New England Family Acupuncture – New Patient Forms

(Please fill out and sign before your first appointment)

Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____ City, State, Zip: _____

Telephone #s Home: _____ Work: _____

Mobile : _____ Email: _____

Preferred contact #: _____ Can we leave a detailed message? _____

Occupation: _____

Primary Care Physician: _____

In Emergency Notify: _____ Phone: _____

How did you hear about our practice? _____

What is the main problem you would like to address with acupuncture?

How long ago did this problem begin (be as specific as possible)?

To what extent does this problem interfere with your daily activities?

What other kinds of treatments have you tried?

Have you consulted with your primary care physician? _____

If Yes, did he/she give you a Western medical diagnosis*? _____

Please list any medications, herbs or supplements you are currently taking for this condition:

Please make a check mark next to symptoms you currently experience or have experienced **within the past 6 months:**

Body Temperature

____ Always Cold
____ Always Hot
____ Hands & Feet Cold
____ Sweating at night
____ Sweating without exertion

Skin/Hair

____ Psoriasis
____ Eczema
____ Hives
____ Other rash
____ Dryness
____ Recently thinning/losing hair

Head/Face

___ Migraines
___ Frequent headaches
___ Dizziness
___ Poor memory
___ Head feels "cloudy" or "heavy"
___ Facial paralysis

Eyes

____ Blurring of vision
____ Floaters
____ Watery eyes
____ Dry eyes
____ Itchy & irritated eyes
____ Blindness

Ears

____ Ringing in ears
____ Loss of hearing
____ Ear infections
____ Congestion
____ Dizziness (related to ears)

Nose/Throat

____ Allergies
____ Sinus infections
____ Sinus headaches
____ Trouble swallowing
____ Sensation of "lump in throat"
____ Chronic laryngitis

Respiratory

____ Shortness of breath
____ Cough
____ Chronic bronchitis
____ Asthma
____ Emphysema
____ Lung cancer

Cardiovascular

____ Pain in chest
____ Tightness in chest
____ Heart palpitations
____ Irregular heart rhythm
____ High blood pressure
____ High cholesterol
____ Hardening of arteries

Appetite/Thirst

____ Increased appetite
____ Decreased appetite
____ Crave sweet taste
____ Crave sour taste
____ Crave salty taste
____ Thirsty
____ No thirst

Digestion

____ Heartburn
____ Chronic gas
____ Nausea
____ Vomiting
____ Abdominal Pain
____ Cramping
____ History of gall stones

Stools

____ Diarrhea
____ Constipation
____ Blood in stool
____ Mucous in stool
____ Irritable Bowel
____ Colitis

Urination

____ Increased frequency
____ Pain or burning on urination
____ Waking to urinate at night
____ Incontinence or leaking
____ Difficulty urinating
____ History of frequent infection
____ History of kidney stones

Sleep

____ Difficulty falling asleep
____ Waking frequently
____ Nightmares
____ Snoring
____ Muscle cramps
__ Sleep apnea

Energy Level

____ Fatigue
____ Difficulty waking
____ Heavy limbs
____ Feeling sleepy
____ Too much energy
____ Restlessness

Muscles & Joints

____ Arthritis in _____
____ Bursitis in _____
____ Tendinitis in _____
____ Stiff or tight muscles
____ Sciatica
____ Neck pain
__ Low back pain

Female Menstrual, Fertility and Sexual Health

____ Irregular Periods
____ Heavy Periods
____ Light Periods
____ PMS
____ Cramping
____ Endometriosis
____ Ovarian cysts
____ Uterine fibroids
____ Sexually transmitted disease

____ Polycystic Ovarian Syndrome
____ Premature Ovarian Failure
____ Perimenopause
____ # of cycles with IVF
____ # of cycles with IUI
____ # of pregnancies
____ # of biological children
____ # of miscarriages
____ # of D&Cs, D&Es

____ Low sex drive
____ Abnormally high sex drive
____ Higher sex drive during period
____ Difficulty achieving orgasm
____ Pain on intercourse
____ Prolapsed uterus
____ Prolapsed bladder

