



454 WARREN ST . APT 3, HUDSON, NY 12534

(518) 828-0205

EASTGATEHUDSON@GMAIL.COM

WWW.EASTGATEACUPUNCTURE.COM

**PERSONAL INFORMATION (CONFIDENTIAL)**

Name \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tel:(Cell) \_\_\_\_\_ Tel:(Home) \_\_\_\_\_

Email \_\_\_\_\_ Occupation \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Marital (Relationship) Status \_\_\_\_\_ Number of Children \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_

Referred by \_\_\_\_\_

Main Complaint: \_\_\_\_\_

What other forms of treatment have you sought? \_\_\_\_\_

What makes the condition better or worse? \_\_\_\_\_

Have you received acupuncture before? \_\_\_\_\_

What would you like to improve most about your physical or emotional health or your lifestyle?

\_\_\_\_\_  
\_\_\_\_\_

Chronic health problems: \_\_\_\_\_

\_\_\_\_\_  
Serious illnesses (age): \_\_\_\_\_

Please list any medications/vitamins/supplements you are currently taking:

Medication	Dosage	Reason

Please list your history of surgeries and hospitalizations:

Surgery / Hospitalization	Age	Outcome

Please check all that apply:

- I have a pacemaker
- I have known allergies
- I am taking coumadin/warfarin
- I am taking lithium (Eskalith, Lithobid, Lithonate etc.)

**PAST MEDICAL HISTORY**

Have you or your immediate family had any of these conditions? Please check all that apply:

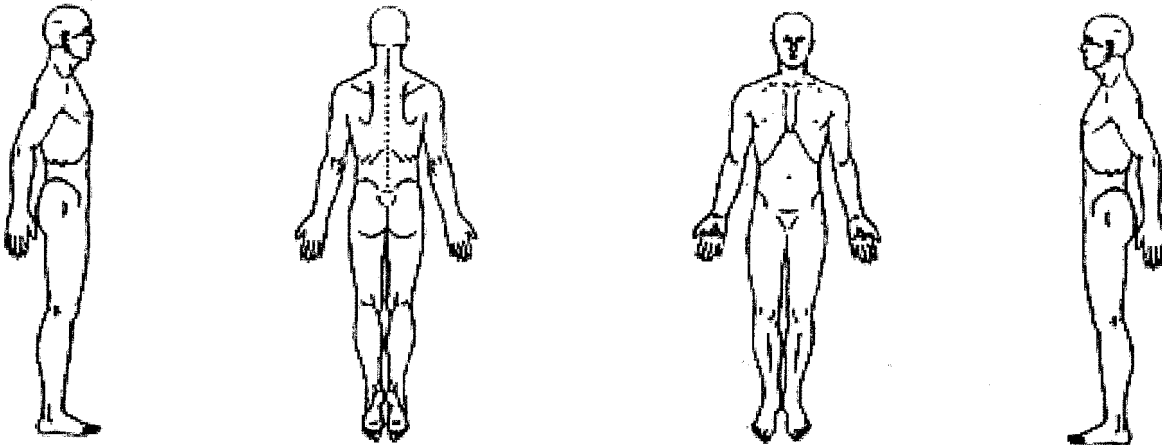
- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> <input type="checkbox"/> Diabetes            | <input type="checkbox"/> <input type="checkbox"/> HIV positive       | <input type="checkbox"/> <input type="checkbox"/> Polio            |
| <input type="checkbox"/> <input type="checkbox"/> Anemia            | <input type="checkbox"/> <input type="checkbox"/> Emphysema           | <input type="checkbox"/> <input type="checkbox"/> Kidney disease     | <input type="checkbox"/> <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> <input type="checkbox"/> Anorexia          | <input type="checkbox"/> <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> <input type="checkbox"/> Lung disease       | <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever  |
| <input type="checkbox"/> <input type="checkbox"/> Appendicitis      | <input type="checkbox"/> <input type="checkbox"/> Goiter              | <input type="checkbox"/> <input type="checkbox"/> Liver disease      | <input type="checkbox"/> <input type="checkbox"/> Suicide attempt  |
| <input type="checkbox"/> <input type="checkbox"/> Asthma            | <input type="checkbox"/> <input type="checkbox"/> Gout                | <input type="checkbox"/> <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> <input type="checkbox"/> STDs             |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> <input type="checkbox"/> Heart disease       | <input type="checkbox"/> <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> <input type="checkbox"/> Bronchitis        | <input type="checkbox"/> <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> <input type="checkbox"/> Thyroid disease  |
| <input type="checkbox"/> <input type="checkbox"/> Bulimia           | <input type="checkbox"/> <input type="checkbox"/> Hernia              | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> <input type="checkbox"/> Other            |
| <input type="checkbox"/> <input type="checkbox"/> Cancer            | <input type="checkbox"/> <input type="checkbox"/> High blood pressure | <input type="checkbox"/> <input type="checkbox"/> Pacemaker          |  |
| <input type="checkbox"/> <input type="checkbox"/> Drug dependency   | <input type="checkbox"/> <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> <input type="checkbox"/> Pneumonia          |  |

