New Acupuncture Patient Information

Your first visit will last about 90 minutes. Follow-up treatments will take 45 - 60 minutes. For your first visit, please arrive 15 minutes prior to your scheduled appointment time to make sure all paperwork is completed and we can get your treatment started on time.

Acupuncture has been practiced for centuries, but may be very different from any health care experience you've had before. I will ask you a number of questions about your health and history, some of which may be unfamiliar to you. You may never have had a health intake that includes looking at your tongue and taking multiple pulses. It will only be unfamiliar the first time! I encourage you to ask me questions about your treatment and progress. Your treatment is individual, as is your response to it. By asking questions you are learning how your own body heals.

To prepare for your first visit:

1. Complete Forms:

    - *Prior to your appointment print and complete **Health History** and **Consent Forms** and bring them with you. The questionnaire will form the basis of an in-depth conversation we'll have at your initial consultation and enable me to customize an effective treatment plan for you.*

2. What to Bring

    - *List of medications, supplements, or herbs, etc. that you are currently taking. Bring any medical and lab reports that are related to your health concern.*

3. What to Wear

    - *Wear loose-fitting, comfortable clothing that is convenient for accessing areas such as the arms, legs, abdomen and back of the body during treatments.*
    - *Refrain from wearing any perfume, cologne or scented lotions. Many of our patients are sensitive to fragrances.*

4. What to Eat/Drink

    - *Eat a light meal prior to your appointment to prevent any possible light-headedness or nausea.*
    - *Don't drink caffeinated beverages (coffee, tea, energy drinks, etc.) or take any pain medications for at least 4 hours prior to your visits*.
    - *Don't eat or drink anything that changes the color of your tongue, and don't brush your tongue the morning of your appointments. In Chinese medicine, the tongue gives us valuable information about your* health.
    - *Use the restroom prior to your appointment. Acupuncture treatments can stimulate your bladder!*

5. After Treatment

    - *Go home: continue to relax. You may feel sleepy or hazy as your body responds to the treatment.*
    - *Refrain from overexertion, drugs or alcohol for at least six hours after treatment.*

Health History

Date: ____/____/____

Name	Gender	Age	Date of Birth ____/____/____
Address	**City**	**State**	**Zip Code**

Phone #
☐ Home ____________________
☐ Cell ____________________
☐ Other ____________________
Email ____________________

Emergency Contact____________________________
Contact Phone # ____________________________
Relationship ____________________________

Occupation:	Height ________ Weight ________	Physician Name Physician Address Physician Phone #

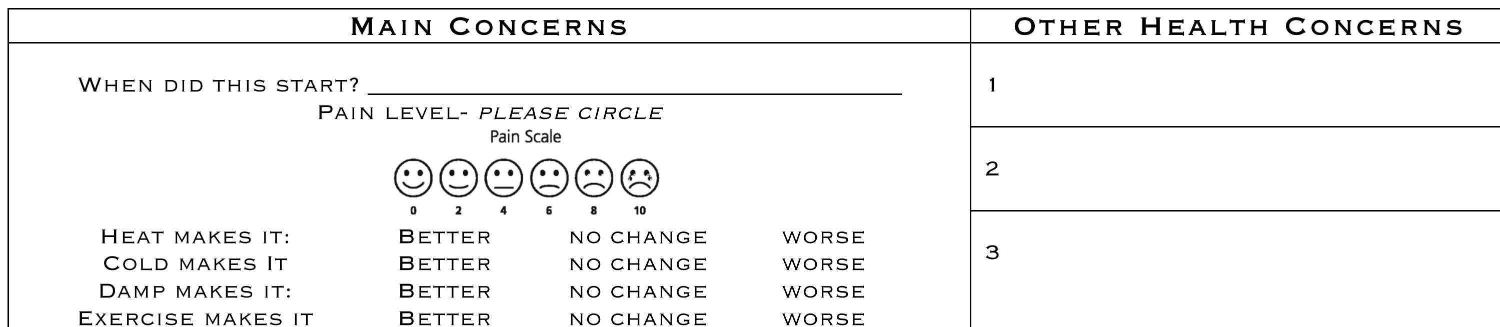
Have you Been treated by Acupuncture or Oriental Medicine Before?

☐No ☐ Yes .... Last Treatment ______/______/______

Relationship status

☐ Single ☐ Divorced
☐ Married ☐ Widowed
☐ Living w/Partner ☐ Other
☐ Separated

How Did you hear about our clinic?



