IDENTIFICATION DATA: Please fill in completely. Please print.

Name:_______________ Date of first visit_______________

Address:_______________ Date of birth_______________

CIty_______________State______Zip_____________Age_________Place of birth_______________

Phone: Home _______________Relationship Status_______________

Work_______________Occupation_______________

Cell_______________Insurance_______________

Email: _______________ Referred by _______________

Have you ever had acupuncture?_____________ For what condition/s?_______________

HEALTH HISTORY

	Self	Comments	Family	Relationship to self/ Comments
Allergies- Please list				
Asthma				
Blood Disorder/Anemia				
Bronchitis				
Cancer Or Tumors				
Diabetes				
Headaches (Frequent / Severe)				
Heart Disease/Disorder				
Hepatitis				
High Blood Pressure				
Kidney Or Bladder Disorder				
Musculoskeletal Disorder				
Seizures				
Stomach/Intestinal Disorder				
Stroke				
Substance Abuse				
Thyroid Disorder				
Transfusion- Prior To 1985				
Tuberculosis				
Urinary Tract Disorder				
Other				

MAJOR HOSPITILIZATIONS

If you have been hospitialized for any serious medical illness/ operations, please write in your most recent hospitalizations. Do not include pregnancies.

Hospitalization	Operation/Illness	Year	Name of Hospital	City and State
First				
Second				
Third				

If you have had more than three such hospitalizations, please note how many:_______________

MEDICINES: Please list **all** medications (include dosage and frequency):______________________

____

____

Please list any allergies to medications:____

VITAMINS/ SUPPLEMENTS/ HERBS (include dosage and frequency) ______________________

____

____

HABITS: Please check any of the habits which apply to you now or int the past:

____Use of tobacco
_____# cigarettes /day _____# packs /day _______Age began ________Stopped______years/months/days ago

____Use of marijuana
_____use how many days/week _____Age began using ______Stopped ______years/months/days ago

____Use of alcohol
_____# drinks/week _____Age began drinking ______Stopped ______years/months/days ago

____Use of caffeine
______# coffees /day ______# teas /day _____# colas /day ______Stopped ______years/months/days ago

____Use of street drugs Please specify drugs:____

Please specify frequency________________________________ _______Stopped ______years/months/days ago

EXERCISE: List what activities you do regularly and frequency:

____

____

What other activities have you done in the past?____

Injuries?____

PARENTING / PREGNANCY HISTORY:

Total pregnancies:_______ Living:______ Ectopics: Miscarriages:_____ Induced abortions:__ ___

Multiple pregnancies:_______Adopted:_________

Ages of children living with you____

MAIN PHYSICIAN CONTACT:

Date of last Physical Exam:_____________________ Name of Physician:_________________________________

Address of Physician:________________________________ Phone # of Physician: _(_____)________________

____

EMERGENCY CONTACT:

Name:____Address:_______________________________

Phone Number:__(______)___________________________ Relationship to you:______________________

Signature:____

Name____Date________________________________

Please place a "C" next to any conditions you currently experience and a "P" next to any conditions you have experienced in the past.

SKIN

____Hives
____Rashes
____Eczema
____Night sweating
____Excess sweating
____Dryness
____Bruises easily
____Changes in moles or lumps
____Other____________________

HEAD AND NECK

____Dizziness
____Fainting
____Neck Stiffness
____Enlarged lymph glands
____Headaches
____Other____________________

NEUROLOGICAL

____Seizures
____Tremors
____Numbness or tingling
____Paralysis
____Other ____________________

EYES

____Blurred vision
____Visual changes
____Poor night vision
____Spots
____Eye inflammation
____Watery eyes
____Itchy eyes
____Other____________________

EARS

____Infection
____Ringing
____Humming
____Decreased hearing
____Other____________________

NOSE, THROAT & MOUTH

____Bleeding
____Sinus infection
____Hay fever or allergies
____Frequent sore throat
____Hoarseness
____Difficulty swallowing
____Changes in taste
____Changes in smell
____Oral ulcers
____Other___________________

RESPIRATORY

____Chronic cough
____Coughing up blood
____Coughing up phlegm
____Difficulty breathing
____Wheezing/asthma
____Frequent colds
____Other____________________

CARDIO-VASCULAR

____Palpitations
____Chest pain
____Chest tightness
____Rapid heart beat
____Poor circulation
____Swelling of ankles
____Phlebitis
____Other____________________

GASTRO-INTESTINAL

____Nausea
____Indigestion
____Stomach pain
____Diarrhea
____Constipation
____Poor appetite
____Excessive hunger
____Vomiting blood
____Bloody or black stools
____Hemorrhoids
____Gallbladder disorder
____Recent weight change +/- ___
____Food cravings_____________
____Other____________________

MALE UROGENITAL

____Pain/itching of genitalia
____Genital lesions/discharge
____Impotence
____Weak urinary stream
____Lumps in testicles
____Other____________________

