**EAST MOUNTAIN ACUPUNCTURE 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 EAST MOUNTAIN ACUPUNCTURE?

**IDENTIFICATION DATA** Please fill in completely.

Name Date
Place of birth
Date of birth Age
Address
Home Phone
Work Phone
Email address Cell Phone

◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Living with

Education Occupation

**FAMILY HEALTH HISTORY**- Complete for each family member, indicating any of the illnesses that they have ever had. Check the appropriate boxes.

| | Yourself | 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) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**PERSONAL LIFESTYLE HABITS**

Use of tobacco: ☐ Cigarettes per day (packs per day) age started
Use of marijuana ☐ How much per day? age started
Use of alcohol ☐ How many drinks per week? age started
Use of caffeine ☐ Colas per day Coffees per day Teas per day
Use of crack / cocaine ☐ How often ?
Use of other recreational drugs ☐
What drug(s)? How often?

**MEDICINES**: Please check off any medication that you are now taking or commonly take.

Aspirin ☐ Ibuprofen/acetaminophen ☐ tranquilizers ☐ antacids ☐
laxatives ☐ sleeping pills ☐ oral contraceptives ☐ herbs ☐
diet pills ☐ anti-depressants ☐ vitamins ☐ (please list below:)

Please list any prescription medication you are currently taking, how often and what conditions they are for.

**DIET:** What might you eat for each meal on a typical day?
BREAKFAST:
LUNCH:
DINNER:
SNACKS:

**ACTIVITIES:** What non-work activities do you do? (i.e., exercise, TV, reading, meditation, etc.) What gives you the most pleasure?

**MAJOR HOSPITALIZATIONS** If you have ever been hospitalized for any serious medical illness or operation, write the most recent ones below. (Do not include normal pregnancies)

| YEAR | OPERATION / ILLNESS |
|---|---|
| | |
| | |
| | |

Date of Last Physical Examination:

Name, address and phone number of doctor

Have you ever been treated with acupuncture and/or Chinese herbal medicine before? ◯ Yes ◯ No

**WHAT IS THE MAIN HEALTH ISSUE FOR WHICH YOU ARE SEEKING ORIENTAL MEDICAL TREATMENT?**

FOR ANY OF THE CONDITIONS LISTED BELOW THAT YOU 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
- premenstrual symptoms
- abnormal bleeding
- menopausal symptoms
- breast lumps
- other

GENERAL

- insomnia
- frequent dreams/ nightmares
- depression
- agitation
- fatigue
- aversion to cold
- frequent urination
- psychiatric treatment
- diabetes
- other

INFECTION SCREENING
(Have you been screened for the following?)

- ☐ 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

ALLERGY SCREENING

Do you have any known allergic reactions to any of these ? If so, please indicate which ones and how you react.

medications

supplements

herbs

food

# 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

PATIENT'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 a specific phone number, please enter that number.

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***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 if you are too sick to come (as long as you call us to cancel before your appointment time) or in the event of genuine emergencies or accidents. Also, if another time slot is available the same day as your missed appointment, we will gladly switch your time slot with not 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.

PATIENT SIGNATURE _____ DATE