



NEW PATIENT (CHILD) INTAKE FORM
Up to Age 13

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: _____
Parent(s): _____	
Address: _____	
	(City) (State) (Zip)
Telephone:	Home: _____
	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"/>
# of Siblings: _____	Birth Order: _____ How did you hear about me? _____

Present health concerns: _____

How long has the child had these: _____

What treatment(s) has the child received/when: _____

Current medications and/or supplements: _____

Traumas, Injuries, Surgeries, Scars (please list location on your body and date of trauma):

Allergies: _____

Has the child had acupuncture before? _____ When/where: _____

Please circle all that apply:



Frequent colds
Headaches
Sinus infections
Nasal discharge
Coughs
Sore throats
Fever
Convulsions
Pneumonia

Ear infections
Eye problems
Nosebleeds
Flushed cheeks
Thirst
Bladder/kidney infections
Thrush, vaginitis, severe diaper rash
Muscle cramps
Blank or staring spells
Sweating issues

Sleep



Sleeps well
Difficulty falling asleep
Goes to bed late
Awakens regularly

Sleeps with parent(s)
Disturbed dreams
Night urination

Moods



Emotionally stable
Moody
Fears/phobias/panic attacks
Recent family divorce
 move
 change of school
Severe emotional trauma

Hyperactive
Withdrawn
Short attention span
Irritable
Pronounced mood changes
Abuse

Diet and Appetite



Good appetite
Very picky eater
Specific preferences and dislikes

Poor eater
Only eats sweets



Digestion and Bowel Movements

Stomachaches

Gas

Irregular bowel movements

Constipation

Belching

Bloating

Loose stools

Anal itching



Skin

Itching

Rashes

Bumpy skin

Cradle cap



Birth History

Explain any complications: _____

Mother's illness during gestation: _____

Birth weight: _____

Normal development?: _____



Family Health History

Major health problems of close family members: _____

Age and cause of death of close family members: _____

Do any family members have:

Allergies

Asthma

Alcohol/drug abuse



Childhood Diseases

Hospitalizations/surgeries: _____

Accidents: _____

Broken bones: _____

Scars: _____

Allergies: _____

Any reaction to vaccinations: _____



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 your 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