Acupuncture Center
OF SOUTHERN NH, LLC

71 Spit Brook Road, Suite 407
Nashua, NH 03060

Welcome! I look forward to helping you to meet your health goals. Please take a few minutes to fill out this questionnaire to help me to serve you better.

Name:_____ Date:_____
Address:_____
City/Town:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____ E-mail address:_____
Best way to reach you:_____
Is it acceptable to leave a message at this number:_____
Would you like to be added to our e-mail list? Yes_____ No_____
Would you like to be added to our mailing list? Yes_____ No_____
If yes, you will receive an invitation to the email provided.
You must click "Subscribe" to receive newsletters.
How would you like your appointment reminder? Phone_____ Text_____ Email_____
How did you learn about our clinic and services?
Telephone book_____ Internet_____ if so, what site?_____
Doctor (please name)_____
Friend/personal referral (name, if desired)_____
Insurance provider list_____ Other_____

Acupuncture Center of Southern NH, LLC
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Acupuncture Informed Consent to Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient named below for whom I am legally responsible) by the acupuncturist named below and/or licensed acupuncturists who now or in the future treat me while associated with or serving as a back-up for the acupuncturist named below.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I understand that acupuncture is generally a safe method of treatment, but that it may have some side effects. These side effects include bruising, numbness, or tingling near the needle sites that may last a few days, as well as dizziness and fainting. Burns and/or scarring are a potential risk of moxibustion, or when the treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile, disposable, single-use needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects may occur. I will notify clinic staff if I am or become pregnant.

I do not expect the clinic staff to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the clinical staff to exercise judgement during the course of treatment which the clinical staff thinks, at the time, based upon the facts known is in my best interest. I understand results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

_____ _____
Patient signature Date

_____ _____
Office signature Date

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Financial Policy

Payment is expected at time of visit. It may be made by cash, check, or credit card.
Acupuncture is a Flexible Spending Account or Health Savings Account eligible expense, and payment may be made via FSA/HSA account card with a Visa or MasterCard logo.

Insurance will be billed as applicable by this office, but you are ultimately responsible for payment for all services. Many insurance companies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

If your level of coverage is uncertain we require that you pay $20 towards today's charges and $20 on each following visit. Your full portion of the bill is expected when payment is received from your insurance carrier. If you have a specific contracted amount for copayment that amount is due each visit.

Any unpaid balances will be considered past due 30 days following treatment or insurance reimbursement, which ever come last. Past due balances may have an interest charge of 1.5% applied per month.

By signing this form you are authorizing this office, upon request from your insurance carrier, the release of any medical or other information necessary to process the claim.

By signing this form you are authorizing payment of medical benefits be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office you agree to send or bring those payments to this office upon receipt. However, if you pay for your visits in full the assignment will not be reported by this provider and any payment will be sent directly to you.

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you ultimately will be personally responsible for payment regardless of your insurance coverage.

Your appointment time is reserved for you. If you cannot make your scheduled appointment, this office requests 24hrs notice. **Failure to provide such notice will result in a $35 late cancelation fee. A No Show/ No Call will result in a $50 fee.**

Your understanding is greatly appreciated.

I have read and agree to the above:

Printed Name : _____ Date: _____

Signature : _____ SSN: _____

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Privacy Policy Acknowledgement

I have received, read, and understand the Notice of Privacy Policies of this clinic. I understand how this clinic may use or disclose my health information. I understand when this clinic may not use or disclose my health information. I understand my health information rights and understand that the office reserves the right to change the Notice of Privacy Policy. I also understand how to place a complaint regarding this Notice and have also been provided the opportunity to review and question the privacy policy of this clinic.

_____ _____

Signature of Authorized Person Date

Acupuncture Center
OF SOUTHERN NH, LLC

Health History Questionnaire

Date:_____
Name:_____ Sex:_____ DOB:_____
Street address:_____
City:_____ State:_____ Zip:_____
Phone number:_____

Height:_____Weight:_____
Occupation:_____

Family Physician:_____
Referred by:_____
Emergency Contact:_____ Relationship:_____
Emergency contact phone number:_____

What is the main problem you would like help with?

_____
_____

When did this problem begin?

_____
_____

To what extent does this problem interfere with your activities of daily living, work, sleep or sex life? _____
_____

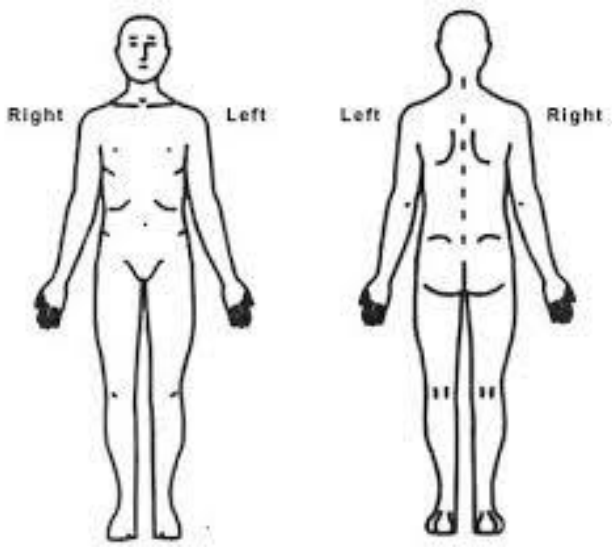
Have you been given a diagnosis for this problem? If so, what?

