EAST MOUNTAIN ACUPUNCTURE PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers will remain confidential.

WHERE DID YOU HEAR ABOUT THE EAST MOUNTAIN ACUPUNCTURE?_____

IDENTIFICATION DATA Please fill in completely & print clearly.

Name_____ Date_____
Address_____ Place of birth_____
_____ Date of birth_____
Parents' e-mail address(es)_____ Age_____
Home Phone_____
Work Phone (parent)_____
Cell phone(s) (parent)_____
Level in school_____ Parents' Occupation(s)_____

FAMILY HEALTH HISTORY- Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	Patient	Mother	Father	Sibling	Spouse	Children
Cancer or tumors						
Diabetes						
Blood or bleeding disorders/ anemia						
seizures						
high blood pressure/ Heart Disease						
allergies						
stroke						
drug abuse/ alcohol abuse						
depression or mental illness						
age at death						
Hepatitis						
Kidney disorder						
thyroid disorder						
musculo-skeletal disorder						
blood transfusion (if before 1985)						

MEDICINES:
Please list any medications, vitamins, or herbs the patient is currently taking or commonly take. Please include how frequently you take them and what conditions they are for.

_____	_____	_____
_____	_____	_____
_____	_____	_____

Was the patient immunized? YES NO
Which immunizations were given? YES NO
Dates of immunization _____

DIET: What is the typical daily diet like? Be honest!
BREAKFAST:
LUNCH:
DINNER:
SNACKS:

Was/ is the baby breast-fed? YES NO How long? _____
At what age was solid food introduced? _____
What foods were introduced? _____

What is a typical weekday schedule like for the patient?

How much time is spent at home, in school, in day care, etc.?

What does the patient do for fun?

MAJOR HOSPITALIZATIONS Has the patient ever been hospitalized?

YEAR	OPERATION/ILLNESS

Any emotional traumas or transitions? (e.g. parent divorce, loss of loved one, moving, changing schools, difficulties in school, strained relationships with parents, etc.) Please give dates if appropriate.

Date of most recent physical examination:_____
Name & address of doctor_____
Phone number of doctor_____

Has the patient been treated with acupuncture &/ or Chinese herbal medicine before? YES NO
What other treatments have been tried for the patient's condition?
WHAT IS THE MAIN HEALTH ISSUE FOR WHICH THE PATIENT IS SEEKING ORIENTAL MEDICAL TREATMENT?
_____

FOR ANY OF THE CONDITIONS LISTED BELOW THAT YOU MAY HAVE OR HAVE HAD, PLEASE PUT A **"C"** IF THE CONDITION IS CURRENT OR A **"P"** IF YOU HAD IT IN THE PAST.

HEAD & NECK

____dizziness
____fainting
____neck stiffness
____enlarged lymph glands
____headaches
____head or neck injury

EARS

____infection
____ringing
____decreased hearing or deafness
____vertigo
____discharge
____hearing aids
____pain

EYES

____blurred vision
____visual changes
____poor night vision
____spots or floaters
____eye inflammation
____double vision
____ glaucoma
____ cataracts
____contact lenses/ glasses
_____year of last eye exam

NOSE, THROAT, & MOUTH

____sinus infection
____hay fever/ allergies
____frequent sore throats
____hoarseness
____difficulty swallowing
____changes in sense of smell or taste
____ mouth or tongue ulcers
____frequent colds
____nosebleeds

SKIN

____hives
____rashes
____eczema / psoriasis
____night sweating
____excess sweating
____dry skin
____easy bruising
____changes in moles, lumps, hair

RESPIRATORY

____chronic cough
____coughing up blood
____coughing up phlegm
____difficulty breathing
____wheezing/ asthma
____frequent colds

CARDIO-VASCULAR

____palpitations
____chest pain or tightness
____rapid heart beat
____irregular heart beat
____poor circulation
____swelling of ankles
____phlebitis
____anemia
____pacemaker
____history of heart attack

GASTROINTESTINAL

____nausea
____indigestion
____stomach pain
____diarrhea
____constipation
____poor appetite
____excessive hunger
____vomiting blood
____blood in stool or black stools
____hemorrhoids
____gall bladder disorder
____recent weight change
____food cravings

MUSCLE & JOINT

____joint disorder
____sore muscles
____weak muscles
____difficulty walking
____backache or pain

NEUROLOGICAL

____seizures
____tremors
____numbness or tingling
____pain
____paralysis
____other

MALE

____pain/itching of genitalia
____genital lesions/ discharge
____impotence
____weak urinary stream
____lumps in testicles
____other

FEMALE

____frequent urinary tract infections
____frequent vaginal infections
____pain/ itching of genitalia
____genital lesions/ discharge
____pelvic inflammatory disease
____abnormal pap smear
____irregular periods
____painful menstrual periods
____pre-menstrual symptoms
____abnormal bleeding
____menopausal symptoms
____breast lumps
____other

GENERAL

____difficulty focusing
____insomnia
____frequent dreams/ nightmares
____depression
____agitation
____fatigue
____aversion to cold
____frequent urination
____psychiatric treatment
____diabetes
____other

INFECTION SCREENING

____HIV risks: self or partner
____TB; self or household
____Hepatitis risk; self or partner
____history of sexually transmitted-disease: self or partner
    ____gonorrhea
    ____chlamydia
    ____syphilis
    ____genital warts
    ____herpes: oral/ genital

EAST MOUNTAIN ACUPUNCTURE, P.L.L.C.