Main Concerns

When did this start? ____

Pain level- *please circle*

Pain Scale

0 2 4 6 8 10

Heat makes it:	Better	no change	worse
Cold makes It	Better	no change	worse
Damp makes it:	Better	no change	worse
Exercise makes it	Better	no change	worse

Other Health Concerns

1

2

3

Health History

	You	Year	Family		You	Year	Family
☐ Cancer – type(s) ____________				☐ Osteoporosis			
☐ Diabetes				☐ Herpes			
☐ Hepatitis				☐ Aids/HIV			
☐ High Blood Pressure				☐ Other STD			
☐ Heart Disease				☐ Rheumatic Fever			
☐ Stroke				☐ Alcoholism			
☐ Seizure				☐ Allergies –Types ____________			
☐ Thyroid Disease				☐ Mental Illness			
☐ Asthma				☐ Kidney Disease			
☐ Pacemaker				☐ Anemia			

Habits		Exercise
	Amount/Frequency	Regularly? ☐ Yes ☐ No
Coffee/Tea	________________	If so, what and How Often:
Tobacco	________________	________________
Alcohol	________________	
Drugs	________________	

Medications

Please note what medications, herbs or supplements you use regularly

Medicine/Vitamins	Dosage	Reason	How Long?

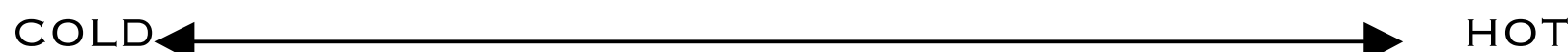
Injuries & Surgeries

Please note area of body & date

Temperature

How warm / cold you feel (not in degrees) relative to other people?
do you wear more or less layers, etc.

Please indicate your body's overall relative Temperature Along The Line With An ***X***

COLD  HOT

☐ Cold hands/ feet
☐ Chills
☐ Cold "in the bones"
☐ Areas of numbness

☐ Excessive thirst
☐ Thirst for cold /hot drinks
☐ Thirst, no desire to drink
☐ Absence of thirst

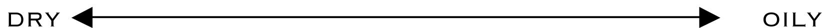
☐ Night sweats
☐ Unusual sweats

When? ________am / pm
Where on body__________

☐ Hot hands, feet, chest
☐ Hot flashes
☐ Hot in afternoon
☐ Hot at night

Moisture

Please indicate your body's relative moisture level along the line with an ***X***
Hair, skin, mouth, etc.

DRY  OILY

☐ Dry skin
☐ Dry hair
☐ Dry eyes
☐ Dry brittle nails

☐ Dry mouth
☐ Dry lips
☐ Dry throat
☐ Dry nose /Nosebleeds

☐ Edema /Swelling______
☐ Rashes________________
☐ Itching ________________
☐ Dandruff

☐ Weight gain / loss
☐ Oily skin
☐ Oily hair
☐ Pimples

Digestion

Please indicate your body's overall digestion along the line with an ***X***

DIARRHEA ◄────────► CONSTIPATION

BM: How often? _____x / every _____days
- [ ] Alternating diarrhea & constipation (IBS)
- [ ] Indigestion
- [ ] Gas
- [ ] Belching
- [ ] Bloating
- [ ] Nausea / Vomiting
- [ ] Bad breath
- [ ] Dry Stools
- [ ] Difficult to pass
- [ ] Tired after BM
- [ ] Excessive hunger
- [ ] Poor appetite
- [ ] Ulcer
- [ ] Hemorrhoids

ENERGY

Please indicate your body's overall energy level along the line with an ***X***

LOW ◄────────► HIGH

- [ ] Sudden energy drop
  Time of day: _____ am / pm
- [ ] Energy drop after eating
- [ ] Fatigue
- [ ] Dependence on caffeine
- [ ] Wired / ungrounded feeling
- [ ] Body / Limbs feel heavy
- [ ] Body / Limbs feel weak
- [ ] Shortness of breath
- [ ] Heart Palpitations
- [ ] Blood pressure High / Low
- [ ] Bleed / Bruise easily
- [ ] Hard to concentrate
- [ ] Poor memory
- [ ] Dizziness / lightheaded
- [ ] Headaches _____x / week

Female Reproductive

Are you sexually active? Y [ ] N [ ]

MENSES (If applicable)

Age at first menses _______
Length of full cycle _______ days
Length of menses _____ days
Last menses start date _____ / _____
# of pregnancies _____
# of births ___premature ___Miscarriages
___Abortions

- [ ] Birth control pill (hormonal)
- [ ] Heavy periods
- [ ] Light periods
- [ ] Painful periods
- [ ] Irregular periods
- [ ] Changes in body/psyche prior to menstruation (PMS)
- [ ] Cramps Before bleeding___
  First day___During period___
- [ ] Fatigue w/ menses
- [ ] Digestive changes w/ menses
- [ ] Mid-cycle spotting
- [ ] Yeast infections

