STILLPOINT ACUPUNCTURE

Transforming lives through the power of Chinese medicine

New Patient Intake

Name:______________________________________ Date of Birth:________________ Today's Date:_________________

Please list the main reason you are here today:	
On a scale of 1-10 (1 = not at all, 10 = severely), how does this complaint interfere with your daily life?	
What seems to help?	What seems to make it worse?
What other therapies have you tried for this complaint?	
Name(s) of any physician or health care practitioner you see or have seen within the past year:	
List all medications, herbs or supplements that you take on a regular basis (use back if necessary):	
List any allergies you have to medications, herbs, or foods:	
List past surgeries and/or hospitalizations:	
Do you have a pacemaker? ☐ Yes ☐ No	Do you have any metal plates or screws in your body? ☐ Yes ☐ No If yes, where?
Do you think you might be pregnant? ☐ Yes ☐ No ☐ Not Sure Are you currently trying to conceive? ☐ Yes ☐ No ☐ Not trying, but also not using birth control If using birth control, what type?	

Family Medical History (please indicate any illnesses in immediate family – parents, children, uncles, aunts, siblings, grandparents)

☐ Allergies/Autoimmune
☐ Arteriosclerosis
☐ Asthma
☐ Addiction
☐ Cancer:_________________
☐ Diabetes
☐ Epilepsy / Seizures
☐ Headaches / Migraine
☐ Heart attack/Disease
☐ High blood pressure
☐ Mental illness
☐ Neurological (Dementia, Parkinson's, MS, etc.)
☐ Obesity
☐ Skin problems
☐ Stroke

Is there anything else we should know about your family?____

Your Past Medical History (please indicate any conditions you have now, you have had in the past, or think might be important)

☐ AIDS/HIV
☐ Addiction
☐ Allergies
☐ Arteriosclerosis
☐ Asthma
☐ Autoimmune disease
☐ Birth trauma (yours)
☐ Cancer:_______________
☐ Childhood illness
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Gout
☐ Heart disease
☐ Hepatitis
☐ Herpes
☐ High blood pressure
☐ Kidney or gallstones
☐ Mental illness
☐ Migraines
☐ Multiple Sclerosis
☐ Pleurisy
☐ Pneumonia
☐ PTSD
☐ Rheumatic Fever
☐ Seizures
☐ Sexual/Physical/Emotional Abuse or Rape
☐ Sexually transmitted infection
☐ Stroke
☐ Tick-related disease
☐ Thyroid disease
☐ Trauma (fall, car accident):____________
☐ Tuberculosis
☐ Ulcers/GERD/Acid Reflux

Is there anything else we should know about your medical history?____

FOR OFFICE USE ONLY	
Initial Diagnosis:	Goal of Treatment Course:
Expected Course of Treatment:	Date of Next Review:
Plan includes Chinese Herbs?	Practitioner Initials?

Symptom Checklist

Name:____ Date:_______________________

Please check any of the following symptoms you experience frequently or have a tendency toward