Male Fertility & Sexual Health

____ Pain on ejaculation
____ Premature ejaculation
____ Difficulty achieving erection
____ Difficulty maintaining erection
____ Pain on urination
____ Sexually transmitted disease
____ Low sperm count
____ Low sperm motility

____ History of undescended testicles
____ Delayed puberty (after age 16)
____ Low testosterone
____ Use of Viagra, Cialis or Levitra
____ # of biological children
____ # of children
____ Abnormal sperm shape
____

____ Low sex drive
____ Abnormally high sex drive
____ Prostate cancer
____ Prostatitis
____ Elevated PSA (no cancer)
____ Enlarged prostate
____
____

Mental Health

____ Anxiety
____ Panic Attacks
____ Depression
____ Bipolar Disorder
____ Seasonal Affective Disorder
____ Phobias
____ Other _____

Emotions – please indicate which, of any, emotions you feel has a negative impact on your life

____ Grief & Loss
____ Sadness
____ Anger
____ Frustration
____ Fear &/or Phobias
____ Worry

____ Over excitement (mania)
____ Lack of fear (recklessness)
____ Lack of anger
____ Lack of sadness
____ Lack of emotion
____ Other _____

Please indicate if anyone in your immediate family has or has a history of the following:

_____ Allergies
_____ Heart Disease
_____ Diabetes
_____ Cancer
_____ Seizures
_____ Stroke
_____ Other (please explain)

Please list the dates and reasons for any hospitalizations or surgeries:

Please list any other medications, supplements or herbs that your are currently taking:

How many packs of cigarettes do you smoke per week?

How much coffee, tea or cola do you drink per week?

How much alcohol do you drink per week?

Please describe any use of drugs for non-medical purposes:

Do you have a regular exercise program? Please describe:

Please describe any other problems you would like to discuss or address with acupuncture/Chinese herbs:

New England Family Acupuncture

Julie Permut, Dipl. OM, MAOM, L.Ac.

Compassionate, Natural Healthcare for the Whole Family

25 Steele Rd. Peterborough, NH 03458 603-924-3400 www.nhacupuncture.com

Our Policies & Fees

Payment & Insurance Coverage:

Payment is due in full at the time of your visit. For your convenience we accept cash (exact change appreciated), check, Visa, Mastercard, Discover and American Express.

Acupuncture may be covered by your insurance. If you believe your insurance will cover treatment, we will verify your coverage for you, either before or after your first acupuncture session. ***Important: until we can verify your insurance coverage for acupuncture, payment is due in full at the time of your visit. If your insurance company denies payment for any portion of your bill for any reason, you are responsible for the cost of treatment at the current rates.***

No-Shows and Late Cancellations:

When you make an appointment, we are reserving time just for you. When you cancel with less than 24 hours we are unable to offer your time to another patient who may be waiting for an appointment. ***Therefore, you will be billed the full appointment fee for no-shows and same-day cancellations that are not due to emergency, illness or dangerous driving conditions.***

Office Closures:

In the event that we need to close the office due to bad weather or another emergency, we will call you to reschedule your appointment.

Gift Certificates:

Gift certificates are available in any amount and may only be redeemed for services provided by Julie Permut, Dipl. OM, MAOM, L.Ac. ***Monetary refunds will not be given for any gift certificate.***

Rates:

For information on our current fee schedule, please inquire at the front desk. Discount packages are available. ***We reserve the right to update our fees at any time.***

Insurance: We accept Cigna and Harvard Pilgrim (most plans). All other insurance patients with acupuncture coverage are asked to pay in full at the time of service and we will help you seek reimbursement.

Acupuncture fees do not include the cost of herbal medicines. You are expected to pay for your herbal prescription when you pick it up. Prepared herbs may be returned unopened for a full refund at any time. Custom herbal teas and prepared herbs that have been opened cannot be returned for a refund.

I have read, understand and agree to the above policies. I also agree that I have had the opportunity to discuss all fees and payment options, and understand my responsibility for payment of services rendered.

