Dix Hills Family Acupuncture, P.C.
"Ancient Healing for the Modern Family"
Jodie Cole, L.Ac., CPC, ADS

Patient Information

Please answer questions to the best of your knowledge.

Date: ________________

Name: ____ SS #: ______________________

Address: ____

City: ______________________________________ State: __________ Zip: ____________

Home Phone: ______________ Other: ______________ Cell: ____________________

Fax: ____________________________ Email: _________________________________

Sex: male ( ) female ( ) Height _____ Weight ____ DOB ______________ Age ______

Emergency Contact: Name ______________________________ Phone _________________

Insurance Information:

Information of the Insured (if different from patient):

Name: ____ SS #: ______________________

Address: ____

City: ______________________________________ State: __________ Zip: ____________

Home Phone: ______________ Other: ______________ Cell: ____________________

Insurance Company Information:

Name: _______________________________ ID #: __________ Group ID #: ____________

Address: ____

City: ______________________________________ State: __________ Zip: ____________

Phone: _______________________________ Fax: _______________________________

No Fault Information:

Is your Visit due to a car accident in New York State? Yes ( ) No ( )
If so, are you covered under No Fault? Yes ( ) No ( )

Policy Holder Name: __________________________ Policy #: ______________________
Date of Accident: ____________________________ File #: ________________________

DIX HILLS FAMILY ACUPUNCTURE

Your primary biomedical doctor's contact information:

Name: ____________________

Address: ____________________

Phone: ____________________ Fax: ____________________

Referred by ____________________ Have you received acupuncture before? Yes ( ) No ( )

If yes, what were you treated for?: ____________________

Please indicate any significant illness you or a blood relative have had:

	You	Relative	When		You	Relative	When
Cancer	( )	( )	______	High Cholesterol	( )	( )	______
Hepatitis	( )	( )	______	Seizure afflictions	( )	( )	______
Hypertension	( )	( )	______	Emotional d/o	( )	( )	______
Infectious dx	( )	( )	______	Tuberculosis	( )	( )	______
Diabetes	( )	( )	______	HIV/AIDS	( )	( )	______
Autoimmune	( )	( )	______	Arthritis	( )	( )	______

Please list any medications and supplements you are currently taking: (continue on back if necessary)

Medicine	Dosage	Reason	How Long	Prescribed by	Last check up

Please check if any of the following statements are true for you.

( ) I have known allergies ( ) I am taking anticoagulants ( ) I have a pacemaker ( ) I am pregnant

Please indicate the use and frequency of the following:

	Yes	No	how much		Yes	No	how much		Yes	No	how much
Coffee/Black tea	( )	( )	______	Water Intake	( )	( )	______	Soda	( )	( )	______
Non-medical drugs	( )	( )	______	Alcohol	( )	( )	______	Tobacco	( )	( )	______

How do you FEEL about the following areas of your life:

	Good	Average	Poor	Your Comments:
Significant other	( )	( )	( )	____________________
Family	( )	( )	( )	____________________
Diet	( )	( )	( )	____________________
Sex	( )	( )	( )	____________________
Self	( )	( )	( )	____________________
Work	( )	( )	( )	____________________
Exercise	( )	( )	( )	____________________
Spirituality	( )	( )	( )	____________________

DIX HILLS FAMILY ACUPUNCTURE

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

____

____

What other forms of treatment have you sought?

____

Please list any other heath problems you now have:

____

____

Please list any allergies or food sensitivities you may have **(including to Latex)**:

____

Please list any accidents, surgeries or hospitalizations (including dates):

____

____

____

Pleases list any special consideration or circumstances you would like your practitioner to be aware of:

____

FOR MEN

Date of last prostate checkup: ________________ PSA results: ____________________

Manual prostate exam results: ______________________________________

Frequency of urination: Day time _________ Night time ________

Color/Quality of urine: ( ) Clear ( )Cloudy ( )Red ( ) Odor

Symptoms related to prostate:

