Amherst Acupuncture & Chinese Medicine
Neil Pregozen, L.Ac.
34 Pomeroy Lane, #5, Amherst, MA 01002
(413) 230-9609

Please take time prior to your initial appointment to complete these pages as thoroughly as possible.

Health History

Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Mobile Phone: _____ **E-Mail:** _____

Date of Birth: _____ **Age:** _____ **Marital Status:** _____

Referred by: _____ **Occupation:** _____

Physician: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

In Emergency Notify: _____ **Phone:** _____

Main Complaints *(symptoms, diagnosis, duration, etc.)*

Medications & Supplements *(those you are currently taking, dosage, and the reason for each)*

Significant Trauma (physical or emotional)

Birth History (prolonged labor, forceps delivery, complications, etc.)

Surgeries (please include date of procedure)

Allergies (chemical, environmental, food, drugs, etc.)

Exercise: # of days per week Length of workout Type of Activity

Diet: ***Please list usual foods for each meal or snack***	***Type, Amount, & Frequency***
Breakfast:	Snacks:
Lunch:	Alcohol:
Dinner:	Caffeine:

Tobacco: **Cigarettes** **Cigars** **Pipe** **Chew**
Amount/Frequency:

Recreational Drugs

What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days, etc.)

Personal History Please check any conditions or symptoms you have now.

☐Arthritis	☐Liver/Gall Bladder Disease	☐Stroke	☐Heart Disease
☐High/Low Blood Pressure	☐Hypo/Hyperglycemia	☐Kidney Disease	☐Elevated Blood Cholesterol
☐Cancer	☐Diabetes	☐Food Allergies/Intolerance	☐Diverticulitis/IBS
☐Ulcer	☐Seizures	☐Hepatitis	☐Raynaud's Disease
☐Chronic Fatigue	☐Anemia	☐Thyroid Imbalance	☐Respiratory Allergies
☐Alcoholism	☐Lyme Disease	☐Chronic Pain Condition	☐Impotence
☐Gastritis/Pancreatitis	☐Asthma	☐Infertility	☐Emphysema

Family Medical History Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

☐Diabetes ___	☐Seizures ___	☐Heart Disease ___	☐Stroke ___
☐High Blood Pressure ___	☐Allergies ___	☐Cancer ___	☐Asthma ___

☐Other_____

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*Please **star** if you have had any of these items listed below **in the last year***
*Put a **check** on the box if you had this in the past but do not any longer.*

General

☐Poor Appetite	☐Poor Sleeping	☐Fatigue	☐Fevers
☐Chills	☐Night Sweats	☐Sweats Easily	☐Tremors
☐Cravings	☐Localized Weakness	☐Poor Balance	☐Change in appetite
☐Bleed/Bruise easily	☐Weight loss/gain	☐Peculiar tastes/smells	☐Dental/gum problems
☐Muscle weakness/fatigue	☐Sudden energy drop	☐Strong thirst (hot or cold drinks)	

Skin and Hair

☐Rashes	☐Ulcerations	☐Hives/Allergic Dermatitis	☐Itching
☐Eczema/Psoriasis	☐Dandruff	☐Loss of hair	☐Recent moles
☐Skin discoloration	☐Acne	☐Change in skin/hair texture	☐Face flushing
☐Dermatitis	☐Warts	☐Fungal Infection	☐Weak or ridged nails

Head, Eyes, Ears, Nose and Throat

☐Dizziness	☐Difficulty swallowing	☐Migraines	☐Glasses
☐Eye Strain	☐Eye pain	☐Poor vision	☐Night Blindness
☐Color Blindness	☐Cataracts	☐Blurred vision	☐Earaches
☐Ringing in ears	☐Poor hearing	☐Spots in front of eyes	☐Sinus problems
☐Nose bleeds	☐Recurrent sore throats/colds	☐Grinding teeth	☐Facial pain
☐Sores on lips/tongue	☐Dental problems	☐Jaw clicks/locks	☐Headaches

Cardiovascular

☐Chest pain or pressure	☐Irregular heart beat	☐Palpitations at rest	☐Fainting
☐Cold hands/feet	☐Swelling of hands/feet	☐Blood clots	☐Phlebitis
☐Shortness of breath	☐Varicose/spider veins	☐Pressure in chest	☐High blood pressure
☐Low blood pressure	☐Spontaneous sweating	☐Dizziness	