**PAIN, MUSCLES, JOINTS & BONES**

Have you experienced any of the following? Please check all that apply:

- Broken bones
- Meniscus tears
- Swollen joints
- Slipped disc
- Tendonitis
- Osteoarthritis
- Fibromyalgia
- Bone pain
- Repetitive strain injury
- Rheumatoid arthritis
- Muscle cramps
- Other

Please indicate areas of sharp stabbing pain with an (X). Please indicate other aches or dull heavy pains with a circle. If the pain radiates or follows a path please mark that path with a line.



Describe the pain, please check all that apply:

- Sharp
- Superficial
- Aching
- Numbness / Tingling
- Dull
- Deep
- Burning
- Worse with humidity
- Better with heat
- Worse in evening
- Better with cold
- Better with exercise
- Worse with heat
- Worse in morning
- Worse with cold
- Worse with exercise

**FOR MEN**

Date of last prostate exam \_\_\_\_\_ PSA results \_\_\_\_\_  
Manual Prostate exam results \_\_\_\_\_  
Other exam or lab results \_\_\_\_\_

Have you experienced any of the following? Please check all that apply:

- Prostate problem       Delayed stream       groin pain       Decreased libido
- Nocturnal emission       Painful erections       Inguinal hernias       Swollen testes
- Itching or rash in groin       Varicocele       Blood in urine or ejaculate       Impotence
- Erectile dysfunction       Increased libido       Testicular pain       Dribbling
- Retention of Urine       Premature ejaculation       Diagnosed Infertility       Other

If seeking fertility treatment, have you had a sperm analysis?  Yes  No  
If so, what were the results?

Volume \_\_\_\_\_ Count \_\_\_\_\_ Motility \_\_\_\_\_ Morphology \_\_\_\_\_

**FOR WOMEN**

At what age did you start menstruating? \_\_\_\_\_  
 Date of last menstrual period? \_\_\_\_\_  
 Number of pregnancies? \_\_\_\_\_ Number of miscarriages? \_\_\_\_\_ Number of abortions? \_\_\_\_\_  
 Number of days of menstrual cycle ( i.e. 28 or 32) \_\_\_\_\_  
 Number of days of menstrual flow(1-5?) \_\_\_\_\_  
 How many pads or tampons do you use on your heaviest day? \_\_\_\_\_  
 Color of blood: Brown, Brownish red, Red, Bright Red, Purple  
 Describe the quality of the flow: Grainy, Mucous, Fleshy, Clots, Liquid, Other \_\_\_\_\_  
 Do you feel weepy or angry before your period? \_\_\_\_\_  
 Please describe any PRE-menstrual symptoms, when they appear and when they are alleviated:

\_\_\_\_\_

Please describe any symptoms that occur during menstruation and when they are alleviated:

\_\_\_\_\_

Please describe any POST-menstrual symptoms, when they appear and when they are alleviated:

\_\_\_\_\_

Are you on the pill or other hormone based contraceptives? If yes, for what purpose?

