

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 my office? _____

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 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
- Mucus 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

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

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Grief & Loss	<input type="checkbox"/> Over excitement (mania)
<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Sadness	<input type="checkbox"/> Lack of fear (recklessness)
<input type="checkbox"/> Depression	<input type="checkbox"/> Anger	<input type="checkbox"/> Lack of anger
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Frustration	<input type="checkbox"/> Lack of sadness
<input type="checkbox"/> Seasonal Affective Disorder	<input type="checkbox"/> Fear &/or Phobias	<input type="checkbox"/> Lack of emotion
<input type="checkbox"/> Phobias	<input type="checkbox"/> Worry	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____		

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

<input type="checkbox"/> Allergies	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Other (please explain) _____
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Cancer	
<input type="checkbox"/> Seizures	

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, Lic. Ac., Dipl. OM

Natural Treatments for Pain Management, Women's Health, and other Chronic Health Concerns
174 Concord St., Ste. 250, Peterborough, NH 03458 603-924-6624 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, Lic Ac., Dipl. OM.

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.**

We accept Cigna (select 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, Lic. Ac., Dipl. OM 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, Lic. Ac., Dipl. OM the nature and purpose of TCM. I understand that results are not guaranteed.

I do not expect Julie Permut, Lic. Ac., Dipl. OM 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, Lic. Ac., Dipl. OM 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, Lic. Ac., Dipl. OM

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, Lic. Ac., Dipl. OM
New England Family Acupuncture
174 Concord Street, Suite 250
603-924-6624
jpermut@nhacupuncture.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