Stony Brook Southampton Hospital

Acupuncture Intake Form & Health History Form

Please print clearly. All records are confidential.

Today's Date_____

Name_____ Date of Birth _____ Age_____ Male/Female

Address _____

Home Phone (_____)_____ Cell Phone (_____)_____ Email:_____

Emergency Contact (Name & Number) _____

Primary Care Physician (Name & Number) _____

Have you ever received Acupuncture before? _____ Date _____

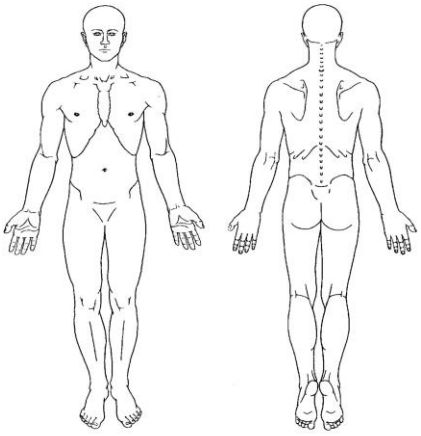
Primary reason(s) for Acupuncture visit? _____

_____

Are you currently in any pain? Yes/No If yes, please rate from 0-10 (Zero being no pain 10 being the worst)____
How long have you had this condition? _____

What seems to make it better? _____ ___ Worse? _____

Please circle on the diagram anywhere you are currently experiencing pain



List **all medication and dosages** you are currently taking (including herbs and supplements):

Do you currently take any blood thinners or having any bleeding disorders? Yes/No_____

Do you have a Pacemaker/Defibrillator? Yes/ No ☐ ☐

Are you currently pregnant? Yes/No ☐ ☐

Reviewed by:_____ Initials:_____ Date:_____
Acupuncturist

PLEASE TURN OVER FOR PAGE 2 ⇨

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REVIEW OF SYMPTOMS: (Please check all that apply)

General Symptoms:

- ☐ Recent weight loss/gain
- ☐ Sweat easily
- ☐ Fatigue
- ☐ Strongly like hot/cold drinks
- ☐ Poor sleep/insomnia
- ☐ Tired after eating
- ☐ Frequent thirst
- ☐ Muscle cramps
- ☐ Night sweating
- ☐ Dizziness

Head, Eyes, Ears, Nose, Throat:

- ☐ Poor vision
- ☐ Eye pain
- ☐ Blurred vision
- ☐ Floaters
- ☐ Red/itchy eyes
- ☐ Excessive phlegm
- ☐ Headaches
- ☐ Nosebleeds
- ☐ Dry mouth
- ☐ Sinus problems
- ☐ Taste alteration
- ☐ Migraines
- ☐ Ringing in ears
- ☐ Poor hearing

Respiratory:

- ☐ Difficulty breathing deeply
- ☐ Asthma
- ☐ Coughing
- ☐ Nasal Drip

Cardiovascular:

- ☐ Palpitations
- ☐ Chest pain
- ☐ Rapid heart beat

Gastrointestinal:

- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Acid reflux
- ☐ Diarrhea
- ☐ Stomach pain/Cramping
- ☐ Gas/Bloating

Skin:

- ☐ Itchy skin

Urogenital:

- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Pain on urination
- ☐ Wake to urinate
- ☐ Urinary tract infections
- ☐ Kidney stones

Gynecological:

- ☐ Irregular periods
- ☐ Painful periods
- ☐ Clots
- ☐ Breast tenderness

Length of cycle _____

Age of menopause_____

Neuropsychological:

- ☐ Anxiety
- ☐ Depression
- ☐ Irritability
- ☐ Stress
- ☐ Difficulty concentrating
- ☐ Seizures
- ☐ Numbness/Tingling

DID YOU FILL OUT BOTH SIDES OF THIS SHEET?

Stony Brook Southampton Hospital

Informed Consent for Acupuncture Treatment

I, the undersigned, hereby request and consent to the treatment of acupuncture and/or therapeutic bodywork. I have discussed the nature and purpose of these modalities and understand that no guarantee of cure or improvement in my condition is given or implied.

