



FREEPORT ACUPUNCTURE CENTER

NEW PATIENT INTAKE FORM

THANK YOU for taking the time to complete this form thoroughly. Some questions may seem unrelated to your condition but they may affect your diagnosis and treatment. All information is confidential.

Name:	_____	Date:	_____
Address:	_____	(City)	_____ (State) _____ (Zip)
Telephone:	Home: _____	<i>Please indicate your preferred contact phone number (i.e. Home, Work, Cell)</i>	
	Work: _____		
	Cell: _____		
Email:	_____		
Would you like to receive appointment confirmations and reminders via email? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Date of Birth:	_____	Age:	_____ Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Height:	_____	Weight:	_____
Occupation:	_____	How did you hear about me?	_____
Primary Care Physician:	_____		

Mary Beth Hassett, L. Ac., Dipl. O.M. Acupuncture & Chinese Herbal Medicine

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www.freeportacupuncture.com

Principal complaint: _____

What is the diagnosis (if any) by an MD: _____

Birth history (any medical procedures or medications?): _____

Vaccination history (any reactions to vaccines? unusual vaccinations?): _____

Childhood Illnesses (0 – 12) any surgeries, accidents, major events? Please list in chronological order:

Age: _____

Age: _____

Adolescent Illnesses (12 – 18) any surgeries, accidents, major events? Please list in chronological order:

Age: _____

Age: _____

Adult Illnesses any surgeries, accidents, major events? List in chronological order and indicate duration:

Age: _____

Age: _____

Age: _____

Age: _____

Family history: Please note all major illnesses in your immediate family (parents, grandparents, siblings) such as diabetes, heart disease, hypertension, neurological, blood, psychological, or orthopedic disorders:

Are you taking any medications? Please list all, even if taken infrequently, as well as medications taken in the past, and include birth control:



Current & Past Medical History

Please check all that apply currently or in the past: Abnormal bleeding/bruising AIDS/HIV+
Alcoholism/drug abuse Anorexia/bulimia Asthma/emphysema Blood donor
Cancer Chronic fatigue syndrome Chronic sinus infections Diabetes
Dieting/weight loss programs Fibromyalgia/chronic pain Gallbladder problems
Heart disease Hepatitis A / B / C Herpes High cholesterol Hypo/Hyperthyroidism
Hypoglycemia Lyme disease Mononucleosis/EBV Multiple sclerosis
Pacemaker Polio Rheumatic fever Sciatica/nerve pain Seizures
Shingles Steroid therapy Stroke Tuberculosis
Any additional information you should tell me about? _____



Respiratory, Eyes, Ears, Nose, Throat & Head

Do you smoke? Yes No If yes, _____ per day, for _____ years.
Please check all that apply: frequent colds chronic runny nose chronic cough cough
blood pain inhaling shortness of breath on exertion at rest asthma
nose bleeds painful/red eyes poor vision see spots dizziness cold sores
bleeding gums TMJ/teeth grinding dry mouth frequent sore throats ear pain
ringing in ears popping ears peculiar taste in mouth bad breath frequent
headaches or migraines describe: _____



Skin & Hair

Please check all that apply: dry skin skin rashes itching
acne eczema hives hair loss premature graying
Other: _____



Gastrointestinal

Please check all that apply: belching nausea vomiting vomiting blood
bloating acid reflux heartburn hernia indigestion ulcers
severe stomach pains other: _____

How often do you have a bowel movement? _____ per day / per week (*circle one*)

Please check all that apply: constipation diarrhea gas burning itchiness
hemorrhoids use laxatives undigested food in stool loose stool
hard/dry stool blood in stool painful bowel movement other: _____



Emotions & Sleep

How do you feel emotionally? _____

Do you have: panic attacks depression anxiety bad temper nervousness
fear attacks poor memory difficulty concentrating other _____

How do you feel about your personal relationship(s)? _____

Your work? _____ How/where do you hold your stress? _____

How many hours do you generally sleep at night? _____ From: _____ to _____

Do you have difficulty with falling asleep staying asleep dream disturbed sleep
waking sweat at night

How many times during the night do you get up to urinate? _____

Do you feel rested when you wake? _____



Muscles, Joints & Bones

Do you have (*please circle*): Pain Tightness Stiffness Where: _____

The pain is: sharp aching numb deep pain burning dull tingling

pain is worse/better with heat pain is worse/better with cold

pain is worse/better with pressure pain is worse in the a.m. p.m. Other: _____

Please check all that apply: I have swollen joints arthritis/joint pain tendonitis

bone pain rheumatism muscle cramping muscle pain repetitive strain injury



Cardiovascular

Have you been diagnosed with heart trouble? _____

Please check all that apply: chest pain palpitations varicose veins

poor circulation high / low blood pressure irregular heart beat cold hands/feet



Urinary

How many times per day do you urinate? _____ Color: clear yellow dark yellow/orange

Please check all that apply: trouble starting stream frequent urination incontinence

pain burning urinary tract/bladder infections blood in urine dribbling when

sneezing kidney stones other: _____



Women

(if male, please skip to questions about **Men** below)

Gynecologist: _____ Date of last PAP: _____

Did your mother take DES? yes no

Age at onset of menses _____ # of days per cycle _____ # of days of flow _____

Do you use pads? Yes No Do you use tampons? Yes No

How is the blood flow? Bright red dark watery thick/sticky

Please check all that apply: irregular menstruation heavy flow light flow clots

Vaginal itching/burning spotting between periods discomfort/pain before period

Discomfort/pain during period breast distention around cycle yeast infection

Herpes Other sexually transmitted disease

Please describe any PMS symptoms: _____

Vaginal discharge? Yes No Color: _____

of pregnancies: _____ # of deliveries: _____ # of miscarriages: _____ # of abortions: _____

Methods of birth control used: _____ Complications? _____

Is fertility an issue? Yes No Tests/drugs/other treatments? _____

Pain related to intercourse? Yes No Changes in sexual energy? Yes No

Relationship difficulties related to intercourse? Yes No

History of sexual abuse or assault? Yes No

Age of cessation _____ Cause: _____ Are you currently going through menopause?