\_\_\_\_\_

Have you frequently experienced . . . (check all that apply):

- Fibroids       Skipped periods       Bleeding between periods       Hot flashes
- Ovarian cysts       Light flow       Diarrhea w/ period       Night sweats
- Endometriosis       Heavy flow       Constipation w/ period       Painful intercourse
- Fibrocystic breasts       Clots in flow       Yeast infections       Fatigue after sex
- Breast lump       Mid-cycle pain       Vaginal discharge       Strong libido
- Breast tenderness       Nipple discharge       Other infections       Weak libido
- Irregular cycles       Pain before period       Itching or burning       Low lubrication
- No periods       Pain during period       Abnormal Pap test       IUD

**PREGNANCY- ONLY FILL OUT IF APPLICABLE**

Are you currently pregnant?  Yes  No If yes, How many weeks? \_\_\_\_\_

Please circle one - Single child, Twins or Triplets?

Any medical complications during pregnancy? \_\_\_\_\_

Number of Previous pregnancies? \_\_\_\_\_ Delivery method? Please circle: Vaginal or C-section

**FERTILITY- ONLY FILL OUT IF APPLICABLE**

Have you been having regular, unprotected intercourse with the goal of becoming pregnant? If so, for how long? \_\_\_\_\_

Have you been medically evaluated by a gynecologist/ obstetrician / reproductive endocrinologist for fertility?

Yes  No If so, have you received any medical diagnosis relating to fertility?

Have you ever experienced or been diagnosed with the following? Please check all that apply:

- Ectopic pregnancy
- Uterine fibroids
- Pelvic adhesions
- Pelvic inflammatory disease
- Uterine or cervical polyps
- Polycystic ovary syndrome
- Chlamydia
- Endometriosis
- Pelvic abnormalities
- Thyroid condition
- Pituitary conditon
- Premature ovarian failure

Have you had any surgeries in the lower abdomen or pelvic area (for any reason)?  Yes  No

If so, please describe: \_\_\_\_\_

Have you had your hormone levels checked by blood test?  Yes  No

If so, what were the results?

FSH (Day 3) \_\_\_\_\_ LH \_\_\_\_\_ TSH \_\_\_\_\_ Estradiol (Day 3) \_\_\_\_\_

Progesterone (7 days past ovulation) \_\_\_\_\_

Have your fallopian tubes been evaluated by hysterosalpingogram?  Yes  No

If so, what were the results? \_\_\_\_\_

Have you tried any of the following to help you time intercourse? Please check all that apply:

- Basal body temperature
- Ovulation predictor
- Checking cervical fluid

Other? \_\_\_\_\_

Have you had any fertility treatments?  Yes  No If so, please check all that apply:

- Clomid
- Intrauterine insemination (IUI)
- In Vitro Fertilization (IVF)
- or other assisted reproductive technology

Have you used any of the following for birth control?

- Birth control pill/patch
- IUD
- Depo-Provera
- Diaphram/Cervical cap
- Other

Has your partner had a sperm analysis?  Yes  No

If so, what were the results?

Volume \_\_\_\_\_ Count \_\_\_\_\_ Motility \_\_\_\_\_ Morphology \_\_\_\_\_

If you have insurance that you would like to check and/or use please fill out the information on our insurance portal on our webpage.

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## Please sign below: Financial Agreements

### **Assignment of Benefits - Allows your insurance company to pay us...**

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Eastgate Acupuncture P.C. medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date

### **Authorization to Release Information - Allows us to submit reports when asked by the insurance companies...**

I hereby authorize Eastgate Acupuncture P.C. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Eastgate Acupuncture P.C. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date

### **Financial Responsibility**

I understand that information provided to me by this office is not a guarantee of payment by my insurance company and that I am responsible for all professional services rendered in the event of non-payment, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date

### **CANCELATION POLICY**

As a courtesy we ask for at least 24 hour notice of cancelation or rescheduling. Same day cancelations or no-shows will be charged at 50%.

