North Shore Acupuncture & Wellness

65 Newburyport Turnpike Newbury, MA 01951 || (978) 494 - 6998

First Name:	Last Name:	
Address:		
City:	State:	Zip:
Phone:		
Email:		
Date of birth:	Age:	Pronouns: She/Her, He/Him, They/Them
Marital status:		
Emergency contact:	Relationship:	Phone:
Referred by:		

Please describe the main reason for your visit today:

_____

_____

_____

Please indicate if you have any of the following:

- ❑ Cardiac pacemaker
- ❑ Seizure disorder
- ❑ Bleeding disorder/ Blood thinners
- ❑ Fainting disorders
- ❑ High blood pressure
- ❑ Believe you are or may be pregnant
- ❑ HIV/AIDS positive
- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ Other:_____

List all major childhood and adult illnesses:

_____

_____

_____

Have you had any surgeries, major accidents or injuries, please explain:

_____

_____

_____

List any major disease or illness in your immediate family and indicate family member:

List all medications or supplements, including herbs and vitamins you are currently taking:

Occupation:

Do you have a regular exercise program? _____ Please describe.

Are you on a restricted diet? _____ What kind?

How much sugar/dessert do you eat per week?

How much dairy do you eat per week?

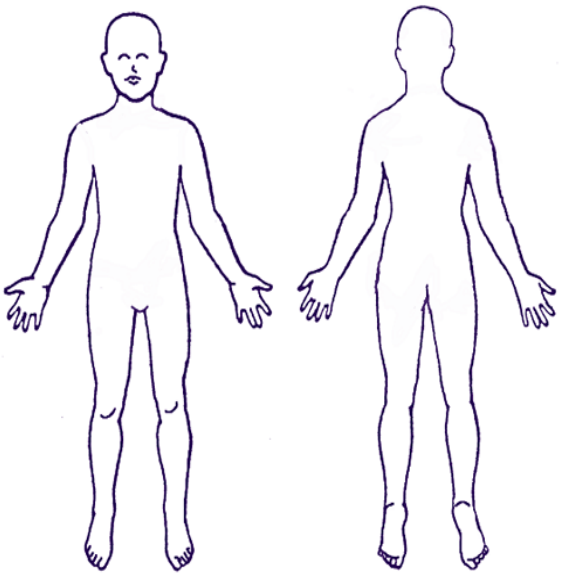
How many packs of cigarettes do you smoke per week?

How much coffee, tea, or cola do you drink per week?

How much alcohol do you drink per week? _____

Do you do any drugs? How much per week?

Indicate painful or distressed areas. Please rate pain on a scale of 1 (No pain) to 10 (Worst pain).



Please check all symptoms that pertain to you at the current time.

□ Cold hands/feet
□ Fatigue
□ Feverish in the afternoon or flushes
□ Heat sensation in hands, feet, chest
□ Night sweats
□ Catch colds easily
□ Sweats easily during daytime
□ Dizziness
□ See floating black spots

□ Cough
□ Sinus congestion
□ Dry mouth, throat, nose, or skin
□ Allergies seasonal or food
□ Chills and fever
□ Stiff neck/shoulders
□ Sore throat
□ Difficult breathing

□ Palpitations
□ Sore on tongue
□ Restlessness
□ Anxiety
□ Chest pain
□ Insomnia

□ Burning sensation after eating
□ Bad breath
□ Large appetite
□ Mouth, canker or cold sores
□ Bleeding, swollen or painful gums
□ Heartburn/belching
□ Stomach pain
□ Vomiting/nausea

□ Low appetite
□ Loose stools
□ Constipation
□ Abdominal bloating or gas after eating
□ Feeling tired after eating
□ Prolapsed organs (previously diagnosed)
□ Bruises easily
□ General feeling of heaviness in body
□ Mental heaviness or fogginess
□ Swollen hands/feet

□ Diarrhea alternating with constipation
□ Tight/suffocating feeling in chest
□ Bitter taste in mouth
□ Blood shot eyes/dry eyes
□ Anger easily
□ Skin rashes
□ Headache

□ Numbness of hands and feet
□ Muscle spasms, twitching, cramping
□ Seizures/convulsions
□ Sore, cold or weak knees
□ Low back pain
□ Frequent urination
□ Get up more than once a night to urinate
□ Lack of bladder control
□ Memory problems
□ Hair loss
□ Ringing in ears

Urine is:

□ Normal color
□ Dark yellow
□ Cloudy
□ Bad odor
□ Burning
□ Difficult
□ Clear
□ Reddish
□ Scanty
□ Painful
□ Urgent

Women only:

Are you pregnant now?
□ Yes □ No

Number of children:_____

Number of pregnancies:_____

Age of first period:_____

Age of menopause if applicable:_____

Is your menses cycle regular?
□ Yes □ No

a. Average number of days in flow:____

b. The flow is:
□ Normal □ Heavy □ Light

c. The color is:
□ red □ dark □ purple
□ light brown □ brown

d. Do you have the following menstruation related symptoms?

