PATIENT INFORMATION (ADULT MALE)

Please provide as complete information as possible, even if you do not feel certain questions pertain to your present condition. All the information you provide is confidential and is useful in determining the best treatment plan for you.

name:_____ date of birth:_____

age:_____ gender (please circle): m or f occupation:_____

street address: _____ home phone:_____

city, state, zip:_____ cell phone:_____

email: _____ work phone:_____

□ single □ married □ divorced □ separated □ widowed □ partnership □ living with □ same sex relationship

emergency contact name: _____ relationship to you:_____

address:_____ home phone:_____

cell phone:_____ work phone:_____

have you had acupuncture before?:_____

how did you hear of us? may we thank someone for referring you?:_____

HEALTH HISTORY

what are your most important health concerns? please list in order of importance:

1. _____ date of onset:_____
2. _____ date of onset:_____
3. _____ date of onset:_____
4. _____ date of onset:_____
5. _____ date of onset:_____

are you under a physician's care for any of your health concerns? (please describe if appropriate):_____

_____

have you sought any other treatment(s) for any of your health concerns? (please describe):_____

_____

is there anything that improves or aggravates your condition?:_____

have you had any blood tests, x-rays, CT scans, MRIs, EKGs, or other tests related to your health concerns within the past year? please list & describe the results to the best of your knowledge and/or memory:

_____

date of last physical exam:_____ name of physician:_____ physician's phone:_____

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please list any hospitalizations and/or surgeries (not including those related to childbirth):

hospitalization / surgery	date	reason

please list any injuries and/or accidents:

accident/injury	date	relation to any health concerns

please indicate if you are taking any of the following:

□ blood thinners (warfarin, coumadin, etc.)
□ diet pills (diuretics, appetite suppressants, etc.)
□ pain relievers (Tylenol, aspirin, etc.)
□ cortisone or other steroids
□ thyroid medication
□ tranquilizers/sedatives
□ sleeping aids
□ laxatives
□ antacids (tums, etc.)

please list all prescription and over-the-counter medications you are currently taking:

name	dosage	reason for taking	date began taking

please list all vitamins, minerals & supplements you are currently taking (include energy drinks, etc.):

name	dosage	reason for taking	date began taking

approximately how many courses of antibiotics have you taken over the past 10 years? _____

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Please mark an x in the appropriate column (leave blank if you do not experience the symptom):

	occasional	frequent		occasional	frequent
cough			shortness of breath		
spontaneous sweating			catch colds easily		
nasal congestion/runny nose			allergies		
post-nasal drip			eczema or psoriasis		
enlarged lymph glands			acne or boils		
sinus congestion or infection			ringworm or fungus		
skin rashes or hives			dry nose, throat or skin		
asthma or wheezing			decreased sense of smell		
bleeding gums			hoarse or sore throat or voice		
low appetite			constipation		
loose stool or diarrhea			hemorrhoids		
acid reflux/heartburn			feelings of claustrophobia		
blood in the stool			excessive appetite		
fatigue after eating			gas or bloating after food		
obsession in work or relations			nausea or vomiting		
insomnia			palpitations		
tongue or mouth sores			anxiety		
sadness			vivid dreams or nightmares		
mental restlessness			excessive sweating		
chest pain			laughing for no reason		
irritability			hearing impairment		
bitter taste in the mouth			difficulty digesting oily foods		
muscle spasms or twitching			difficulty in making decisions		
neck/shoulder tension			ringing in the ears		
low back pain			decreased sex drive		
sore, cold or weak knees			frequent urination		
hair loss			cold hands and feet		
urinary incontinence or urgency			body feels heavy		
dizziness/fainting			poor concentration		
floaters in field of vision			sticky taste/feeling in mouth		
hot hands and feet			foggy headed		
afternoon fevers			night sweats		
flushed cheeks			edema or ankle swelling		
headaches			cloudy urine		
heat or cold intolerance			bruise easily		
excessive thirst			muscle weakness		
change in weight			numbness/tingling		
nose bleeds			pain on urination		
ear aches or infections			athlete's foot		

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do you have a bowel movement every day?: _____#per day/week?:_____

please describe any allergies and/or food sensitivities:_____

_____

_____

_____

LIFESTYLE HISTORY

height:_____ weight:_____ weight one year ago:_____ maximum weight:_____ when?:_____

do you exercise?:_____ how many times a week?_____

what type of exercise?:_____

do you drink coffee/black tea?:_____ # 8 oz cups per day/week?:_____

do you drink soda?:_____ is it caffeinated? _____ # 12 oz glasses per day/week?:_____

how much water do you drink per day?:_____

please describe your typical diet:

breakfast:_____

lunch:_____

dinner:_____

snacks:_____

meals per day:_____ do you eat at regular times each day?:_____

#snacks per day:_____ how often do you eat out (or order in)?:_____

are you vegetarian, vegan, kosher? are there other restrictions to your diet?:_____