_____ _____

Patient Signature **Date**

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Informed Consent for Traditional Chinese Medical Treatment

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of Traditional Chinese Medicine (TCM) on me (or on the patient named below for whom I am legally responsible) by Julie Permut, Licensed Acupuncturist.

There are some risks to treatment, including but not limited to some bruising of the skin and/or slight bleeding. If moxibustion or heat therapies are used there is a slight risk of burn and/or scarring. The risk of infection is very small when all needles are sterile and Clean Needle Technique procedures are followed. I understand that Julie Permut, Dipl. OM, MAOM, L.Ac. is certified in Clean Needle Technique and uses only pre-sterilized, one-use, disposable needles.

I have had an opportunity to discuss with Julie Permut, Dipl.OM, MAOM, L.Ac. the nature and purpose of TCM. I understand that results are not guaranteed.

I do not expect my practitioner to be able to anticipate and explain *all* the risks and complications of treatment. I wish to rely on her to exercise judgment which she feels at the time is in my best interest, based upon the facts then known, during the course of treatment.

I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, before or during the diagnosis or treatment.

I understand that Julie Permut, Dipl. OM, MAOM, L.Ac. is not providing Western (allopathic) medical care, and that I should look to my Western primary care physician (i.e. MD) for those services and for routine check-ups.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures, and I accept all risks identified. 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 with Julie Permut, Dipl. OM, MAOM, L.Ac.

PATIENT SIGNATURE:
(Or Patient Representative, please indicate your relationship to the Patient)

DATE:

For practitioner's use only:

Questions asked & answers given:

Practitioner's signature & Date:

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Privacy Policy

My policy is to keep your healthcare records safe. Your records will be kept in a folder of papers with your name on it. Your records include what you tell us about your health history and symptoms, what signs we observe in your pulse and tongue, any copies of tests you give us (blood tests, MRI or x-ray reports, doctor's reports, etc.) and details about the treatments we give you (our opinions about your case, acupuncture points and techniques used, herbal medicines prescribed, referrals made to other kinds of practitioners).
We can legally share your healthcare information with your doctors, nurses or other healthcare providers if it is important to your care, but I cannot legally share your information for non-healthcare reasons. If your insurance company is paying for any part of your treatment, it will require that we send copies of our diagnosis, treatment plan and notes about each treatment.

Your Rights and Our Responsibilities:

- You have the right to see and get a copy of your healthcare records, and you have the right to ask us to make changes to them if you find a mistake. If you ask for copies of your healthcare records, we must give them to you within 30 days. We have the right to charge you for the cost of copying and sending your records.
- You have the right to get a copy of this notice. If you ask us for a copy, you will have to sign it at the end where it says "I have asked for and received a copy of this Privacy Notice".
- You have the right to ask us not to use or share your medical information in certain ways. We will make every effort to do what you ask, but when we cannot, we must let you know in writing.
- You have the right to ask us to contact you by different means, as long as the request is reasonable (for example, to call you at home rather than at work).
- It is our responsibility to protect your healthcare records and abide by the terms of this notice.
- It is our responsibility to train our assistants and employees to protect your healthcare records and abide by the terms of this notice.
- For more information, please visit our website at nhacupuncture.com/privacy-policy/

If you have further questions about this notice, please contact:

Julie Permut, Dipl. OM, MAOM, L.Ac.
New England Family Acupuncture
25A Steele Rd.
Peterborough, NH, 03458
nefacupuncture@gmail.com

If you feel your right to healthcare privacy has been violated, you should contact:

Office for Civil Rights
U.S. Department of Health & Human Services
JFK Federal Building - Room 1875
Boston, MA 02203
(617) 565-1340; (617) 565-1343 (TDD)
(617) 565-3809 FAX

I have read and understand this Privacy Notice. I understand my rights regarding my healthcare records held by New England Family Acupuncture.

Patient Signature (parent or guardian if patient is under 18 years of age) Date Signed

I have asked for and received a copy of this Privacy Notice

Patient Signature (parent or guardian if patient is under 18 years of age) Date Signed