□ Blood clots
□ Cramps
□ Nausea
□ Breast distension
□ PMS
□ Bleeding between periods
□ Heavy vaginal discharge between periods

e. Birth control:_____

Men Only:

□ Discharge
□ Pain or swelling of testicles
□ Ejaculatory problems
□ Impotence/erectile dysfunction

Signature _____
Date_____

Office Policies

Please read through the office policies carefully. If you need clarification or would like to discuss any concerns you may have regarding policies, please do so before you begin treatment.

Appointments
I encourage you to schedule appointments in advance to ensure you receive and retain the time slot you most desire. If you have scheduled appointments in advance and wish to make changes, it is your responsibility to cancel existing appointments. If you receive my voicemail, kindly leave a message with your name and number where you can be reached and I will call you back promptly.

No Show/Cancellation Policy
Your missed appointment is a missed opportunity to extend a visit to someone else in need. I request a minimum of 24 hours notice to cancel an appointment. If you have missed or rescheduled an appointment with less than 24 hours notice, you will be responsible for the 50% charge of the customary office visit fee.

Late Arrivals
I understand occasional unforeseen circumstances arise which may prevent you from being on time to a scheduled appointment. I unfortunately have time constraints that do not allow for patients being more than 20 minutes late. If you find that you are running late, please call the office to avoid making an unnecessary trip. This will be considered as a late cancellation and subject to the above policy. *If possible, I will make every effort to accommodate your circumstances.*

Payment
Payment is due at the time services are rendered. If your insurance covers your acupuncture treatments you will be responsible for the initial fees until your billing goes through, at which point you will be reimbursed for these fees.
Checks, credit cards and cash are acceptable forms of payment.
If a check is returned, a fee of $25.00 will be applied to your account.

Insurance Billing
I will work to the best of my ability to submit billing to insurance companies for eligible patient's. You will be responsible for any balance not paid by insurance.
By signing below you agree that North Shore Acupuncture & Wellness may release the necessary medical information and other information required for processing health insurance claims when applicable.
By signing below you agree to authorize direct payment of medical benifits to North Shore Acupuncture & Wellness for acupuncture services provided.
Payment for deductibles, if not met, is the responsibility of the patient as well as any copayment or remaining balance after insurance payment. I participate with many insurance plans that may allow nominal out of pocket expense. Your copay is due at the time of service. You are also responsible for portions of your bill that exceed your insurance limits.

By signing below I acknowledge and accept the office policies of North Shore Acupuncture & Wellness, as described above.

If you have questions or concerns, please feel free to call (978) 494-6998.

Signature _____
Date_____

Notice of Privacy Practices

Commitment to Your Privacy

I am dedicated to maintaining the privacy of your medical information. In conducting business, I will create records regarding you and the treatment and services I provide to you. These records are my property. However, I am required by law to:

- Maintain the confidentiality of your medical information
- Provide you with this notice of our legal duties and privacy practices concerning your medical information.
- Follow the terms of our notice of privacy in effect at this time.

How I May Use and Disclose Your Medical Information

The following categories describe the different ways in which I may use and disclose your medical information:

Treatment: I will use and disclose your medical information to provide, coordinate, or manage your health care and any related services.

• Payment: Your medical information will be used in order to bill and collect payment for services and items you may receive from us.

• Appointment Reminders: I may use and disclose your medical information to remind you that you have an appointment.

• Release of Information to Family / Friends: I may release your medical information to a family member or friend involved in your care, or assists in taking care of you.

• Required by Law: I will use, provide or disclose your medical information when required by applicable law.

• Workers' Compensation: In a workers' compensation case, your medical information may be disclosed by my practice as authorized to comply with workers' compensation laws and other similar legally established programs.

Rights Regarding Your Medical Information

You have the following right regarding the medical information we maintain about you:

Requesting Restrictions: You have the right to request a restriction in my use or disclosure of your medical iinformation for treatment, payment or health care operations. Additionally, you have the right to request that I restrict disclosure of your medical information to individuals involved in your care or the payment for your care, such as family members and friends. I am not required to agree to your request. However, if I do agree, I ambound by our agreement except when other wise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in my use or disclosure of your medical information, you must make your request in writing to me. Your request must describe in clear and concise fashion:

1. the information you wish restricted;
2. whether you are requesting to limit my practice's use disclosure or both; and
3. to whom you want the limits to apply.

• Right to Provide an Authorization for Other Uses and Disclosures: I will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to me regarding the use and disclosure of your medical information may be revoked at any time in writing. After you revoke your authorization I will no longer use or disclose your medical information for the reason described in authorization.

By signing below, you are acknowledging receipt of the "Notice of Privacy Practices" of North Shore Acupuncture & Wellness.

If you have questions or concerns, please feel free to call (978) 494-6998.

Signature _____

Date_____