FEMALE REPRODUCTIVE SYSTEM

____Frequent urinary tract infections
____Frequent vaginal infections
____Pain/itching of genitalia
____Genital lesions/discharge
____Pelvic inflammatory disease
____Abnormal pap smear
____Irregular menstrual periods
____Painful menstrual periods
____Premenstrual syndrome(PMS)
____Abnormal bleeding
____Menopausal symptoms
____Breast lumps
____Other____________________

MUSCLE & JOINT

____Joint disorder
____Sore muscles
____Weak muscles
____Difficulty walking
____Spinal curvature
____Backache
____Back pain
____Other___________________

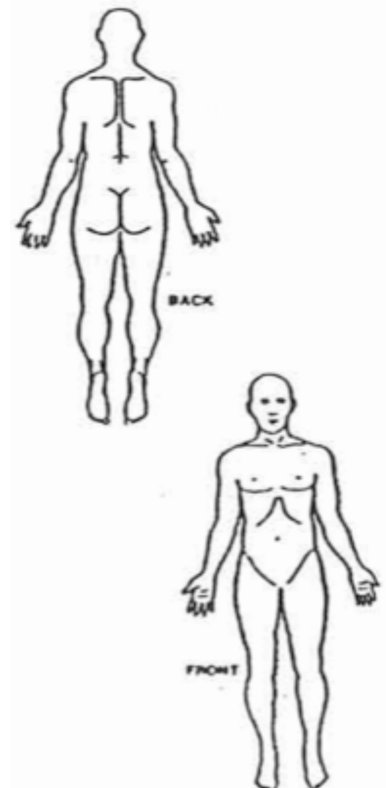
GENERAL

____Insomnia
____Frequent dreams/nightmares
____Depression
____Agitation
____Fatigue
____Aversion to cold
____Aversion to heat
____Frequent urination
____Irritability
____Thirst
____History of psychiatric treatment
____Other____________________

INFECTION SCREENING

____HIV risks: self or partner
____TB: self or partner
____Hepatitis risk: self or partner
History of sexually transmitted diseases:
____Gonorrhea: Self or partner
____Chlamydia: Self or partner
____Syphillis: Self or partner
____Genital warts: Self or partner
____Herpes: oral/genital: Self or partner

Mark any areas of pain with an "X" on the diagram below:



PRIVACY POLICY & PATIENT RECORD OF DISCLOSURES

This notice describes general office practices regarding confidentially of your medical information.

Office practices:

- All information regarding patients, their treatment, diagnoses and appointments is kept strictly confidential within the confines of the practitioner. Only the practitioner (and an assistant, if necessary) will see the patent's chart and financial data.
- There is no electronic transfer of your health data from this office. Occasionally email will be used to schedule appointments or answer questions but only with your authorization.
- For treatment purposes, information will be provided to another practitioner or insurance provider only after your written consent is given.
- Discussion of treatment is confined to the consultation room or treatment room, not in the presence of other patients.

Communication:

- I routinely communicate with patients over the phone to schedule and confirm appointments. While the name "Sally Rappeport is given in messages, no reference to medical service is made. Occasionally I call to give instructions or to notify you that herbs and supplements are in the office.
- If you prefer to be contacted ONLY at your work, home or other phone number or by email, please provide that information below:

____

____

Signature of Patient or Personal Representative

____

Print name of Patient or Personal Representative

____

Date

RECORD OF DISCLOSURE OF PERSONAL HEALTH INFORMATION

Date	Disclosed to whom	Address, phone, fax or email	Auth.

PATIENT ADVISORY TO CONSULT A PHYSICIAN

It is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment. In compliance with Article 160, Section 82.11 (b) of NYS Education law, please read and sign the following statement:

We, the undersigned, do affirm that ______________________________(patient) has been advised by Sally Rappeport, L.Ac. to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

____ ______________________
Patient (or Parent or Guardian) Signature Date

____ ______________________
Licensed Acupuncturist Signature Date

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with Traditional Oriental Medicine by Sally Rappeport, L.Ac. I understand that methods of treatment may include but are not limited to: acupuncture, moxibustion, cupping electrical stimulation and Tui Na (Chinese Massage).

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Infection is another possible risk, although in this office only sterile, disposable needles are used and a clean and safe environment is maintained. Bruising is a common side effect of cupping. Burns and scarring are potential risks of moxibustion. I understand that while this form contains the major risks of treatment, other side effects and risks may occur.

I agree to notify Sally Rappeport, L.Ac. if I am currently pregnant or become pregnant. I understand that special precautions are taken with pregnant women when applying acupuncture and other Traditional Oriental Medicine procedures.

By voluntarily signing below I show that I have read, or have had read to me, this 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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____ ______________________
Patient (or Parent or Guardian) Signature Date

____ ______________________
Licensed Acupuncturist Signature Date

CANCELLATION POLICY

Please be informed that the office has a 24-hour cancellation policy.

For Monday appointments, this means Friday cancellation. You will be charged in full for missed appointments without 24-hour notification; however, emergencies will be considered. This enables Sally to schedule another patient in your time slot.

Thank you for your cooperation.

I understand the 24-hour cancellation policy.

____________________________________ ____________________
Patient's Signature Date