Respiratory

☐Cough/Wheezing	☐Coughing blood	☐Asthma	☐Bronchitis
☐Pneumonia	☐Pain with deep inhalation	☐Tight sensation in chest	☐Difficult inhale/exhale
☐Difficulty breathing when lying down		☐Production of phlegm… what color? _____	

Gastrointestinal

☐Nausea	☐Vomiting	☐Diarrhea	☐Constipation
☐Gas	☐Belching	☐Black stools	☐Blood in stool
☐Indigestion	☐Bad breath	☐Rectal pain	☐Hemorrhoids
☐Bloating/Edema	☐Chronic laxative use	☐Loose stools (>2 per day)	☐Abdominal pain/cramps
☐Changes in appetite	☐Acid reflux/GERD	☐Hernia	☐Poor appetite
☐Excessive appetite	☐Significant thirst	☐IBS/Crohn's Disease	

Genito-Urinary

☐Pain on urination	☐Frequent urination	☐Blood in urine	☐Urgent urination
☐Unable to hold urine	☐Kidney stones	☐Scanty flow	☐Copious flow
☐Impotence	☐Sores on genitals	☐Urinary tract infection	☐Burning urination
☐Premature ejaculation	☐Decreased libido	☐Prostatitis	☐Dribbling after urination
☐Nocturnal emission	☐Pain in testicles	☐Herpes	☐Infections
☐Night urination… What time?_____ How often?_____			☐Excessive libido

Gynecological/Reproductive

☐Difficult/Painful intercourse	☐Ovarian cysts	☐Age of first menses_____
☐Vaginal dryness	☐Endometriosis	☐Date of last menses_____
☐Vaginal sores	☐Uterine Fibroids	☐Date of last PAP/Pelvic_____
☐Vaginal discharge	☐Fibrocystic breast tissue	☐Number of pregnancies____
☐Infertility	☐Polycystic Ovarian Disease	☐Number of ectopic pregancies_____
☐Irregular menstruation	☐PMS	☐Number of live births_____
	☐Painful menstruation	☐Number of miscarriages_____
		☐Number of abortions_____

Do you practice birth control?_____
What type?_____ How long?_____

Musculoskeletal

☐Neck pain	☐Shoulder pain	☐Hand/wrist pain	☐Carpal Tunnel
☐Knee pain	☐Sprains/Strains	☐Sciatica	☐Foot/ankle pain
☐Hip pain	☐Muscle pain	☐Muscle weakness	☐Tendonitis
☐Back pain Low___ Middle___ Upper___		☐Bursitis	☐Rotator Cuff

☐Soreness/weakness in lower body (back, knee, hip, ankle, foot)

Neuropsychological

☐Seizures	☐Loss of balance	☐Vertigo/Dizziness	☐Areas of numbness
☐Lack of coordination	☐Poor memory	☐Concussion	☐Depression
☐Anxiety/Panic attacks	☐Bad temper/irritable	☐Easily susceptible to stress	☐Seasonal Affective Disorder
☐Nervousness	☐ADD/ADHD	☐Manic Depression	

Have you ever been treated for emotional problems?	☐Yes ☐No
Have you ever considered or attempted suicide?	☐Yes ☐No
Have you ever been treated for substance abuse?	☐Yes ☐No

Comments: Please inform me of any other conditions or concerns that you would like to discuss.

Acupuncture Consent to Treatment & Care

I hereby request and voluntarily consent to the performance of acupuncture treatments and other Asian medicine procedures on me (or on the patient named below, for which I am legally responsible) by Neil Pregozen, L.Ac., and/or another licensed acupuncturist who is serving as back up for Neil Pregozen.

I understand that methods or treatments may include and are not limited to: acupuncture (insertion of sterile, disposable needles into the skin), gua sha (rubbing of skin with a smooth object), moxibustion (application of heat to the skin by the burning of mugwort herb), cupping (application of heated glass cups to the skin along the meridians of the body), herbal consultations, bodywork, and nutritional conversations. I understand that no guarantees concerning the use and effects of these treatments are given to me, and that I am free to refuse or discontinue any form of treatment at any time.