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date

# Please sign below: Medical Agreements

## PATIENT ADVISORY TO CONSULT A PHYSICIAN

As a healthcare provider, my primary concern is in your health and well-being. While Oriental Medicine has a great deal to offer as a health care system, it does not replace the abilities of the Western biomedical system.

Therefore, I highly recommend that you consult a physician for any condition or conditions for which you are seeking acupuncture or herbal treatment.

In order to comply with Article 160, Section 8211.1 (b) of the New York State Education Law, I request that you read and sign the following statement:

WE, THE UNDERSIGNED, DO AFFIRM THAT \_\_\_\_\_ (patient's name) HAS BEEN ADVISED TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Licensed Acupuncturist Signature

\_\_\_\_\_  
Date

## NOTICE OF SIDE EFFECTS RELATED TO ACUPUNCTURE

Acupuncture may result in temporary soreness, bruising, redness or puffiness at the site of insertion, muscle twitching, temporary fatigue, light headedness or emotional release. Many of these are positive signs that the acupuncture is working as intended.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## HIPPA NOTICE OF PRIVACY PRACTICES

I HAVE READ AND UNDERSTAND THE HIPPA PRIVACY PRACTICE NOTIFICATION. (See next page)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## **NOTICE OF PRIVACY PRACTICES (HIPPA NOTIFICATION)**

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.

I am required by law to maintain the privacy and confidentiality of your protected health information and to provide you with notice of my legal duties and privacy practices in regard to your protected health information.

### **Disclosure of your Health Care Information**

**Treatment:** Your health care information may be disclosed to other health care professionals within my practice if I am working in tandem with another acupuncturist or assistant for the purpose of treatment, payment, or health care operations.

**Workers' Compensation:** I may disclose your health care information as necessary to comply with State Workers' Compensation Laws.

**Emergencies:** I may disclose your health care information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency, or of your death.

**Public Health:** As required by law, I may disclose your health care information to public health authorities for the purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

**Judicial and Administration Proceedings:** I may disclose your health information in the course of any administrative or judicial proceedings.

**Law Enforcement:** I may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, missing person or material witness, complying with a court order of subpoena, and other law enforcement purposes.

**Deceased Persons:** I may disclose your health information to coroners or medical examiners.

**Organ Donation:** I may disclose your health information to organizations involved in the procuring, banking, or transplanting of organs and tissues.

**Research:** I may disclose your health information to organizations conducting research that has been approved by an institutional Review Board.

**Public Safety:** It may be necessary to disclose your information to appropriate persons in order to prevent or lessen a serious or imminent threat to the health and safety of a particular person or to the general public.

**Specialized Government Agencies:** I may disclose your health information for military, national security, prisoner and government benefits purposes.

**Scheduling and Appointments:** I may call your home or e-mail you to confirm your scheduled appointments. If you are not home, I will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during the recording or message other than the date and time of your appointment.

### **Your Health Information Rights**

-You have the right to request restrictions on certain uses and disclosure of your health information. Please be advised that I am not required to agree to the restrictions that you requested.

-You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

-You have the right to inspect and request a copy of your health information.

-You have the right to request that I amend your protected health information. I am not required to agree to amend your protected health information. If your request is denied, you will be provided with an explanation of my reasons for denial and information about how you can disagree with the denial.

-You have the right to receive an accounting of disclosures of your protected health information made by me.

-You have the right to receive a paper copy of this Notice of Privacy Policy.

### **Changes to the Notice of Privacy Policy**

-I reserve the right to amend this Notice of Privacy Policy at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, I am required by law to comply with this notice. If you have any questions about this notice please ask me.

### **Complaints**

Complaints about your privacy rights can be directed formally to: DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509 HHH Building, Washington D.C. 20201