

Heller Acupuncture

Moshe Heller LAc.

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have any questions, please ask. Thank you.

Personal Information

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Occupation _____ Person responsible for your account _____

Who should we thank for referring you to this office? _____

Sex: Male__ Female__ Height _____ Weight _____ Birth date _____ Age _____

Marital Status: Married__ Single__ Divorced__ Widowed__ Number of children _____

Have you received acupuncture therapy before? Yes__ No__

When? _____ With whom? _____

Please indicate any significant illness you or a blood relative (grandparent, parent or sibling) have had:

Illness	You	Your relative	Approx. date	Illness	You	Your relative	Approx. date
Cancer	_____	_____	_____	Diabetes	_____	_____	_____
Hepatitis	_____	_____	_____	Heart Disease	_____	_____	_____
High blood pressure	_____	_____	_____	Seizures	_____	_____	_____
Rheumatic Fever	_____	_____	_____	Emotional Disorders	_____	_____	_____
Infectious Disease	_____	_____	_____	Tuberculosis	_____	_____	_____

Sexually Transmitted Diseases: Gonorrhea__ Syphilis__ AIDS__ HPV__ Chlamydia__
Herpes__ Date _____

List any medications and supplements you are currently taking(continued on back if necessary)

Medicine and Dosage	Reason	How long?	Prescribed by	Date of last check up

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Please indicate the use and frequency of the following:

	Yes	No	How much?
Coffee/black tea	_____	_____	_____
Non-medical drugs	_____	_____	_____
Tobacco	_____	_____	_____
Alcohol	_____	_____	_____
Water intake	_____	_____	_____
Soda pop	_____	_____	_____

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health problems you now have.

List any allergies, food sensitivities or food cravings that you have.

List any accidents, surgeries, or hospitalizations (include date).

Lab Results (please include copies)

How do you feel about the following areas of your life? (please check the appropriate spaces and indicate any problems you may be experiencing)

	Great	Good	Fair	Poor	Bad
Significant other	_____	_____	_____	_____	_____
Family	_____	_____	_____	_____	_____
Diet	_____	_____	_____	_____	_____
Sex	_____	_____	_____	_____	_____
Self	_____	_____	_____	_____	_____
Work	_____	_____	_____	_____	_____
Exercise	_____	_____	_____	_____	_____
Spirituality	_____	_____	_____	_____	_____

Your Comments:

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For Women

Age of first period (menarche) _____ Age of last period (menopause) _____

Number of days between periods _____ Number of days of flow _____

Color of flow _____ Clots? Yes ___ No ___ Color _____

Average number of pads you use per day:

1st day _____ 2nd day _____ 3rd day _____ 4th day _____ + days _____

Have you been diagnosed with: Fibroids _____ Fibrocystic Breasts _____

Endometriosis _____ Ovarian cysts _____ PID _____ Other _____

Location of pain: Lower abdomen _____ Lower back _____ Thighs _____ Other _____

Nature of pain (please indicate before, during or after menses):

Cramping _____ Stabbing _____ Burning _____

Aching _____ Dull _____ Bloating _____

Consistent _____ Intermittent _____

Bearing down sensation _____

Other symptoms related to menses:

Discharge _____ Vaginal Dryness _____ Headache _____

Nausea _____ Constipation _____ Diarrhea _____

Swollen Breasts _____ Mood swings _____ Ravenous appetite _____

Poor appetite _____ Hot flashes _____ Night sweats _____

Increased libido _____ Decreased libido _____ Insomnia _____

Are you pregnant? Yes _____ No _____ # of pregnancies _____ # of live births _____

of abortions _____ # of miscarriages _____

Date of last: Gynecologic exam _____ Pap smear _____ Mammogram _____

Bone Density scan _____ Results _____

For Men

Date of last prostate check up _____ PSA results _____

Manual prostate exam results _____

Lab Results:

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Frequency of Urination: daytime _____ Nighttime _____

Color of urine: clear _____ murky _____ Odor: _____

Symptoms related to prostate:

Prostate problems	___	Delayed stream	___	Dribbling	___
Rectal Dysfunction	___	Incontinence	___	Retention of Urine	___
Back pain	___	Increased Libido	___	Decreased Libido	___
Premature Ejaculation	___	Impotence	___	Groin pain	___
Testicular pain	___	Other:	___		

Symptom Survey

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
NO MARK () = NEVER EXPERIENCE CHECK MARK (√) = SOMETIMES EXPERIENCE
PLUS SIGN (+) = FREQUENTLY EXPERIENCE

___ lack of appetite	___ excessive appetite	___ loose stool or diarrhea
___ digestive problems, indigestion	___ vomiting	___ belching, burping
___ heartburn/ reflux	___ feeling the retention of food in stomach	___ tendency to become obsessive in work, relationships ...