( ) Delayed stream ( ) Dribbling ( ) Incontinence ( ) Retention of urine

( ) Rectal dysfunction ( ) Increased libido ( ) Decrease libido ( ) Premature ejaculation

( ) Impotence ( ) Groin pain ( ) Testicular pain ( ) Back pain

DIX HILLS FAMILY ACUPUNCTURE

FOR WOMEN

Age of first period (menarche) ____________________ Are you pregnant? ( ) Yes ( ) No

Age of last period (menopause)____________________ Number of pregnancies __________

Number of days between periods____________________ Number of live births __________

Number of days of flow ____________________ Number of miscarriages __________

Number of pads/tampons on heaviest day ______________ Number of abortions __________

Color of flow: ( ) Red ( ) Purple ( )Dark ( ) Brown

Clots: ( ) Yes ( ) No

Date of last Gynecological exam __________ Pap smear __________ Mammogram ______________

Results: ____

____

Have you been diagnosed with:

( ) Fibroids ( ) Fibrocystic breasts ( ) Endometriosis ( ) PID ( ) Ovarian cysts

( ) Other: ____

Symptoms associated with menses:

Pain ( ) No ( ) Yes (if yes, check Nature of pain)

Nature of pain:

( ) Cramping ( ) Stabbing ( ) Burning ( ) Constant

( ) Aching ( ) Dull ( ) Intermittent ( ) Bear down sensation

Discharge: ( ) No ( ) Yes (if yes, check nature of discharge)

Nature of discharge:

( ) Clear ( ) White ( ) Yellow ( ) Other color ______________

( ) Thick ( ) Thin ( ) Scanty ( ) Copious

( ) Headache ( ) Swollen breasts ( ) Increase libido ( ) Constipation ( ) Insomnia

( ) Mood swings ( ) Irritability ( ) Decreased libido ( ) Vaginal dryness ( ) Nausea

( ) Hot flashes ( ) Poor appetite ( ) Night sweats ( ) Palpitations ( ) Diarrhea

( ) Increased appetite ( ) Other ______

DIX HILLS FAMILY ACUPUNCTURE

GENERAL SYMPTOM SURVEY (for everyone)

Please check the symptoms you have experienced recently:

Gastrointestinal/Digestive Problems:

( ) Poor appetite
( ) Excessive appetite
( ) Full feeling
( ) Vomiting
( ) Nausea
( ) General fatigue/lack of energy
( ) Belching/Burping
( ) Gas/Bloating
( ) Indigestion
( ) Abdominal pain or cramping
( ) Constipation
( ) Tired after meals
( ) Easily bruised
( ) Heartburn/Acid Reflux
( ) Sudden weight loss
( ) Colitis/Diverticulitis
( ) Blood in Stools
( ) Excessive weight gain
( ) Pasty taste in mouth
( ) Bitter taste in mouth
( ) Gall stones
( ) Loose stools/diarrhea
( ) Hemorrhoids
( ) Jaundice
( ) Difficulty digesting fatty or oily foods
( ) Use of laxatives/fiber: ______
( ) Other: ______
( ) Food allergies: ______

Respiratory:

( ) Wheezing
( ) Frequency catching colds
( ) Asthma
( ) Hay fever
( ) Shortness of breath
( ) Intolerant to weather changes
( ) Bronchitis
( ) Nasal problems
( ) Skin Problems
( ) Recent use of antibiotics
( ) Difficulty breathing
( ) Frequent yawning
( ) Sighing often
( ) Tightness in chest
( ) Dry cough
( ) Cough with Phlegm
( ) Cough with blood
( ) Allergies: ______

Cardiovascular – Circulation

( ) Palpitations
( ) High Blood Pressure
( ) Low Blood Pressure
( ) Chest Pain
( ) High cholesterol
( ) Irregular Heart Beat
( ) Murmur
( ) Varicose Veins
( ) Too hot/cold
( ) Numbness in extremities
( ) Ankle/hand swelling
( ) Easy to faint
( ) Dizziness
( ) Normal
Other ______