Yes No

If yes, have you had a Bone Density Test? Yes No

Are you on hormone replacement therapy? Yes No

Unusual lactation or breast discharge? Yes No Fibroids? Yes No

Breast tenderness? Yes No If yes, when: _____

Do you do a monthly self-exam? Yes No History of breast cancer in family? Yes No

Have you had a mammogram? Yes No If yes, when: _____



Men

Please check all that apply: prostatitis impotence penis blood/mucous discharge

Other: _____



Energy & Exercise

Do you fatigue easily? Yes No

What time of day is your energy highest? _____ Lowest? _____

What kind of exercise do you do? _____
_____ times per week

Do you feel better with exercise? ___ Worse? ___ Explain: _____



Diet & Food

How is your appetite? _____ Please list any food cravings: _____

Please list any food intolerances: _____

Please indicate which two (2) tastes you prefer:

Sweet ___ Sour ___ Bitter ___ Salty ___ Spicy ___

Write a few of your typical meals and beverages. Include approximate times.

TIME

MEALS

BEVERAGES

_____ Breakfast _____

_____ Lunch _____

_____ Snacks _____

_____ Dinner _____

of 8 oz. Glasses of water per day: _____



FREEPORT ACUPUNCTURE CENTER

Acupuncture Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below name licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, and nutritional counseling.

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. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately*.

I have been informed that I have a right to refuse any form of treatment. 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. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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.

Initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above.

Initials

I agree to pay for any missed or forgotten appointments without 24-hour notice of cancellation.

Initials

I agree to pay all charges incurred for services rendered, over and above insurance coverage.

Initials

Patient's Name

Patient's Signature

Date Signed

Are you Pregnant?

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.

Name of Patient _____

Patient's Representative _____

Relationship or Authority of Patient _____

Witness _____



Notice of Privacy Practices

This notice and the accompanying Practices Regarding Disclosure of Patient Health Information, describes how health information about you may be used and disclosed, and how you can get access to your health information. Please review this information carefully.

Understanding your health record A record is made each time you visit Mary Beth Hassett, L. Ac., at Freeport Acupuncture Center. Your symptoms, the practitioner’s judgments, and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

Understanding your health information rights Your health record is the physical property of Mary Beth Hassett, L. Ac., but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record, and to request that appropriate amendments be made to you health record. You have the right to request restriction on certain uses and disclosure of your information, to authorize disclosure of the record to others, and to be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information. Should we need to contact you, you have the right to request communication by alternate means or to alternate locations.

Our responsibility Mary Beth Hassett, L. Ac., is required to maintain the privacy of your health information and to provide you with this notice of my privacy practices. I am required to follow the terms of this notice and to notify you if I am unable to grant your request to disclose or restrict disclosure of your health information to others. Mary Beth Hassett, L. Ac., reserves the right to change practices and promises and to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, I agree not to use or disclose your health information without your authorization.

TO RECEIVE ADDITIONAL INFORMATION OR REPORT A PROBLEM, you may contact Freeport Acupuncture Center. If you believe your privacy rights have been violated, you have the right to file a complaint with us and/or the U.S. Secretary of Health and Human Services with no fear of retaliation by this office.

I, _____, have received a copy of this Notice of Privacy Practices and the accompanying Practices Regarding Disclosure of Patient Health Information. I understand my health information will be used and disclosed consistent with these Notices.

Signature of patient or representative: _____ Date: _____

Print patient name: _____ Patient Date of Birth: _____

Practices Regarding Disclosure of Patient Health Information

Your health information will be routinely used for treatment, payment, and quality-monitoring, and your consent, or the opportunity to agree or object, is not required in these instances:

Treatment Information obtained by me at Freeport Acupuncture Center, will be entered in your record and used to plan the course of treatment. Your health information may be shared with others involved in your care or providing consultation about your treatment. Your practitioner's own expectations and those of others involved in your care may also be recorded.

Payment Your record may be used to receive payment for services rendered by Mary Beth Hassett, L. Ac., or a superbill may be provided to you with accompanying documentation that identifies you, your diagnosis and/or my impressions, and procedures performed.

Quality Monitoring Mary Beth Hassett, L. Ac., may use your health information to assess the care you received and compare your treatment outcome to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

In addition, the following disclosures are required by law and do not require your consent:

Food and Drug Administration (FDA) This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.

Workers' Compensation This office will release information to the extent authorized by law in matters of worker's compensation.

Public Health This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This office is further required by law to report communicable disease, injury, or disability.

Law Enforcement Your health information will be disclosed in response to a valid subpoena for law enforcement purposes, as required under state or federal law. In the event that we believe in good faith that one or more patients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards, provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys.

It is the practice of Mary Beth Hassett, L. Ac., to consider the following as routine uses and disclosures for which specific authorization will not be requested.

Business Associates Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.

Communications with Family Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being.

(Please retain this page for your records)

THANK YOU