INFORMED CONSENT

I, _____, hereby consent to be treated by **Ron Hershey, L.Ac.,** with acupuncture &/or other Oriental medical procedures, which may include acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, or nutritional and lifestyle counseling.

I understand that acupuncture is performed by the insertion of pre-sterilized acupuncture needles through the skin, with or without the addition of heat or electrical stimulation, to certain points on the body, with the intent of improving bodily functions, relieving pain, and treating certain diseases or bodily dysfunctions.

I have been informed that acupuncture, when performed by qualified licensed practitioners, is a safe method of treatment, but rarely, some side effects do occur. The most common of these are bruising or tingling near the needling sites for a few days, fatigue, or temporary aggravation of pre-existing symptoms. Other theoretically possible, though extremely rare, side effects may be fainting, spontaneous miscarriage or pneumothorax. If I experience any symptom I believe may be a result of treatment, I've been advised to contact my acupuncturist promptly for guidance.

I understand that I should also inform my acupuncturist prior to being treated if I believe that I might be pregnant.

I accept the fact that no guarantee is made concerning the outcome of my acupuncture or herbal medicine treatments and that I may stop treatment at any time.

I,_____ (patient's or patient's representative's name printed), have been advised by RON HERSHEY, L.Ac that acupuncture/herbal medical treatment is not a substitute for the care of a medical doctor.

PATIENT'S NAME _____ (PRINTED)

PATIENT'S SIGNATURE_____ DATE _____

ACUPUNCTURIST'S SIGNATURE_____ DATE _____

EAST MOUNTAIN ACUPUNCTURE

NOTICE OF PRIVACY PRACTICES

Our office is dedicated to providing respectful and confidential service. Protecting your privacy and healthcare information is fundamental to our practice, and is also mandated by law.

Please be advised that we may gather personal and health information about you in several ways:

- Directly from you, our patient
- From other healthcare providers
- From third party payers (i.e., insurance companies)

Note that we may use and disclose medical information about you (without your specific consent or authorization) for the following reasons only:

- To confer with other healthcare practitioners to better understand the optimal course of treatment
- To facilitate payment from insurance companies for the treatment and services you receive from us
- To share our findings with your referring primary care practitioner.

We may disclose your medical information to any other medical practitioners, friends, or family only with your written consent. You may request a medical information disclosure consent form from our office.

Communication:

We routinely communicate with patients over the phone to schedule appointments or to address concerns or answer questions. If we leave a message, we will identify ourselves by name and mention we are from EAST MOUNTAIN ACUPUNCTURE.

If you prefer to ***only be contacted*** *at work, home or other phone number*, please write that number here: _____

Patient Rights:

- Upon written request, you have the right to access, review or receive copies of your healthcare records.
- Upon written request, you have the right to request that we place restrictions on the disclosure of your protected
- health information. In your request, you must indicate what information you want to limit. We are not required to agree to this request.
- You are entitled to a copy of this notice.
- Upon written request, you have the right to a summary of what we have disclosed about you and to whom.

Complaints:

If you have questions or complaints, please contact Ron Hershey at 914-271-3684. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to:

DHHS (Office of Civil Rights)
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201

*By signing below, I acknowledge that I have read, reviewed, understood and agreed to the statement of Privacy Policy for healthcare services with EAST MOUNTAIN ACUPUNCTURE. I also confirm that this office has attempted to provide me with a copy of the statement of privacy policies.

_____ _____

Patient signature Date

EAST MOUNTAIN ACUPUNCTURE, PLLC

132 Grand Street; Croton-on-Hudson, NY 10520
914-271-3684

A WORD ABOUT SCHEDULING

We strive to make our office run as smoothly as possible and to help make your experience here as satisfying and pleasant as we can.

To do this, we allow plenty of time for your visit. Unlike many physicians' offices that schedule six to eight patients per hour to compensate for those who do not show up, we regularly see only one or two people per hour. For a first visit, an entire hour and a half is set aside just for you.

To enable us to continue this level of individualized attention, however, we must insist that the time we set aside for you is respected. Consequently, should you be unable to keep your appointment, we require notice of at least 24 hours before your appointment time. If you call to cancel when the office is closed, please leave a message on our voicemail to indicate your wish to cancel.

If you forget your appointment, if you are running late and cannot make the appointment, if you have transportation difficulties, or if you call to cancel with less than 24 hours notice, we are obliged to charge you the full fee for the visit. Naturally, we will make an exception to this in the event of genuine emergencies, such as acute illnesses or accidents. Also, if another time slot is available the same day as your missed appointment, we will gladly switch your time slot with no penalty. If, however, no other time is available that day, you will still be charged for your missed appointment.

For insurance patients: You will be charged directly for **the full fee** (not just the co-pay) for visits missed or for which adequate notice was not given. Insurance companies do not cover missed visits. If your insurance company fails to cover treatments that you havereceived after having agreed to do so, you will also be responsible for the balance.

This policy is not intended to be punitive. It simply allows us to keep an appointment schedule that favors longer visits. This means our patients spend less time in the waiting room and more time in consultation and treatment with us.

We are grateful for your cooperation and goodwill in this matter.

Sincerely,
Ron Hershey, L.Ac.

Please sign below to acknowledge that you have read our scheduling policy and that you accept these terms.
Thank you.

X_____(name printed and signed)