___ insomnia, difficulty sleeping	___ heart palpitations	___ cold hands and feet
___ nightmares	___ mentally restless	___ laughing for no apparent reason
___ angina pains	___ abdominal pains	___ chest pain
___ sciatic pain	___ headaches	___ pain or coldness in the genital area

___ cough	___ shortness of breath	___ decreased sense of smell
___ nasal problems	___ skin problems	___ feeling of claustrophobia
___ bronchitis	___ colitis or diverticulitis	___ constipation
___ hemorrhoids	___ recent use of antibiotics	___ eye problems
___ jaundice (yellowish eyes or skin)	___ difficulty digesting oily foods	___ gall stones
___ light colored stool	___ soft or brittle nails	___ easily angered or agitated
___ difficulty in making plans/decisions		___ spasms or twitching of muscles

___ low back pain	___ knee problems	___ hearing impairment
___ ear ringing	___ kidney stones	___ decreased sex drive
___ hair loss	___ urinary problems	___ fatigue
___ edema	___ blood in stool	___ black tarry stool
___ easily bruised	___ difficult to stop bleeding	___ asthma
___ tendency to catch colds easily	___ intolerance to weather changes	___ allergies
___ hay fever	___ dizziness	___ tendency to faint easily
___ high cholesterol levels	___ sudden weight loss.	

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INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE TREATMENT

I request and consent to the performance of acupuncture and other Chinese medicine procedures. I understand that my signature on this form indicates that I have read the following, and understand that if I have any questions about this information, I should ask the practitioner.

1. Nature of Treatment: The treatment modalities may include acupuncture, massage therapy, acupressure, cupping, gua-sha, electric acupuncture, Chinese herbs. I understand that the treatments will be explained to me prior to treatment for my condition.
2. Purpose of Treatment: I understand that the purpose of the treatment is to resolve my condition, the reason that I am requesting treatment. The procedures used will attempt to remedy bodily dysfunction or diseases, to modify or prevent the perception of pain, and to make normal the body's physiological functions.
3. Risks of Treatment: I understand that Chinese medicine procedures have been shown to be safe and effective. However, I understand that there are some uncommon risks. These may include:
 - ❖ Mild discomfort during or after the insertion of a needle, dizziness, fainting, localized bruising or swelling, gastro-intestinal upset with the use of Chinese herbs, temporary aggravation of symptoms that existed prior to treatment; Some herbs and acupuncture points are contraindicated during pregnancy. Please notify your practitioner if you are or might be pregnant.
4. Use of Disposable Needles: I understand that to prevent any possibility of infection from acupuncture, all needles used are pre-sterilized, one time use, surgical stainless steel needles that are disposed of after usage as medical waste. Needles are never reused.
5. Unforeseen risks: I understand that the practitioner can not anticipate or explain all risks and complications which may occur during or after treatment. I understand that they will exercise judgment based upon their determination of my best interests. I understand that I may stop treatment at any time.

Patient advisory to consult a physician: To comply with Article 160, section 8211.1 (b) of NYS Education law, we must advise that you consult a physician regarding your condition.

OFFICE POLICIES & PROCEDURES:

Insurance Policies: I authorize payment of insurance benefits otherwise payable to me directly to the practitioner. I agree to pay for treatment sessions, co-payments, deductibles, and coinsurances for the services performed in the event that my health insurance policy does not cover those services or as required by my policy. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Appointment Policies: Please be on time for appointments. Failure to cancel an appointment with less than 24 hours notice will result in full payment. Please note that your insurance carrier is not responsible for this fee, you are. Your consideration is well appreciated

HIPPA Privacy Act: Ensures that all of your personal and health information remains confidential at all times between this office, your insurance company and you. Should you have any questions about the privacy of your information at this office, you may ask Moshe Heller at any time.

Your signature indicates that you have read, understand and agree with the above information.

Signature of patient (or parent if minor) _____ Date _____