_____

do you experience any gas, burping, bloating, acid reflux or other digestive symptoms after eating any foods?:

_____

Do you use tobacco?:_____ how many times per day/week?:_____

have you used tobacco in the past?:_____ when did you stop?:_____

do you drink alcoholic beverages?:_____ how many drinks do you have per day/week?:_____

do you use recreational drugs?:_____ how many times per day/week/month/year?:_____

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have you been treated for drug/alcohol addiction?:_____

hours you sleep per night:_____ time you go to bed:_____ wake up?:_____

do you sleep well?:_____ do you awake feeling rested?:_____

what is your average stress level (*1 is lowest, 10 is highest*) please circle: 1 2 3 4 5 6 7 8 9 10

what is your average energy level (*1 is lowest, 10 is highest*) please circle: 1 2 3 4 5 6 7 8 9 10

at what time of day is your energy typically at its best?: _____ at its worst?:_____

how do you feel about the following areas of your life?

	great	**good**	**fair**	**poor**	**bad**
significant other					
family relations					
friendships					
living arrangements					
self image					
sex					
work					
vacations/time off					
exercise					
spirituality					

how much change are you willing to/able to make at this time to improve your health (please circle)

minimal some complete

FAMILY HISTORY

father's current age:_____ please circle: good health poor health deceased (cause & age:_____)

mother's current age: _____ please circle: good health poor health deceased (cause& age:_____)

please indicate whether you or any family member has, or has had in the past, any of the following conditions:

disorder/illness	**which family member (include yourself) give important details**	**date**	**frequency (if applicable)**
alcoholism/addictions			
allergies/asthma			
alzheimer's disease			
anemia			
arthritis			
autoimmune disorders			
birth defects			
bleeding disorders			
blood clots			
cancer (specify type)			

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disorder/illness	which family member (include yourself) give important details	date	frequency (if applicable)
depression/anxiety			
diabetes			
epilepsy			
gallbladder problems			
glaucoma			
heart disease			
heart murmurs			
hepatitis			
high cholesterol			
high blood pressure			
HIV/AIDS			
infectious disease			
kidney disease			
kidney stones			
mental illness			
osteoporosis			
pacemaker or defibrillator			
shingles			
stroke			
tuberculosis			
urinary tract infections			
yeast infections			

FOR MEN

date of last prostate exam:_____ psa results:_____

lab results/diagnosis:_____

frequency of urination – daytime:_____ night time:_____

color of urine:_____ is urine clear or murky?:_____ is there any odor?:_____

	occasional	frequent		occasional	frequent
back pain			increased libido		
delayed urine stream			decreased libido		
dribbling urine			discharge/sores		
incontinence			premature ejaculation		
retention of urine			inability to ejaculate		
testicular pain			difficulty achieving erection		
testicular masses			difficulty sustaining erection		
hernia			impaired fertility		
groin pain			rectal dysfunction		

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are you sexually active?:_____ STD's?:_____

is there anything else you would like us to know?:_____

_____

_____

thank you for taking the time to answer these questions. we appreciate your time and effort.
i certify that the information I have provided above is correct and accurate to the best of my knowledge.

_____	_____	_____
Patient's (or Patient Representative's) Signature	*Patient's Name*	*Date*
_____	_____	
Patient Representative's Name	*Representative's relationship to patient*	

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YOU ARE ADVISED TO CONSULT A PHYSICIAN

I (Sarah Coles McKeown, MS, L.Ac., LMT) am committed to your health and wellbeing. Although I have a great deal to offer you as your Acupuncturist and Massage Therapist, it is important that you understand that I cannot replace your physician.

Receiving biomedical care from your primary care physician and appropriate specialists (in addition to acupuncture treatment) is integral to your continued health and wellbeing – in both preventing and resolving illnesses, injuries, and other conditions. Consequently, I recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Article 160, Section 8211 (b) of New York State Education Law, I request that you read and sign the following statement:

We, the undersigned, do affirm that _____ (*please write in patient name)* has been advised by Sarah Coles McKeown, MS, L.Ac., LMT, to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

To be completed by patient (or patient's representative if patient is a minor or physically or legally incapacitated):

_____	_____	_____
Patient's (or Patient Representative's) Signature	*Patient's Name*	*Date*
_____	_____	
Patient Representative's Name	*Representative's relationship to patient*	
_____	_____	_____
Licensed Acupuncturist's Signature	*Licensed Acupuncturist's Name*	*Date*

TELEMEDICINE CONSENT

I understand that telemedicine. is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when she/he/they are located at a different site than the provider.