☐ Fatigue/ Low Energy ☐ Bruise Easily ☐ Tired After Eating ☐ Low Appetite ☐ Strong Appetite ☐ Loose Stools ☐ Constipation ☐ Abdominal Bloating ☐ Heartburn / Reflux ☐ Post Nasal Drip ☐ Nausea / Vomiting ☐ Frequent Hiccups or Belching ☐ Flatulence ☐ Hemorrhoids ☐ Bad Breath ☐ Excessive Vaginal Discharge ☐ Tendency To Worry / Obsess	☐ Frequent Irritability / Frustration ☐ Depression Tendency to Feel Stressed ☐ Frequent Sighing ☐ Abdominal Pain ☐ Pain In Neck and Shoulders ☐ Headaches ☐ Pain Under Ribcage ☐ Floaters ☐ Can't See Well at Night ☐ Red Eyes ☐ Wake Between 1-3am ☐ Trouble Falling Asleep ☐ Dizziness ☐ Tight Muscles ☐ Painful Periods ☐ Irregular Periods ☐ Inability to Cry
☐ Recurrent Colds / Infections ☐ Sinus Problems ☐ Allergies ☐ Sweat Easily ☐ Do Not Sweat ☐ Blood Or Mucus in Stool ☐ Pain In Teeth / Gums ☐ Skin Problems ☐ Shortness Of Breath ☐ People Ask You To Speak Up Often ☐ Feel Sad	☐ Low Back Pain ☐ Frequent Urination ☐ Knee Pain ☐ Low Sex Drive ☐ High Sex Drive ☐ Erectile Dysfunction ☐ Night Sweats ☐ Hot Flashes ☐ Poor Hearing ☐ Ringing in Ear ☐ Wear Socks To Bed ☐ Congenital Abnormalities ☐ Vaginal Dryness
☐ Difficulty Sleeping ☐ Heart Palpitations ☐ Anxiety ☐ Memory Problems ☐ Sores on Tongue ☐ Startle Easily ☐ Laugh Inappropriately	Other Symptoms Not Listed Here:
For Practitioner Use Only	

Consent for Treatment

Name: ____ Phone: (H)_____________________ (C)_____________________

Street:____ City:__________________________ State:________ Zip:_______

Email: ____ Referred by: ____

Gender: ______ Age: ________ Ht: ________ Wt: _______ Birthdate: ____________ Occupation:_____________________

Employer Name/Address: ____

Personal Physician: ____ Date of last physical exam:__________

Emergency contact:____ Phone: _________________________

Phone number(s) preference for scheduling and other questions:____

I, the undersigned, hereby consent to receive acupuncture treatment from the licensed practitioners of Stillpoint Acupuncture.

I am fully aware that the acupuncture needles are sterile and disposable and that no needle used to treat me has ever been used on another person.

I fully understand that there is no stated or implied guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand that complications may result from acupuncture treatment. Among these possible complications are: bruising, fainting, numbness, weakness, nausea, hematoma, infection, burns, pain and discomfort, pneumothorax, and aggravation of present symptoms.

I understand that acupuncture and Chinese medicine is not a substitute for standard Western medicine, that certain health disorders may require allopathic diagnosis and treatment, and that I am free to seek allopathic medical advice and treatment at any time, either in lieu of or concurrently with acupuncture treatment.

I fully realize that I may withdraw from my treatment at any time.

I understand and agree to hold harmless, to indemnify and protect against court action the individual therapist as well as the management of this clinic, in the event of accidental injury on these premises.

Name (please print): ____

Signature: ____ Date: ____________________

Parent or Guardian Signature

I, the parent or guardian of the above named minor, hereby consent to all the above terms and conditions implied in the above document and hereby give permission for my minor child to undergo acupuncture treatments for the purposes and considerations above expressed.

Parent/Guardian Signature: ____ Date: ___________________

Stillpoint Acupuncture embraces equality, diversity and inclusion as crucial elements of healthy people and healthy communities.

STILLPOINT ACUPUNCTURE

Transforming lives through the power of Chinese medicine

Cancellation Policy

• Please help keep our practice working well for everyone by giving 24-hours' notice if you must cancel any appointment.

• If you miss your appointment or cancel with less than 24-hours' notice, you will be charged for the missed appointment.

• We understand that urgent situations arise and urge you to call the office to discuss cancellations caused by illness, injury or other emergency.

• You will often receive a reminder text or email 48 hours before your appointment. These reminders are a courtesy, and not guaranteed. Not receiving a reminder does not excuse a missed appointment.