MENOPAUSE

Age changes began ________
Age at last menses ________

- [ ] Hot flashes _____x/ day
- [ ] Vaginal dryness
- [ ] Night sweats _____x / week
- [ ] Loss of sex drive

Male Reproductive

Are you sexually active? Y [ ] N [ ]
- [ ] Change of sexual drive
- [ ] Erectile dysfunction
- [ ] Premature ejaculation
- [ ] Sores on genitals
- [ ] Discharge
- [ ] Prostate disease
- [ ] Genital Pain
- [ ] Jock Itch
- [ ] Vasectomy
- [ ] Hernia
- [ ] Hemorrhoids

Emotions

What emotion(s) dominate your experience?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Fear
- ☐ Timid / shy
- ☐ Indecision

Urinary (if applicable)

- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Difficulty starting / stopping
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Burning sensation
- ☐ Cloudy urine
- ☐ Blood in urine

Sleep

hours per night ______

- ☐ Difficulty falling asleep
- ☐ Wake ___x/ night @_____am / pm
- ☐ Wake to urinate *How often?*________
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested upon waking

Head, Eyes, Ears, Nose, Throat

- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excess earwax

- ☐ Sore throat
- ☐ Frequent Coughs
- ☐ Swollen Glands
- ☐ Hoarseness
- ☐ Trouble Swallowing
- ☐ Poor vision
- ☐ Night Blindness

- ☐ Headache
- ☐ Migraine
- ☐ Head Injury
- ☐ Dizziness
- ☐ Vertigo
- ☐ Hay Fever

- ☐ Sinus congestion
- ☐ Nose Bleeds
- ☐ Loss of Smell
- ☐ Phlegm (*color*_______)

- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Teary Eyes
- ☐ Dry Eyes
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Spots in front of eyes

- ☐ Dental problems
- ☐ Mouth sores
- ☐ Jaw Problems /TMJ
- ☐ Teeth Grinding

Thank You For Taking The Time To Complete Prior To Your First Treatment

INFORMED CONSENT FOR ACUPUNCTURE

I hereby request and consent to the performance of Acupuncture treatments and other Chinese Medicine procedures on me by Gabrielle Applebaum, or other licensed acupuncturists who may be employed by or contracted with Fabric Spa, LLC.

"Acupuncture" is the stimulation of a certain point or points on or near the surface of the body by the insertion of special needles. Acupuncture may allow for the relief of one's symptoms without the need for medications or other invasive therapies, and improve the balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

I understand that methods or treatments may include, but are not limited to: Acupuncture, Moxabustion, Cupping, Electro- Acupuncture, Tui-Na (Chinese massage), Gua-sha, and Nutritional Counseling.

I have been advised that only pre-sterilized needles are used, which are disposed of after each use/treatment.

I understand that in the practice of acupuncture there are some risks including but not limited to: slight pain or discomfort at the site of needle insertion, infection, minor bruising/bleeding, weakness, fainting, nausea, burning, pneumothorax, spontaneous miscarriage, and aggravation of problematic symptoms existing prior to acupuncture treatment.

I understand that it may be necessary for my acupuncturist to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives permission to release any medical records for the reasons set forth in this paragraph.

I have read the above consent form. I have had an opportunity to ask questions, and by signing below, I agree to the above-mentioned procedures. I intend this consent form to cover the entire course of treatment, present and future.

"With this knowledge, I voluntarily consent to the above procedures."

____

Patient Name (*Please Print*)

____________________________________ ______________________________

Signature of Patient Date

Fabriq Spa Protects Your Health Information And Privacy

Dear Valued Patient ,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g*. requests for medical records, claim payment information).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at (215) 922-3235.

Yours truly,

Gabrielle Applebaum, Acupuncturist
L.Ac, M.Ac, Dipl.Ac, MTS

Acknowledgement of Privacy
For Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Fabric Spa, LLC Gabrielle Applebaum (collectively, the "Recipients") for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. The Recipients are not required to agree to the restrictions that I may request. However, if the Recipients agree to a restriction that I request, the restriction is binding upon them.

I have the right to revoke this consent, in writing, at any time except to the extent that the Recipients have taken action in reliance on this consent

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the Recipients' Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Recipients. This Notice of Privacy Practices also describes my rights and the duties of my practitioners with respect to my identifiable health information.

The Recipients reserve the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

_______________________________ ______________
Signature of Patient or Authorized Representative Date

____
Printed Name and Relationship