

Significant Trauma (physical or emotional)

Birth History (prolonged labor, forceps delivery, complications, etc.)

Surgeries (please include date of procedure)

Allergies (chemical, environmental, food, drugs, etc.)

Medications (names & dosages) Please attach an additional page if necessary.

Vitamins/Supplements/Herbs

Exercise

Days per week	Length of workout	Type of Activity
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Diet

Meals per day	Snacks	Caffeinated Drinks	Alcohol per week
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What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days etc.)

Personal History

Please check any conditions or symptoms you have now.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Elevated Blood Cholesterol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> Diverticulitis/IBS |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Raynaud's Disease |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Imbalance | <input type="checkbox"/> Respiratory Allergies |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Chronic Pain Condition | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Gastritis/Pancreatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Infertility | <input type="checkbox"/> Emphysema |

Family Medical History

Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- | | | | |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Diabetes ____ | <input type="checkbox"/> Seizures ____ | <input type="checkbox"/> Heart Disease ____ | <input type="checkbox"/> Stroke ____ |
| <input type="checkbox"/> High Blood Pressure ____ | <input type="checkbox"/> Allergies ____ | <input type="checkbox"/> Cancer ____ | <input type="checkbox"/> Asthma ____ |
| <input type="checkbox"/> Other _____ | | | |

Please **check** if you have had any of these items listed below in the last **year**

Put a **star** on the box if you had this in the past but do not any longer.

General

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sweats Easily | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Bleed/Bruise easily | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Peculiar tastes/smells | <input type="checkbox"/> Dental/gum problems |
| <input type="checkbox"/> Muscle weakness/fatigue | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Strong thirst (hot or cold drinks) | |

Skin and Hair

- | | | | |
|---|--------------------------------------|--|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Face flushing |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Warts | <input type="checkbox"/> Fungal Infection | <input type="checkbox"/> Weak or ridged nails |

Head, Eyes, Ears, Nose and Throat

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Migraines | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night Blindness |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Jaw clicks/locks | <input type="checkbox"/> Headaches |

Cardiovascular

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Varicose/spider veins | <input type="checkbox"/> Pressure in chest | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Spontaneous sweating | <input type="checkbox"/> Dizziness | |

Respiratory

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight sensation in chest | <input type="checkbox"/> Difficult inhale/exhale |
| <input type="checkbox"/> Difficulty breathing when lying down | | <input type="checkbox"/> Production of phlegm... what color? _____ | |

Gastrointestinal

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bloating/Edema | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Loose stools (>2 per day) | <input type="checkbox"/> Abdominal pain/cramps |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid reflux/GERD | <input type="checkbox"/> Hernia | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Significant thirst | <input type="checkbox"/> IBS/Crohn's Disease | |

Genito-Urinary

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Scanty flow | <input type="checkbox"/> Copious flow |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Sores on genitals | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Burning urination |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Pain in testicles | <input type="checkbox"/> Herpes | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Night urination... What time? _____ How often? _____ | | | <input type="checkbox"/> Excessive libido |

Gynecological/Reproductive

- | | | |
|--|---|--|
| <input type="checkbox"/> Difficult/Painful intercourse | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Age of first menses _____ |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Date of last menses _____ |
| <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Date of last PAP/Pelvic _____ |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Fibrocystic breast tissue | <input type="checkbox"/> Number of pregnancies _____ |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Polycystic Ovarian Disease | <input type="checkbox"/> Number of ectopic pregnancies _____ |
| <input type="checkbox"/> Irregular menstruation | <input type="checkbox"/> PMS | <input type="checkbox"/> Number of live births _____ |
| | <input type="checkbox"/> Painful menstruation | <input type="checkbox"/> Number of miscarriages _____ |
| | | <input type="checkbox"/> Number of abortions _____ |

Do you practice birth control? _____

What type? _____ How long? _____

Musculoskeletal

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Back pain Low___ Middle___ Upper___ | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Rotator Cuff | |
| <input type="checkbox"/> Soreness/weakness in lower body (back, knee, hip, ankle, foot) | | | |

Neuropsychological

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety/Panic attacks | <input type="checkbox"/> Bad temper/irritable | <input type="checkbox"/> Easily susceptible to stress | <input type="checkbox"/> Seasonal Affective Disorder |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Manic Depression | |

Have you ever been treated for emotional problems?

Yes No

Have you ever considered or attempted suicide?

Yes No

Have you ever been treated for substance abuse?

Yes No

Comments Please inform me of any other problems you would like to discuss.