I have read the above and agree to terms________. (Please initial)

Special Consent for Community Clinic

Name: ____________________________________ D.O.B: ______________ Today's Date: ___________

- I understand that the Stillpoint Acupuncture Clinic is designed to provide lower cost acupuncture in a group setting. These treatments are designed primarily to reduce stress and to alleviate physical and emotional pain. While I may experience significant benefit from the acupuncture I receive here, I do not expect the acupuncturists in the Clinic to be able to comprehensively manage all my health concerns.
- I understand that if I would like more comprehensive treatment of my health, I am free to make a private appointment at Stillpoint Acupuncture (or any other health care office) and pay the regular fees associated with that appointment.
- I understand that because treatments in this clinic are provided in a group setting, there is a possibility that my conversations may be overheard, and I will not hold Stillpoint acupuncture responsible for any breach of confidentiality that occurs because I am talking about personal issues while other people are present in the room. I understand that pen and paper will be provided for me if I wish to communicate something privately to my practitioner.
- I agree not to repeat the private conversations of others that I may inadvertently overhear as a participant in this Clinic.

I understand that the treating practitioner in the Community Clinic may change without notice.

I have read the above and agree to terms________. (Please initial)

HIPPA 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.

At Stillpoint Acupuncture, we make every effort to keep your personal and medical information confidential. We are required by law to maintain the privacy of our patients' Protected Health Information and to provide our patients with notice of our legal duties and privacy practices. The following explains what we do with the information we ask you to provide:

- Your name and contact information (e.g. name, email address and phone number) will be seen by the practitioner, our office staff and Acuity Scheduling in order to schedule appointments and contact you with reminders for your appointments. Our office staff may also send you health related newsletters or information regarding health-related benefits and services.
- Your medical information is kept in a file and accessed by the practitioners in order to make medical decisions and to document your treatments. Your file may also be seen by our office staff in order to a) file the chart, b) contact you regarding scheduling, c) prepare your chart for your next visit, or d) to prepare an herbal formula the practitioner has prescribed.
- Each person who has access to your chart has signed a confidentiality agreement. A copy of this agreement can be made available to you upon request.
- We may periodically access your chart in order to conduct research that helps us improve our care. For example, we may look at all the charts of people with back pain in order to determine how often those treatments are effective.

We will not disclose your Protected Health Information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure, except for the items below:

- Court or administrative ordered subpoena or discovery request
- Law enforcement officials as required by law if we believe you have been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To workers' compensation agencies for workers' compensation benefits determination.
- We may forward information regarding your treatments to your insurance company or Veterans Affairs to arrange payment for services provided to you.
- We will not provide information from your chart to anyone outside our office unless that is specifically requested by you in writing and you may also revoke such written authorization.
- We will not discuss your case with anyone else unless you specifically give us permission to do so. This includes your family members and other medical providers.

STILLPOINT ACUPUNCTURE

Transforming lives through the power of Chinese medicine

Patients' rights regarding Protected Health Information:

- You may request a copy of your Protected Health Information.
- You have the right to request that your Protected Health Information be amended or corrected.
- You have the right to receive an accounting of certain disclosures of your Protected Health Information.

- You have the right to request restrictions on uses and disclosures of your Protected Health Information.
- You have the right to be notified of any breach of your Protected Health Information.
- You have the right to receive confidential communications from Stillpoint Acupuncture by alternative means or at alternative locations.
- You have the right to file a complaint if you feel that your rights have been violated. There will be not retaliation for filing a complaint. Complaints can be filed with our Privacy Officer or with:

Office for Civil Rights
Department of HHS
Jacob Javits Federal Building
26 Federal Plaza – Suite 3313
New York, NY 10278
Phone (212)2643313
Fax (212)2643039

Special note to participants in the acupuncture clinic:
As you know, the clinic setting is less private than our office setting. In order to protect your privacy here, we use check in forms for expressing to your practitioner anything you may not want to be overheard.
Stillpoint Acupuncture is required to abide by the terms of this Notice of Privacy Practices.
Stillpoint Acupuncture retains the right to update the Notice of Privacy Practices and will notify the patients of the update in writing when they next visit the office.

I have read this document and agree with its terms.

Signed:_____________________________________ Effective Date:____________

Would you like a copy of this agreement? ___yes ___no