PATIENT INFORMATION (PEDIATRIC)

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

child's (patient's) name:_____ date of birth:_____

age:_____ gender (please circle): m or f place of birth:_____

parent's/legal guardian's names:_____

primary contact information:

street address: _____ home phone:_____

city, state, zip:_____ cell phone:_____

email: _____ work phone:_____

secondary contact information:

street address: _____ home phone:_____

city, state, zip:_____ cell phone:_____

email: _____ work phone:_____

parent(s)/guardian(s) are:
□ single □ married □ divorced □ separated □ widowed □ partnership □ living with □ same sex relationship

emergency contact name: _____ relationship to you:_____

address:_____ home phone:_____

cell phone:_____ work phone:_____

has the patient had acupuncture before?:_____

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

HEALTH HISTORY

what are the patient'smost 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:_____

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is the patient under a physician's care for any of these health concerns? (please describe if appropriate):_____

_____

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

_____

is there anything that improves or aggravates these conditions?:_____

has the patient had any blood tests, x-rays, CT scans, MRIs, EKGs, or other tests related to these 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 address:_____ physician's phone:_____

please list any hospitalizations and/or surgeries:

hospitalization / surgery	**date**	**reason**

please list any injuries and/or accidents:

accident/injury	**date**	**relation to any health concerns**

patient's height:_____ patient's weight:_____

# of siblings:_____ oldest/middle/youngest child?:_____

CONCEPTION/PREGNANCY/BIRTH HISTORY

length of pregnancy (in weeks): _____ complications during pregnancy?:_____

_____

length of labor (in hours):_____ complications during labor/delivery?:_____

_____

type of delivery: □ vaginal □ caesarian weight at birth:_____

IMMUNIZATION & MEDICATION HISTORY

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tupe	yes	no	age(s)	date(s)
hepatitis B				
rotavirus				
DPT (diphtheria, pertussis, tetanus)				
haemophilius influenza type b				
pneumococcal				
inactivated poliovirus				
influenza				
MMR (measles, mumps, rubella)				
varicella (chicken pox)				
hepatitis a				
meningococcal				
human papillomavirus				
other:				

please list all prescription and over-the-counter medications the patient is currently taking:

name	dosage	reason for taking	date began taking

please list all vitamins, minerals & supplements the patient is currently taking (include energy drinks, etc.):

name	dosage	reason for taking	date began taking

approximately how many courses of antibiotics has the patient taken since birth? _____

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Please review the following symptoms and mark an x in the appropriate column (leave blank if the patient does 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 activities/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			foggy headed		
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			pain on urination		
afternoon fevers			night sweats		
flushed cheeks			edema or ankle swelling		
headaches			cloudy urine		
heat or cold intolerance			bruise easily		
excessive thirst			muscle weakness		
nose bleeds			numbness/tingling		
ear aches or infections			athlete's foot		

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Does the patient have a bowel movement every day?: _____#per day/week?:_____

please describe any allergies and/or food sensitivities in detail:_____

_____

_____

_____

_____

LIFESTYLE HISTORY

does the patient drink soda?:_____ is it caffeinated? _____ # 12 oz glasses per day/week?:_____

how much water does the patient drink per day?:_____

please describe the patient's typical diet:

breakfast:_____

lunch:_____

dinner:_____

snacks:_____

meals per day:_____ does the patient eat at regular times each day?:_____

#snacks per day:_____ how often does the patient eat out (or order in)?:_____

is the vegetarian, vegan, kosher? are there other restrictions to the patient's diet?:_____

_____

does the patient experience gas, burping, bloating, acid reflux or other digestive symptoms after eating any foods?:

_____

hours the patient sleeps per night:_____ time the patient goes to bed:_____ wakes up?:_____

does the patient sleep well?:_____ does the patient awake feeling rested?:_____

at what time of day is the patient's energy typically at its best?: _____ at its worst?:_____

how much change are you willing to/able to make at this time to improve the patient's health (please circle)

minimal some complete

FAMILY HISTORY

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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 the patient or any family member has, or has had in the past, any of the following conditions:

disorder/illness	**which family member (include the patient) 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)			
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 YOUNG WOMEN

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Is the patient menstruating?:_____ age menses began:_____ date of last period:_____

Is the patient sexually active?:_____ STD's?:_____

what form of birth control does the patient currently use?:_____ how long has she used it?:_____

what other types of birth control has she used in the past?:_____

Is the patient now pregnant?:_____ date of last ob/gyn exam:_____

has the patient ever been pregnant?:_____ has the patient ever given birth?:_____

	occasional	frequent		occasional	frequent
endometriosis			fibrocystic breasts		
ovarian cysts			breast cancer		
uterine fibroids			breast lumps		
abnormal pap smear			nipple discharge		
yeast infections			vaginal discharge or odor		
urinary tract infections			herpes		
pain/itching of genitalia			human papilloma virus (HPV)		
genital lesions/discharge			hysterectomy		
pelvic inflammatory disease (PID)			uterine prolapse		

# of days between periods:_____ # of days of bleeding:_____ bleeding between periods?:_____

color of menstrual blood:
____ pale/light red ____ dark red
____ red ____ dark red/brown
____ bright red ____ clots

amount of blood:
____ spotting ____ heavy
____ light
____ even throughout

# of pads/tampons used:
____ day 1 ____ day 4
____ day 2 ____ day 5
____ day 3 ____ day 6+

are the periods painful? before period:_____ during period:_____ after period:_____

is the pain:
____ mild
____ moderate

is the pain located in:
____ low abdomen ____ thighs
____ low back ____ other

is the quality of the pain:
____ cramping ____ aching ____ burning
____ stabbing ____ dull ____ constant
____ comes & goes

other symptoms related to the patient's period:

	occasional	frequent		occasional	frequent
discharge			swollen or painful breasts		
headaches			mood swings		
nausea			increased appetite		
constipation			decreased appetite		
diarrhea			insomnia		

FOR YOUNG MEN

Is the patient sexually active?:_____ STD's?:_____

date of last prostate exam:_____ psa results:_____

lab results/diagnosis:_____

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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		

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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