

Christina Wolf Acupuncture – New Patient Forms
(Please fill out and sign before your first appointment)

Name: _____ Date of Birth: _____
 Address: _____ City, State, Zip: _____
 Telephone #s Home: _____ Work: _____
 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

Cardiovascular

- ___ Pain in chest

Appetite/Thirst

- ___ Increased appetite

- ___ Cough
- ___ Chronic bronchitis
- ___ Asthma
- ___ Emphysema
- ___ Lung cancer

- ___ Tightness in chest
- ___ Heart palpitations
- ___ Irregular heart rhythm
- ___ High blood pressure
- ___ High cholesterol
- ___ Hardening of arteries

- ___ 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
- ___ Mucous 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

- Anxiety
- Panic Attacks
- Depression
- Bipolar Disorder
- Seasonal Affective Disorder
- Phobias
- Other _____

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

- Grief & Loss
- Sadness
- Anger
- Frustration
- Fear &/or Phobias
- Worry
- Over excitement (mania)
- Lack of fear (recklessness)
- Lack of anger
- Lack of sadness
- Lack of emotion
- Other _____

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

- Allergies
- Heart Disease
- Diabetes
- Cancer
- Seizures
- Stroke
- Other (please explain)

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:

Christina Wolf Acupuncture

Natural Treatments for Pain Management, Women's Health and Fertility
174 Concord St., Ste. 250, Peterborough, NH 03458 603-924-6624 www.nhacupuncture.com
25 Nashua Rd., Ste. F2, Londonderry, NH 03053 603-434-3456 www.healinghandsnh.com

Our Policies & Fees

Payment & Insurance Coverage:

Payment is due in full at the time of your visit. For your convenience we accept cash, check, Visa, Mastercard, Discover and American Express.

Acupuncture may be covered by your insurance. If you believe your insurance will cover treatment, we are happy to verify your coverage for you, either before or after your first acupuncture session. **Important: until we can verify your coverage, 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 full amount owed.**

No-Shows and Late Cancellations:

When we make an appointment, I am reserving time just for you. When you give me less than 24 hours notice of cancellation, I am unable to offer your time to another patient who may be waiting for an appointment. As you may already know, insurance companies do not reimburse for cancelled sessions. **Therefore, no-shows and late cancellations (less than 24 hours notice) will be billed to you at \$35.00. Late cancellations due to bad weather or emergency are understandable, in those cases the cancellation fee will be waived.**

Office Closure Due to Bad Weather:

Weather in New England is unpredictable. In the event of a winter storm or very heavy rains, please call and listen to my outgoing voicemail message to find out if the office will be open. If I have to close the office or cancel your appointment due to bad weather, I will call you as soon as I can to reschedule your appointment.

Gift Certificates:

Gift certificate may only be redeemed for services provided by Christina Wolf, Lic Ac. **Cash refunds will not be given for any gift certificate.**

Rates:

Initial Visit	\$85 with 20% discount (offered to patients paying out-of-pocket) \$80 with 25% discount (offered to patients with certain insurance plans*)
Follow-Up Visit	\$70 with 20% discount \$66 with 25% discount
2 nd Follow-Up Visit in one week	\$35

**Check with your insurance provider to find out if a 25% discount is offered for alternative medicine.*

We accept any insurance that covers acupuncture – please check with your insurer to find out if acupuncture is included in your benefits. Co-payments and co-insurance vary by insurer and are always on the day of your visit.

The above 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 and fees.

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 Christina Wolf, 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 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 Christina Wolf, Lic. Ac. is certified in Clean Needle Technique and uses only pre-sterilized, one-use, disposable needles.

I have had an opportunity to discuss with Christina Wolf, Lic. Ac. the nature and purpose of TCM. I understand that results are not guaranteed.

I do not expect Christina Wolf, Lic. Ac. 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 Christina Wolf, Lic. Ac. 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. 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 Christina Wolf, Lic. Ac.

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 Notice

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 me about your health history and symptoms, what signs I observe in your pulse and tongue, any copies of tests you give me (blood tests, MRI or x-ray reports, doctor's reports, etc.) and details about the treatments I give you (my opinions about your case, acupuncture points and techniques used, herbal medicines prescribed, referrals made to other kinds of practitioners).

I 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 I send copies of my diagnosis, treatment plan and notes about each treatment.

Your Rights and My Responsibilities:

- You have the right to see and get a copy of your healthcare records, and you have the right to ask me to make changes to them if you find a mistake. If you ask for copies of your healthcare records, I must give them to you within 30 days. I 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 me 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 me not to use or share your medical information in certain ways. I will make every effort to do what you ask, but when I cannot, I must let you know in writing.
- You have the right to ask me 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 my responsibility to protect your healthcare records and abide by the terms of this notice.
- It is my responsibility to train my assistants and employees to protect your healthcare records and abide by the terms of this notice.

If you have further questions about this notice, please contact:

Christina Wolf, Lic. Ac.
Christina Wolf Acupuncture
174 Concord Street, Suite 250
603-924-6624
cjwolf@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 Christina Wolf 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