REMEDY NYC

12 West 27th Street, 9th floor
New York, NY 10010

**Please take the time to fill out the forms carefully. Please note this is a confidential record of your medical history and will be kept in the office. Information contained here will not be released to any person except when you have authorized us to do so.*

Last Name ____________ First Name ____________ Today's Date ____________

Address: ____________ City ____________ State ____________ Zip ____________

Home Phone (   ) ____________ Work (   ) ____________ Cell (   ) ____________

Date of Birth ____________ Age ______ Male [ ] Female [ ] Email address ____________

Occupation ____________ Employer ____________

Education (highest grade or degree achieved) ____________

Married [ ] Single [ ] Divorced [ ] Partner [ ] Name of Spouse ____________

Height ____________ Weight ____________

Emergency Contact ____________ Phone (   ) ____________ Relationship to Patient ____________

Referred by ____________

Have you ever had Acupuncture or Oriental Medicine before? ____________ If so, when? ____________

MAJOR COMPLAINTS (*in order of importance, along with duration of the symptoms*)

1. ____________ Severe [ ] Moderate [ ] Slight [ ]
2. ____________ Severe [ ] Moderate [ ] Slight [ ]
3. ____________ Severe [ ] Moderate [ ] Slight [ ]

Have you been given a diagnosis for this condition? ____________ If so, what? ____________

What kinds of treatment have you tried? ____________

Are you currently receiving treatment for this? ____________ If so, please describe ____________

Does anything improve your condition? ____________ Does anything aggravate your condition? ____________

MEDICAL HISTORY
(Please check all that apply)

Diagnosed	Date Diagnosed		Date Diagnosed
High Blood Pressure [ ]	____ /____ / ____	Diabetes [ ]	____ /____ / ____
High Cholesterol [ ]	____ /____ / ____	Thyroid Disease [ ]	____ /____ / ____
Cancer [ ]	____ /____ / ____	Hepatitis [ ]	____ /____ / ____
HIV [ ]	____ /____ / ____	Seizures [ ]	____ /____ / ____
Heart Disease [ ]	____ /____ / ____	Rheumatic Fever [ ]	____ /____ / ____
Birth Trauma [ ] (prolonged labor, forceps delivery, etc)	____ /____ / ____	Others [ ]	____ /____ / ____

Surgeries/Dates ____________

Significant Traumas (auto-accidents, falls, etc) ____________

MEDICATIONS/SUPPLEMENTS *(List medications you are currently taking, including prescription medicine, supplements, herbal supplements, and over-the-counter medicines you take on a regular basis, the dosage, duration, reason)*

ALLERGIES *(to medications, chemicals, foods, etc)*

FAMILY MEDICAL HISTORY *(please check all that apply)*

Conditions	Mother	Father	Sibling	Grandparent
Heart disease				
Cancer				
Hypertension				
Stroke				
Asthma				
Allergies				
Migraines				
Depression				
Other mental illness				
Substance abuse				
Osteoporosis				
Diabetes				
Glaucoma				

LIFESTYLE HISTORY

Do you typically eat at least three meals a day? If no, how many?

Do you exercise? What type of exercise? How long / how many days per week?

How many hours per night do you sleep? Do you wake up during the night?

Do you go back to sleep w/o problem? Do you wake up rested?

How many hours per week do you work? Do you enjoy work? Why/Why not?

Nicotine / Alcohol / Caffeine use per day:

How many glasses of water do you drinks a day? Other drugs:

Interests / Hobbies

NUTRITION

Do you follow a special diet? If yes, how would you describe the diet? (vegetarian, vegan, low carbs, etc)

What do you eat on a ‘typical’ day?

Foods you tend to crave

Foods you dislike

PLEASE CHECK ALL THAT APPLY*:*

GENERAL

- ☐ Poor appetite
- ☐ Fevers
- ☐ Localized weakness
- ☐ Changes in appetite
- ☐ Excessive appetite
- ☐ Night sweats
- ☐ Poor coordination
- ☐ Strong thirst
- ☐ Insomnia
- ☐ Sweat easily
- ☐ Bleed or bruise easily
- ☐ Sudden energy drop
- ☐ Fatigue
- ☐ Chills
- ☐ Catch cold easily
- ☐ Poor balance

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Phlebitis
- ☐ Fainting
- ☐ Difficult breathing
- ☐ Low blood pressure
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Swelling of hands and feet
- ☐ Blood clots
- ☐ Irregular heart beat
- ☐ Cold hands/feet
- ☐ Dizziness