Urinary/Genital

( ) Frequent
( ) Bladder Infections
( ) Burning w/urination
( ) Urgency
( ) Incontinence
( ) Kidney stones or infections
( ) Night-time urination
( ) Edema
( ) Low Back Pain
( ) Knee problems
( ) Hearing Impairment
( ) Ear ringing
( ) Bone spurs
( ) Decreased sex drive
( ) Infertility
( ) Hair loss
( ) Sexual dysfunction
( ) Decreased sense of smell
( ) Normal

Appetite:

( ) Poor
( ) Good
( ) Hungry
( ) Loss of taste

Type of diet:
( ) Standard American Diet
( ) Vegetarian
( ) Vegan
( ) Macrobiotic
( ) Gluten Free
( ) Other

How often do you eat/drink in a week/month/year?

Eggs ______
Dairy ______
Fruits ______
Vegetables ______
Meat/Fish ______
Hot/Spicy Food ______
Sweets ______
Whole Grains ______
Alcohol/Type ______
Coffee/Tea ______
Soda (regular/diet) ______
Meals per day: ______
Do you eat at regular hours? ( ) Yes ( ) No
Cravings: ______
Food Allergies: ______

Thirst

( ) Less than normal ( ) Thirst but does not drink ( ) Excessive thirst ( ) Prefer cold drinks
( ) Prefer hot drinks ( ) Prefer room temperature drinks ( ) Normal

Weight:
( ) Normal ( ) Underweight ( ) Overweight ( ) Recent gain ( ) Recent loss

Energy:
( ) Normal ( ) Low after eating ( ) Low ( ) Excess ( ) Up and down
( ) Tired in the Afternoon ( ) Other: ______________________________

Sleep:
( ) Dream Often ( ) Difficulty falling asleep ( ) Awake easily ( ) Nightmares
( ) Restless ( ) Difficulty going back to sleep ( ) Tired after sleeping ( ) Sleep too much
Average # of hours of sleep ____________ Other: ______________________________

Body Temperature:
( ) Warm ( ) Feel warmer late afternoon ( ) Cold ( ) Flushed face
( ) Night sweats ( ) Alternate chills and fever ( ) Warm Palms ( ) Profuse Perspiration
( ) Warm soles ( ) Cold hands and feet ( ) Normal Other: ____________

Headaches – Dizziness:
( ) Headaches ( ) Get dizzy when stands ( ) Vertigo ( ) Dizziness
( ) Motion sickness ( ) Poor balance ( ) Faint easily ( ) Migraines
( ) Poor memory ( ) Other: ______________________________
Location of headaches: ______________________________

Skin:
( ) Dry ( ) Bruises easily ( ) Hives ( ) Itching
( ) Oily ( ) Cuts heal slowly ( ) Acne ( ) Eczema
( ) Rashes ( ) Normal Other: ______________________________

Hair:
( ) Dry ( ) Oily ( ) Dandruff ( ) Falling out ( ) Early grey ( ) Normal

Nails:
( ) Soft ( ) Ridges and lines ( ) Spots ( ) Grow slowly ( ) Purple ( ) Pale
( ) Break easily ( ) Yellow ( ) Normal Other: ______________________________

Eyes:
( ) Wear glasses/contacts ( ) Eyelids swollen ( ) Normal ( ) Poor night vision ( ) Itchy ( ) Dry
( ) Sensitive to light ( ) Painful ( ) Twitch ( ) Color blindness ( ) Tear easily ( ) Red
Other: ______________________________

Ears:
( ) Poor hearing ( ) Ringing (high pitch) ( ) Ringing (low pitch) ( ) Discharges
( ) Ear aches ( ) Normal Other: ______________________________

Nose:
( ) Stuffy nose ( ) Environmental sensitivity ( ) Sneezes a lot ( ) Bleeding
( ) Loss of smell ( ) Sinusitis ( ) Normal Other:__________