_____

What other treatments have you tried for this problem?

_____

Have you ever been treated by acupuncture or Oriental medicine before? _____



Mark the areas of your body where you feel the described sensation. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.

X **Numbness**
+ Burning
*** Pin & Needles**
= Stabbing

Name:_____ Date: _____

Past medical history:

Have you been diagnosed with any of the following? (circle all that apply):

Cancer	Diabetes	High blood pressure	Heart disease	Asthma
Seizures	Venereal disease	Thyroid disease	Hepatitis	Stroke

Other (please specify): _____
Surgeries: _____
_____
Significant traumas (motor vehicle accidents, falls, bone fractures, etc.): _____
_____
Allergies:_____

Medications you now take, including over the counter and herbal supplements:
_____
_____

Occupational stress (chemical, physical or emotional): _____
_____
Do you have a regular exercise routine? If yes, please describe: _____
_____
Have you ever been on a restricted diet? If yes, please describe: _____
_____
Please describe your average daily diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Do you smoke? If so, how much: _____
How many caffeinated beverages do you consume daily: _____
How much water do you drink daily? _____
How much alcohol do you drink? _____
Do you use any drugs for non-medical purpose? If so, please describe: _____
_____

Please circle if you have had any of the following in the last 3 months:
General:

Fever	Peculiar taste or smells	Strong thirst (hot or cold drinks)
Sweat easily	Cravings	Poor sleep
Night sweats	Change in appetite	Fatigue
Chills	Weight loss	Sudden drop in energy (time of day?)
Bleed/bruise easily	Weight gain	

Name: _____ Date:_____

Skin and hair:

Rashes	Ulcerations	Hives
Itching	Eczema	Acne
Dandruff	Hair loss	Recent moles

Change in skin or hair texture: _____
Any other skin or hair problems? _____

Head, eyes, ears, nose, throat:

Dizziness	Concussions	Migraines
Glasses	Eye strain	Eye pain
Poor vision	Night blindness	Color blindness
Cataracts	Blurry vision	Spots in front of eyes
Ringing in ears	Poor hearing	Earaches
Sinus problems	Nose bleeds	Recurrent sore throat
Grinding teeth	Facial pain	Sores on lips/in mouth
Teeth problems	Jaw clicks	Headaches

Any other head or neck problems? _____

Cardiovascular:

Chest pain	Fainting	Blood clots
Phlebitis	Irregular heart beat	Cold hands or feet
High blood pressure	Low blood pressure	Peripheral Artery Disease
Swelling of hands	Swelling of feet	Varicose veins

Any other heart or blood vessel problems: _____

Respiratory:

Asthma	Shortness of breath	Difficulty breathing
Cough	Coughing blood	Pain with deep breath
Bronchitis	Pneumonia	Wheezing

Difficulty breathing while lying down
If you are producing phlegm, what color is it? _____
Any other lung or breathing problems: _____

Gastrointestinal:

Nausea	Vomitting	Heartburn/indigestion
Diarrhea	Constipation	Blood in stools
Rectal pain	Hemorrhoids	Gas
Belching	Bloating	Bad breath
Bleeding gums	Chronic laxative use	

Any other problems with your stomach or intestines: _____

Name: _____ Date: _____

Urinary:

Frequent urination	Painful urination	Kidney stones
Urgency to urinate	Blood in urine	Incontinence
Wake up to urinate	Decrease in flow	

What color is your urine: _____

Any other problems with your urinary system? _____

Male reproductive:

Impotence	Premature ejaculation	Spermatorrhea
Testicular pain	Testicular injury	Prostatitis
Prostate Cancer	Benign Prostatatic Hypertrophy	
Low sperm count	Low motility	
Sore on genitals	STDs	

Any other reproductive problems? _____

Female reproductive:

Are you pregnant? _____

Is it possible you are pregnant? _____

Age of first menses: _____ Duration of menses: _____

Time between menses: _____

Number of pregnancies: _____ Number of live births: _____

Number of premature births: _____ Miscarriages: _____

Abortions: _____

Age of menopause: _____

When was your last GYN exam? _____

Do you practice birth control? If so what and for how long? _____

_____

Do you have:

Breast lumps	Vaginal discharge	Sores on genitals
Irregular periods	Painful periods	Heavy bleeding
Light bleeding	Infertility	STDs

Western Infertility Treatment

Changes in body or psyche prior to menstruation? _____

Any other reproductive problems? _____

Musculoskeletal:

Neck pain	Hand/wrist pain	Foot/ankle pain
Shoulder pain	Hip pain	Muscle pain
Back pain	Knee pain	Muscle weakness

Any other muscle, joint or bone problems? _____

Name: _____ Date: _____

Neurological:

Seizures	Stroke	Concussion	Dizziness
Numbness	Tremors (where?)	Loss of balance	Poor memory
Lack of coordination			

Any other neurological problems? _____

Psychological:

Depression	Anxiety	Fearful	Sadness
Easily angered	Easily worried	Easily susceptible to stress	
Overly joyful			

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other psychological problems? _____

If there is anything you wish to bring to our attention that has not been asked on this form, please mention it here. _____

_____