Acupuncture Whole Health

182 Rockingham Rd. #8, Londonderry, NH 03053

603.432.777

www.acupuncturewholehealth.com

INFORMED CONSENT TO TREATMENT

I, the undersigned hereby authorize Acupuncture Whole Health’s acupuncturists licensed in the State of New Hampshire to perform Chinese Medicine treatments which may include acupuncture, electrical stimulation, moxibustion, cupping, Gua Sha, bleeding techniques, herbal therapy, or dietary and lifestyle recommendations. This authority shall extend to remedying any unforeseen conditions or reactions to treatment(s). I recognize the potential risks and benefits of these procedures as described below:

- 1. Acupuncture treatments consist of the insertion of slender sterilized, disposable, one-time use needles into acupuncture points on the body. The needles may be retained in the skin for up to 40 minutes during which time you may experience tingling, pressure, heat, a traveling sensation, or a mild fullness in the insertion areas.
2. Acupuncture treatments may consist of the use of heat supplied by an infrared heat source or by the burning of the herb Artemisia vulgaris, commonly known as mugwort. The process of burning mugwort is called “moxabustion”. Methods of moxabustion will be discussed with you in detail prior to treatment.
3. It may be recommended to provide electrical stimulation to the acupuncture needles. This is done by attaching wires from a small battery-operated stimulator to the heads of the acupuncture needles. A slight vibratory, pulsing, or tapping sensation may be felt as a result of this technique. I will notify my acupuncturist should I have a heart monitor or pacemaker so that my practitioner can avoid using electro stimulation during treatment.
4. HERBS: I understand that some uncommon but possible side effects of Chinese herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must follow the dosage and directions of the acupuncturist, and I will stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.
5. Cupping and Gua Sha are Chinese techniques used to release muscle tension. These procedures produce a deep redness of the skin that may remain visible for up to 2 weeks. This redness of the skin is an indication of increased blood circulation in the treated areas. Some tenderness of the treated areas may be felt for several hours following the treatment. This treatment method does not result in permanent markings to the skin.
6. PREGNANCY: I will notify my acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid using points and herbs that are contraindicated during pregnancy.
7. POTENTIAL BENEFITS: I understand that I may experience relief of symptoms, improved sense of wellbeing, reduced stress and an overall balance of bodily energies which may lead to prevention or elimination of main complaints.
8. POTENTIAL RISKS: I understand that there are uncommon but possible side effects of acupuncture treatment that may include the following: lightheadedness, nausea, minor pain or soreness in the treatment areas that may last up to a few days, temporary bruising / swelling, sensations of heat / cold / tingling or numbness, skin irritation or slight bleeding at needle site, generalized fatigue, temporary aggravation of symptoms. Very rare side effects include the following: fainting, infection at the needle site, pneumothorax, broken needles.

I agree to contact my practitioner immediately if I experience any problem which I associate with the treatments listed above and will seek immediate help from a physician / hospital if I experience a medical emergency. During the course of treatment, I agree to inform my acupuncturist of all health issues and medication changes.

I have read all the information detailed in the informed consent to treatment and I have discussed all questions related to treatment with the attending practitioner. I understand the nature of the treatment and I have been informed that I have the right to refuse any form of treatment. I understand that no guarantee can be made concerning the results of my treatment.

Print Name _____ Signature of Patient _____

(or Person Authorized to Consent) _____ Date _____

CONSENT TO TREAT A MINOR CHILD

I authorize Acupuncture Whole Health to administer Acupuncture and Oriental Medicine as deemed necessary to

_____ (name) who is my _____ (relationship).

Adult’s Signature _____ Date _____



Acupuncture Whole Health

182 Rockingham Road #8
Londonderry, NH 03053
603-432-7777

Payment Policy

Payment is expected at the time of your visit. *We cannot accept payment for treatments ahead of the date of your visit.* We accept cash, checks, Visa & Mastercard. There will be a **\$20 fee** for each **returned check**.

Fee Structure:

All services are administered in private treatment rooms.

First Acupuncture Treatment (1.5 hours)	\$75
Acupuncture Treatment (1 hour)	\$55
Second Acupuncture Treatment in 1 week	\$45
One-Sided Acupuncture Treatment (40-50 minutes)	\$45

INSURANCE: We are an in-network Harvard Pilgrim provider and are able to bill them directly for acupuncture services covered under certain plans.

Please check with your health insurance company for information regarding acupuncture coverage under your plan. We will provide you with a statement you can submit for reimbursement if we are an out-of-network provider. Statements are also provided for flex-spending account reimbursement.

CANCELLATION POLICY: In consideration of others who may be on a waiting list for appointments, we ask that you give us at least 24 hours notice in advance of an appointment that will not be kept.

All appointments that are **canceled with less than 24 hours notice, or are missed altogether without notifying my office**, will be charged a **\$25.00 fee** payable at the next visit.

We recognize that emergencies happen, and would be happy to consider these on an individual basis, of course.

I agree to the above policy:

Print name _____

Signature _____ Date _____



Acupuncture Whole Health

182 Rockingham Road #8

Londonderry, NH 03053

603-432-7777

Notice of Privacy Practices

This notice 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 our office. Your symptoms, our 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 to 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 our physical property, 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 restrictions on certain uses and disclosures of your information, to authorize disclosure of the record to others, and 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 Responsibilities: We are required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We are required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. We reserve the right to change our practices and promise to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, we agree not to use or disclose your health information without your authorization.

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

I understand that Acupuncture Whole Health's acupuncturists may record medical and other information concerning my treatment. I understand my records will be kept confidential and will not be released without my written consent, except when bound by law to do so. I understand that Acupuncture Whole Health abides by state and federal regulations regarding patient privacy and I know that I can ask for more information regarding these regulations. I understand that I have the right to request to receive a copy of my medical records as maintained by Acupuncture Whole Health.

Print Name: _____

Signature: _____ Date _____