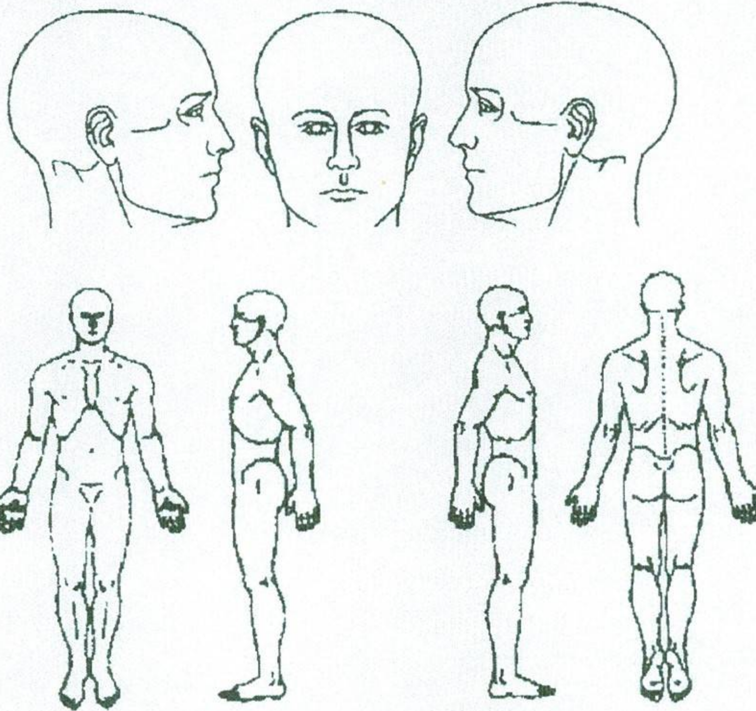
Mouth and Throat:
( ) Dry ( ) Difficulty swallowing ( ) Gum problems ( ) TMJ
( ) Mouth sores ( ) Feel lump in throat ( ) Grind teeth ( ) Normal
Other: ______________________________

Emotional/Stress Level:
( ) Depression ( ) Insomnia/difficult sleeping ( ) Difficulty making decisions ( ) Often sad
( ) Easily Frightened ( ) Frequently laughing ( ) Often angry ( ) Anxiety

( ) Difficulty sleeping ( ) Heart palpitations ( ) Nightmare ( ) Insomnia
( ) Thinking a lot ( ) Cold hands and feet ( ) Often crying ( ) Worry a lot

Please Indicate Areas of Pain

1 – being least pain **5 – being most severe pain**



- ☐ Back pain or trouble ------------ 1 2 3 4 5
- ☐ Muscle pain, spasm, cramping - 1 2 3 4 5
- ☐ Muscle weakness ---------------- 1 2 3 4 5
- ☐ Restless or nervous legs -------- 1 2 3 4 5
- ☐ Spinal disc problems ----------- 1 2 3 4 5
- ☐ Stiff or painful neck ----------- 1 2 3 4 5
- ☐ Swelling ------------------------- 1 2 3 4 5
- ☐ Tendonitis (where:______________________)

Please tell me everything you can about your pain:

____

____

____

____

____

____

____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ______________________________
(PRINT NAME PLEASE)

Signature: ______________________________ Date: __________

Witness: ______________________________ Date: __________

Dix Hills Family Acupuncture
Jodie Cole, L.Ac.

Patient Advisory to Consult a Physician

Jodie Cole, MS L.Ac., is committed to your health and well-being. While Oriental Medicine and Acupuncture has a great deal to offer as health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult your physician regarding any condition or conditions you are seeking acupuncture treatment.

In compliance with Article 160, Section 8211.1(b) of NYS Education Law, it is requested that you read and sign the following statement:

I undersigned, do affirm that

____

Print Patient Name

Has been advised by Jodie Cole, MS L.Ac., to consult a physician regarding the condition(s) for which they are seeking acupuncture treatment.

____

Patient Signature Date

____

L.Ac. Signature Date

Dix Hills Family Acupuncture
Jodie Cole, L.Ac.

