
Spirituality	____	_____	____	____		_____

For Women

Age of 1st period (menarche) _____ Are you pregnant? ___Yes ___No # of pregnancies _____

Age of last period (menopause) _____ # of live births _____ # of abortions___ # of miscarriages___

Number of days between periods _____ Date of last: Gynecological exam _____ Pap smear _____

Number of days of flow _____ Mammogram_____Bone Density Scan_____

Color of flow: _____ Results: _____

Clots? ___Yes ____No Color_____

Average number of pads you use per day: 1st day _____ 2nd day _____ 3rd day_____ 4th day – days_____

Have you been diagnosed with: __Fibroids __Fibrocystic breasts __Endometriosis__Ovarian Cysts __PID Other___

Location of Pain: __ Lower abdomen ___ Lower back ___ Thighs ____ Other _____

Nature of Pain: (Please indicate before, during or after menses)

Cramping___ Stabbing___

Burning____ Aching____

Dull_____ Bloating____

Consistent____Intermittent_____

Bearing down sensation_____

Other symptoms related to menses

__Discharge __Vaginal dryness ___ Headaches

___Nausea __Constipation ___Diarrhea

___Swollen breasts ___Mood Swings ___Ravenous appetite

___Poor appetite ____Hot flashes ____Night sweats

____Increased libido ___Decreased libido ___Insomnia

For Men

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____

Lab results _____

Frequency of Urination: daytime _____ nighttime_____ Color of urine __ clear __ murky odor: _____

Symptoms related to prostate

___prostate problems ___Delayed stream ___Dribbling ____Incontinence ___ Retention of Urine

___Rectal dysfunction ___Increased libido ___Decreased libido ___Premature ejaculation ___Impotence

___Back pain ___Groin pain ___Testicular pain other: _____

Symptom Survey (For Everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

No mark ( ) = never experience check mark (/) = sometimes experienceplus sign (+) = frequently experience

___ lack of appetite ___insomnia, difficulty sleeping ___chest pain ___feeling of claustrophobia

___excessive appetite ___heart palpitations ___sciatic pain ___bronchitis

___loose stools or diarrhea ___cold hands and feet ___headaches ___colitis or diverticulitis

___digestive problems, indigestion ___nightmares ___pain or coldness in the genital area ___constipation

___vomiting ____mentally restless ___cough ____hemorrhoids

___belching, burping ____laughing for no apparent reason ___shortness of breath ____recent use of antibiotics

___heartburn/reflux ____angina pains ___decreased sense of smell ___eye problems

___feeling retention of food in stomach ___abdominal pains ___nasal problems ___jaundice (yellowish eyes or skin)

___tendency to become obsessive in work, relationships, etc. ___skin problems ___difficulty digesting oily foods

___gallstones ___light colored stool ___soft or brittle nails ___easily angered or agitated

___difficulty in making plans or decisions ___spasms or twitching of muscles ___low back pain ___knee problems

___hearing impairment ___ear ringing ___kidney stones ___decreased sex drive

___hair loss ___urinary problems ___fatigue ___edema

___blood in stool ___black tarry stool ___easily bruised ___difficult to stop bleeding

___asthma ___tendency to catch colds easily ___intolerance to weather changes ___allergies

___hay fever ___dizziness ___tendency to faint easily ____high cholesterol levels

___sudden weight loss

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I request and consent to the performance of Acupuncture and other Chinese medical procedures. I understand that my signature on this form indicates that I have read the following, and understand that if I have any concerns about this information, I should ask the practitioner.

1. **Nature of Treatment:** The treatment modalities may include acupuncture, massage therapy, acupressure, cupping, guasha or electrical acupuncture. I understand that the treatments will be explained to me prior to treatment for my condition.
2. **Purpose of Treatment:** I understand that the purpose of the treatment is to resolve my condition, the reason I am requesting treatment. The procedures used will attempt to remedy bodily dysfunction and diseases, to modify or prevent the perception of pain, and to make normal the body's physiological functions.
3. **Risks of Treatment:** I understand that Chinese medical procedures have been shown to be safe and effective. However, I understand that there are some uncommon risks. These risks may include:

- Mild discomfort during or after the insertion of a needle, dizziness, fainting, localized bruising or swelling, temporary aggravation of symptoms that existed prior to treatment; some acupuncture points are contraindicated during pregnancy. Please notify your practitioner if you are or might be pregnant.

4. **Use of Disposable Needles:** I understand that to prevent any possibility of infection from acupuncture, all needles used are pre-sterilized, one time use, surgical stainless steel needles that after usage are disposed of as medical waste. Needles are never reused.
5. **Unforseen risks:** I understand that the practitioner cannot anticipate or explain all risks and complications which may occur during or after treatment. I understand that they will exercise judgement based upon their determination of my best interests. I understand that I may stop treatment at any time.

Patient advisory to consult a physician regarding to patient's condition: in compliance with the State of NJ Acupuncture Regulation 45:2C-5

Your signature indicates that you have read, understand and agree with the above information.

Signature of Patient (or parent if minor): _____ Date: _____

Signature of Practitioner: _____ Date: _____

Acupuncture Patients:

Please schedule all appointments with the staff at the front desk; Teresa does not handle her schedule.

Please call if you are running late for your appointment, if you are going to be more than 10-15 mins. late we may need to reschedule. We will always do our best to fit you in.

Please arrive prepared for your appointment. If you need to change or use the restroom, please arrive 5-10 mins. early to do so.

Please make sure all paperwork is filled out *before* your scheduled appt. time.

Please have a seat in the waiting area. Teresa will be with you at your scheduled appointment time.

Please respect other patients privacy. Do not open or knock on treatment room doors.

If you show up earlier than your scheduled appointment time it is not a guarantee that you will be seen before your scheduled appointment time.

We appreciate your cooperation.

X_____ X_____

PATIENT SIGNATURE WITNESS

Financial Policy

Please have your insurance ready on the day of your visit.

Out of Network Payments: Our office is out of network with most insurance companies. If your insurance has out of network benefits, you insurance may be sending you the payments for your visit. You are solely responsible for payments and agree to forward any and all payments to our office immediately.

Self-Pay: If you do not have a health insurance or if your health insurance will not pay for services, you will be considered a self-pay patient. Our office will provide an affordable payment option upon your visit or once we are able to verify your insurance. Kindly make the full payments on your visit. We accept Cash, Checks, and Credit card.

Deductible: The annual amount you pay for covered health care services before your insurance contributes to your medical bills.

Copay: A fixed amount you pay for a covered health care service after you've paid your deductible.

I _____, have acknowledged that I have read and
Print name
understood the above statement.

_____ _____

Patient Print name **Date**

_____

Patient Signature

(Guardian must sign for patients under 18)