Acupuncture is a technique in which sterile, stainless steel, disposable needles are inserted into specific points on the body to cause a desired healing effect via regulating the flow of QI (vital energy) in the body. Techniques may include: stimulation of needles, tuina, cupping, guasha, seven-stars hammer, pachi-pachi, and diode rings. Needles are counted prior to and post treatment to ensure proper removal. The benefits of acupuncture may include alleviation of pain or other symptoms, an overall sense of wellbeing, improved sleep, and increased energy levels. I have been informed that acupuncture is safe, but that it may have side effects, including but not exclusive of, bruising, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and guasha. Unusual risks of acupuncture include miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk and we minimize this risk through promotion of a clean, safe environment and single use sterile needles. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I will notify the acupuncturist prior to treatment if I develop any new symptoms, diagnoses from prior visits or if I have been diagnosed with the following conditions: drug or alcohol use, pacemaker, seizure disorder, bleeding disorder, use of blood thinners, infectious skin disorder or disease, pregnancy.

By voluntarily signing below, I acknowledge that I have been told about the risks of acupuncture and other procedures, and that I have been given an opportunity to ask any questions. I intend for 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 signature Date

_____ _____

Licensed Acupuncturist Date

PATIENT ADVISORY TO CONSULT A PHYSICIAN

We are committed to your health and well being. While acupuncture and Oriental medicine has a great deal to offer as a health care system, it cannot replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture and Oriental medicine treatment.
To comply with Article 160, Section 821 1.1 (b) of NYS Education law, please read and sign the following:

WE, THE UNDERSIGNED, DO AFFIRM THAT_____
(Patient)
HAS BEEN ADVISED BY _____ TO CONSULT A
(Licensed acupuncturist)
PHYSICIAN REGARDING THE CONDITION(S) FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

_____ _____

Patient Signature Date

_____ _____

Licensed Acupuncturist Signature Date

OVER

Stony Brook Southampton Hospital

Welcome to the Southampton Hospital Wellness Department

Southampton Hospital would like to thank you for selecting us as your provider of wellness services. We will do everything possible to assure that your treatment is of the highest quality. You will always be treated professionally and with respect while you are in our care. We take pride in the quality of care that we provide. We have established some guidelines in order to ensure the highest of quality care for all of our patients:

- Contact us if you anticipate arriving more than 15 minutes late for your appointment to determine if we will still be able to meet your needs. **Please call us 24 hours in advance if you need to cancel and/or reschedule an appointment.**
- If you are unable to keep an appointment and do not call to cancel 24 hours in advance, we will not be able to use that time to schedule another patient in your place. **In that case, you will be charged the full fee for your service. It will be your responsibility to pay. This fee must be paid before your next scheduled appointment.** The intention of this policy is to enable us to utilize all our treatment slots to meet the increasing need for our therapy patients.
- For PHYSICAL THERAPY ONLY: Most insurances, including Medicare, determine the number of visits that they will cover you for therapy. You are responsible for any co-pays or deductibles required by your insurance plan. If you have any questions about your coverage, please ask the front desk staff.

We appreciate your cooperation and will do our best to accommodate your needs.

Release of Medical Records

I authorize the release of any medical information necessary to my physician and my insurance provider to process claims or authorize visits. This information may include history and date of current illness, medical and surgical history, diagnostic results, as well as information regarding my progress during rehabilitation.

Signature:_____ Date:_____

Acknowledgement of Receipt of Privacy Notice

I, _____, acknowledge that I have been provided with a copy of Stony Brook Organized Health Care Arrangement-Joint Notice of Privacy Practices.

Patient Signature:_____ Date:_____

Signature of Registrar:_____ Date:_____

Advanced Directives

Do you have and Advanced Directive (Living Will, DNR, Health Care Proxy)? Yes_____ No_____

If **YES**, please bring a copy to keep in your chart. If **NO**, and you would like to know more and/or develop an Advanced Directive, please speak with our receptionist, so that we may provide you this information.

Signature:_____ Date:_____