Informed Consent to Acupuncture Treatment

I, or the patient named below, for whom I am legally responsible, hereby consent to receiving Acupuncture and other Oriental Medicine procedures by Jodie Cole, MS L.Ac., and /or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to: Acupuncture, moxibustion, cupping and guasha, electrical stimulation, Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days. Occasional dizziness or fainting may occur. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. You, as the patient, is encouraged to actively and openly communicate with the practitioner about their treatment experience so as to allow adjustments to be made which aim to maximize your comfort. Bruising is a common side effect of cupping and gua sha. Unusual and rarely occurring risks of acupuncture (less than one per 10,000 treatments) include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although Jodie Cole, MS, L.Ac., uses sterile disposable needles and maintains a clean and safe environment. Burns and /or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral and animal sources) that have been recommended are traditionally considered safe, although at large doses may be toxic. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue. Please inform the practitioner if these or any other side effects are experienced after taking herbs so that appropriate modifications can be made to the formula. These side effects can generally be avoided when herbs are administered by a properly trained herbalist.

I will notify Jodie Cole, MS L.Ac., who is caring for me if I am or become pregnant.

I do not expect Jodie Cole, MS L.Ac., to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on Jodie Cole, MS L.Ac., to exercise judgment during the course of my visits which she thinks, based upon the facts then known, in my best interest. I understand the results are not guaranteed.

I understand all my records will be kept confidential and will not be released to any party without my written consent, in full compliance of HIPAA regulations. My signature below indicates that a written copy of Jodie Cole, MS L.Ac.'s, Notice of Privacy Practices was provided to me. I have also been informed that if I require additional information about this notice I may call Jodie Cole, MS L.Ac.

By voluntarily signing below, I show that I have read the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present and any other future condition(s) for which I seek treatment.

____________________________ ____________________________

Print Patient Name Signature of L.Ac.

____________________________ ____________________________

Signature of Patient or Representative Date of consent

Dix Hills Family Acupuncture
Jodie Cole, L.Ac.

Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The privacy of your medical information is important is important to us. You may be aware that U.S. government regulations established under HIPPA (Health Information Portability and Accountability Act) govern the protection of health information. This notice describes how it may be used, as well as certain rights you have as a patient.

Use And Disclosure of Protected Information

All information regarding patients, their treatments, diagnosis and appointments is kept strictly confidential. Patient's chart and financial data will be seen only by the practitioner. There is no electronic transfer of your medical data. For treatment purposes, private information will be provided to another practitioner only after your written consent is given. Your medical information may be used, without further notice to you, or specific authorization by you, where required by law:

- For public health purposes
- To report child abuse
- In judicial or administrative proceedings
- By a health oversight agency for oversight activities authorized by law
- Under law enforcement purposes
- By a coroner or medical examiner
- To avert serious threat to health or safety
- Under military authorities if you are a member of the armed forces of the United States

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or telephone, at your residence, to remind you of appointment(s). No reference to medical service will be made. Occasionally, we may call to give instructions or to notify you that herbs or supplements are in the office. If you wish for us to make use of alternative methods of communicating with you, please provide that information on the signature sheet.

Rights That You Have

You have the right to inspect and obtain copies of your medical information. A reasonable fee will be charged for copying. You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for the requested amendment. If we disagree with requested amendment, we will notify you of such disagreement, and we will further notify you of your rights. You have the right to request an accounting of any disclosures we make of your medical information, except for:
disclosures we make directly to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization or for emergency or notification purposes.

Obligation That We Have

We are required by law to maintain the privacy of protected health information and to provide individual with notice of our legal duties and privacy practices. We are required to abide by the terms of this notice as long as it currently is in effect. Please sign the attached acknowledgement of receipt as we are required under law to show that we gave you this information.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have read and understand the Notice of Privacy Practices and have therefore been advised of how medical information may be used and disclosed in the office, and have also been informed of how I may gain access to and control this medical information.

____
Signature of Patient or Personal Representative

____
Print name of Patient or Personal Representative

____
Relationship of Personal Representative to Patient

____
Date

If you wish for us to make use of alternative methods of communicating with you, please provide that information below:

____

____

____