I _____ agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by bloom acupuncture and Sarah Coles McKeown, MS, LAc, LMT. [Note: the likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that medical records of telemedicine services will be kept at the bloom acupuncture site facility.

Please sign below to indicate that you understand and accept this policy.

_____	_____	_____	
Patient's (or Patient Representative's) Signature	*Patient's Name*	*Date*	*(c 1/3)*

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NOTICE OF PRIVACY PRACTICES

This Notice together with the Practice Regarding Disclosure of Health Information, describe how health information about you may be used and disclosed. These documents also describe how you can gain access to your health information. **Please review this information carefully.**

UNDERSTANDING YOUR HEALTH RECORD
A record is made each time you visit Sarah Coles McKeown, MS, L.Ac., LMT's office for treatment. This record includes symptoms, clinician observations, diagnosis and treatment. The record may also contain other pertinent information provided by you or another of your health care practitioners with whom your Acupuncturist may have spoken.

YOUR HEALTH INFORMATION RIGHTS
Your health record is owned by Sarah Coles McKeown, MS, L.Ac., LMT, however, the content is always available to you for your review. You have the right to request a review of your file and to obtain copies of documents contained in your file. You also have the right to request that amendments be made to your record. In addition, you may request that the use of your information be restricted from certain uses and disclosures and to request a list of individuals or entities to whom your information has been disclosed. You may revoke any authorizations you have given regarding disclosure of your health information at any time. This revocation must be provided to us in writing.

OUR RESPONSIBILITIES
Sarah Coles Mckeown, MS, L.Ac., LMT is required to maintain the privacy of your health information and to provide you with a copy of this Notice of Privacy Practices. Sarah Coles McKeown, MS, L.Ac., LMT will follow the terms of this notice and advise you if this office is unable to comply with a request you may make regarding the use of your health information. Sarah Coles McKeown, MS, L.Ac., LMT reserves the right to amend these privacy policies and will use this office's best efforts to notify you of any such amendments. Other than for reasons stated in this notice, Sarah Coles McKeown, MS, L.Ac., LMT and this office will not use or disclose your health information without your consent.

I, _____, have received a copy of this notice of privacy practices and a copy of the Practices Regarding Disclosure of Patient Health Information. I understand my health information will be used and disclosed consistent with these notices.

_____	_____	_____
Patient's (or Patient Representative's) Signature	*Patient's Name*	*Date*
_____	_____	
Patient Representative's Name	*Representative's relationship to patient*	

(c 2/3)

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PAYMENT POLICY

Payment in full is expected at the time of service, unless other arrangements have been made in advance. Cash, checks and credit cards are acceptable forms of payment.

All returned checks will be subject to a returned check fee.

INFORMATION RELEASE

I authorize the release of all medical information acquired from my examination and treatment for purposes of claims administration, evaluation, and review, or for financial audit.

LATENESS POLICY

Transportation in New York City can be unpredictable. Being on time for appointments can sometimes be a challenge. However, when you make an acupuncture appointment you are scheduled for up to and no longer than one hour of time (one and a half hours for initial appointments). If you are unable to arrive on time for your appointment, it may be necessary for Sarah Coles McKeown, L.Ac. to limit your treatment time so as not to inconvenience patients scheduled for appointments after your appointment time.

Sarah Coles McKeown, L.Ac. will do her best to begin your appointment at your scheduled appointment time. However, due to the nature of medical care and the unforeseen needs of other patients, infrequently your appointment may not begin at the time scheduled. On these occasions, the delay in beginning your appointment will not affect the duration of your treatment.

If you have special time constraints, please let Sarah Coles McKeown, L.Ac. know when you arrive for your appointment or upon scheduling your appointments.

CANCELLATION AGREEMENT

Your appointment time is reserved solely for you, even when others request an appointment at the same time. Consequently, a 24-hour cancellation policy applies to your appointment.

It is your responsibility to notify this office if you are unable to keep the appointment time reserved for you. If for any reason you are unable to cancel your appointment 24-hours prior to your scheduled appointment time, you are responsible for, and will be billed for, the complete treatment fee for that appointment.

Please sign below to indicate that you understand these policies.

_____	_____	_____
Patient's (or Patient Representative's) Signature	*Patient's Name*	*Date*
_____	_____	
Patient Representative's Name	*Representative's relationship to patient*	

(c 3/3)

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