RESPIRATORY

- ☐ Asthma
- ☐ Pneumonia
- ☐ Pain with deep inhalation
- ☐ COPD
- ☐ Bronchitis
- ☐ Cough
- ☐ Excessive phlegm (color?)
- ☐ Other:
- ☐ Frequent colds
- ☐ Coughing blood

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Easily susceptible to stress
- ☐ Disorientation
- ☐ Mania
- ☐ Concussion
- ☐ Areas of numbness
- ☐ Anxiety
- ☐ Irritability
- ☐ Tremors
- ☐ Lack of coordination
- ☐ Poor memory
- ☐ Paralysis
- ☐ Headaches
- ☐ Loss of balance
- ☐ Easily agitated
- ☐ Numbness/tingling of limbs

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems?

GASTROINTESTINAL

- ☐ Nausea
- ☐ Blood in stools/black
- ☐ Indigestion
- ☐ Ulcers
- ☐ Vomiting
- ☐ Bad breath
- ☐ Gallbladder disorder
- ☐ Hernia
- ☐ Diarrhea
- ☐ Rectal pain
- ☐ Gas / Bloating
- ☐ Other:
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Parasites
- ☐ Belching
- ☐ Pain or cramps
- ☐ IBS

SKIN & HAIR

- ☐ Rashes
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Hair loss
- ☐ Dryness
- ☐ Pimples / Acne
- ☐ Tumors, lumps
- ☐ Recent moles
- ☐ Changes in hair or skin
- ☐ Other:

HEAD & NECK

- ☐ Dizziness
- ☐ Fainting
- ☐ Neck stiffness
- ☐ Enlarged lymph nodes
- ☐ Headaches
- ☐ Concussions

EARS

- ☐ Infections
- ☐ Ringing / Tinnitus
- ☐ Decreased / poor hearing
- ☐ Other:

EYES

- ☐ Blurred vision
- ☐ Visual changes
- ☐ Poor night vision
- ☐ Floaters / Spots
- ☐ Cataracts
- ☐ Glasses / contacts
- ☐ Eye inflammation
- ☐ Other:

NOSE, THROAT, MOUTH

- ☐ Nose bleeds
- ☐ Sinus infections
- ☐ Hay fever or allergies
- ☐ Recurring sore throats
- ☐ Grinding teeth
- ☐ Difficulty swallowing
- ☐ sores on lips or tongue
- ☐ Jaw clicks

GENITO-URINARY

- ☐ Kidney stones
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Night urination
- ☐ Other:

MUSCULO-SKELETAL

- ☐ Stiff neck / shoulders
- ☐ Low back pain
- ☐ Back pain
- ☐ Knee pain
- ☐ Muscle spasm, twitching
- ☐ Sore, cold, weak knees
- ☐ Joint pain
- ☐ Arthritis

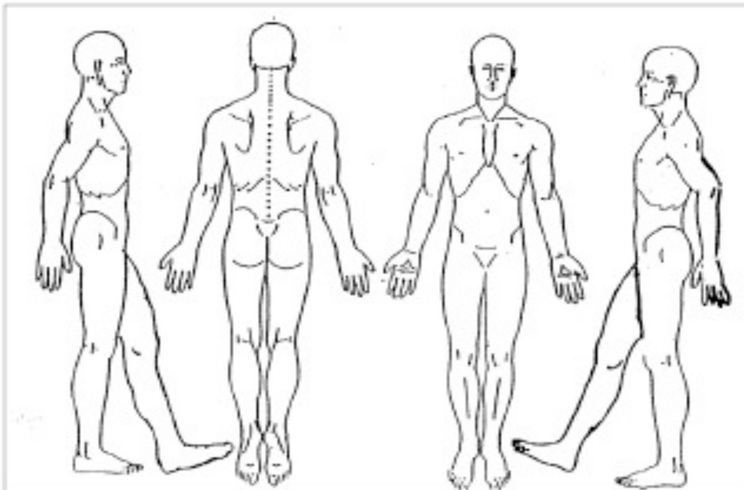
FEMALE

- ☐ Frequent urinary tract infection
- ☐ Frequent vaginal infections
- ☐ Pain / itching of genitalia
- ☐ Genital lesions / discharge
- ☐ Pelvic inflammatory disease
- ☐ Abnormal pap smear
- ☐ Irregular menstrual periods
- ☐ Painful menstrual periods
- ☐ Premenstrual syndrome
- ☐ Abnormal bleeding
- ☐ Menopausal syndrome
- ☐ Break lumps
- ☐ Hot flashes
- ☐ Other:

MALE

- ☐ Pain / itching of genitalia
- ☐ Genital lesions / discharge
- ☐ Weak urinary stream
- ☐ Lumps in testicles
- ☐ Impotence
- ☐ Other:

PLEASE MARK ALL AREAS OF PAIN ON THE DIAGRAM:



FOR WOMEN:

Are you pregnant now? Yes [ ] No [ ]

Please indicate number of occurrences: Live Births: Pregnancies: Miscarriages: Abortions:

Age of First Period: Menopause (if applicable):

Date of Last Pap Smear: Last Mammogram:

FOR MEN:

Do you have any bothersome urinary symptoms? Yes [ ] No [ ]

Describe:

OTHER INFORMATION:

Please list and briefly describe any other information that might be important

CANCELLATION AND OFFICE POLICIES

We take pride in the quality of care we offer to our patients. In order to do this we have a strict cancellation policy. All appointments require advanced notification of cancellation by 9am of the previous business day prior to the scheduled appointment. Although we appreciate as much notice as possible, if sufficient time is not given, the full fee will be charged to the patient.

Payment is expected at the time of visit. We currently only accept cash and checks. There will be a $25 charge for returned checks. If you have questions or concerns about these policies, please feel free to ask.

I have read, understand and agree to the above described policies.

______________________________	______________________________	____________________
Patient Name (print)	Patient Signature (*or Representative)*	Date

ADVICE TO CONSULT A PHYSICIAN

While Oriental Medicine has a great deal to offer as a health care system, it cannot totally 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 treatment.

To comply with Article 160. Section 8211.1(b) of NYS Education Law, we request that you read and sign the following statement.

We the undersigned do affirm that ____(patient), has been advised by

____________________________________ (Licensed Acupuncturist) to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

______________________________	______________________________	____________________
Patient Name (print)	Patient Signature (*or Representative*)	Date
______________________________	______________________________	____________________
Licensed Acupuncturist (print)	Licensed Acupuncturist Signature	Date

INFORMED CONSENT

I hereby request and consent to Oriental Medicine diagnosis and treatment by the above named Practitioner. I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, tui na massage, and Chinese or Western herbal medicine are nutritional counseling. I have had the opportunity to discuss the nature and purpose of treatment with the Practitioner. I have been informed that acupuncture is a safe method of treatment, but it may have side effects including bruising, numbness or tingling near the needling sites that may last a few days and dizziness and fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, though we use sterile disposable needles for each patient. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the main risks, other side effects and risks may occur. I also understand that the herbs and nutritional supplements that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I also understand that they come from plant, animal and mineral sources and that some herbs may be inappropriate during pregnancy.

I do not expect the Practitioner to be able to anticipate and explain all risks and complications. I wish to rely on the Practitioner to exercise judgment during the course of the treatment that the Practitioner feels is correct at the time, based upon the facts then known, is in my best interests.

In the event that herbal therapy is recommended, I understand that I am responsible for payment for the costs of such herbs and that it is my responsibility to pick up herbal orders that are placed with an herbal pharmacy on my behalf. In the event that I do not pick up herbs that have been ordered on my behalf, I understand that I am nonetheless responsible for payment of their costs. I understand that the nature of the services provided may be altered in the event of pregnancy as some procedures may be harmful under such circumstances. Accordingly, I agree to advise my practitioner if I am pregnant and understand that this is a continuing obligation.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above mentioned procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

______________________________	______________________________	____________________
Patient Name (print)	Patient Signature (*or Representative*)	Date
______________________________	______________________________	____________________
Licensed Acupuncturist (print)	Licensed Acupuncturist Signature	Date

NOTICE OF PRIVACY POLICIES

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to us.

As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

Protected Health Information Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provided providing treatment to you. However, this information will not be provided unless you have authorized it in writing.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be use and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved In Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information maybe used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

Required By Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters. We may also write a thank you card to whomever referred you to our practice.

Patient Rights

Access: At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you $0.83 per page for the first 30 pages and $0.63 for every page after that plus $19.00 for staff time to locate and copy you protected health information. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associated disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

Questions and Complaints

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in any way. We are available to assist you with any questions, concerns, or complaints.

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201

877-696-6775 (toll free)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I have read and understood the HIPAA privacy policies and consent to the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

_______________________ _______________________ _______________________

Patient Name (print) Patient Signature Date

For Office Use Only

We attempted to obtain written acknowledgment of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please specify)

____