The treatments offered are generally recognized as safe treatments. I am aware that some risks are possible, as with any treatment. These could include, but are not limited to, brief pain or discomfort, small local bruising, slight bleeding, tingling, dizziness, burning from mugwort herb. Rare instances have been reported of fainting, nausea, spontaneous miscarriage, or pneumothorax. There may be brief and temporary aggravation of symptoms existing prior to treatment.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although as with any consumable, may be toxic in large doses. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately.*

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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. _____
initials

I understand it may be necessary for my practitioner 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 my practitioner permission to release my medical records for the reasons listed above. _____
initials

I understand that there will be a charge for missed appointments and appointments canceled with less than 24 hours notice unless the cancellation results from an emergency (a sudden, unexpected situation or set of circumstances). I understand that insurance does not pay for missed appointments or late cancellations, and that I will be personally responsible for the charges. _____
initials

I agree to pay all charges incurred for services rendered, over and above insurance coverage. _____
initials

_____ _____
Patient's Name **Guardian's Name & Relationship (if applicable)**

_____ _____
Patient's Signature **Guardian's Signature**

_____
Date

_____
Are you pregnant?

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Notice of Privacy Practices

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.

USE AND DISCLOSURE OF HEALTH INFORMATION

I may use your health information, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for the purposes of providing you treatment, obtaining payment for you for your care and conducting health care operations.

Treatment – Your health information will be recorded and used to determine the course of treatment that should work best for you. The sharing of your health information may include other health care providers involved in your care within the confines of my practice.

Payment – Your health care information will be used in order to assist you to be able to receive reimbursement payments for services. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.

Health Care Operations – Your health care information will be used as necessary in order to improve the quality and effectiveness of the care and services I provide. For example, with your written consent, I may discuss your case with another health care provider to increase my understanding of your unique situation. In the event of a medical emergency which, for the sake of your welfare, requires information from me about your state of health that is critical to your proper care in a medical setting other than my office, I will communicate with the necessary medical personnel any information that I deem to be appropriate. In signing this disclosure you are giving consent for me to take such an action.

Appointment reminders – I may contact you with appointment reminders.

Treatment alternatives – I may contact you with information about treatment alternatives and other health-related activities that may be of interest to you.

Patient Education – I may contact you to inform you of new services that I offer or of events that I am hosting or attending.

Communications with Family – In an urgent situation, one or more people, a family member, or close personal friend, identified by you, may be given information relevant to your care. This space is available for you to provide names and contact information for those with whom you explicitly authorize me to communicate:

Your Emergency Contact: _____

Contact Information: _____

Research/Education – Your information will be disclosed to researchers or educators upon the assurance that protocols have been established to ensure the privacy of your health information.

Law Enforcement – Your health information will be disclosed when it is required under Federal, State, or Local law.

Other than stated above when applicable, I agree not to use or disclose your health information without your written authorization. Other than activity that has already occurred, you may revoke this authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

Your health record is the physical property of the health care practitioner or facility that compiled it but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information (a copy fee may be requested), and to receive an accounting of the disclosures that have been made of your health information (after the effective date of this Notice) for most purposes other than treatment, payment or health care operations. Other disclosures excluded are direct disclosures to yourself, family or friends involved in your care. You may also request communications of your health information be made by reasonable alternative means or to reasonable alternative locations. You will need to provide details about how to contact you including a valid alternative address. If we are unable to contact you using the information you provide, we may contact you using any information on file. We will not require you to explain why you want this communication. We will honor reasonable requests. However, if we are unable to contact you using the requested ways or locations, we may contact you using any information on file, including an email address given to us by you. You also may want to communicate with us via e-mail. Because e-mail may contain your personal health information and e-mail is not a secure communication, we ask for your specific authorization to communicate with you using this method by signing this form and initialing here _____.

All requests must be submitted to me in writing (Neil Pregozen, 34 Pomeroy Lane, #5, Amherst, MA 01002). You have the right to a paper copy of this Notice and may request one at any time by contacting me at 413-230-9609. You have the right to file a complaint with me or the Secretary of Health and Human Services, with no fear of retaliation.

MY RESPONSIBILITIES

I am required by law to maintain the privacy of your health information and to provide you this Notice of duties and privacy practices. I am required to abide by the terms of this Notice and to notify you if I am unable to grant your requested restrictions or desires. I reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that I maintain. If I change this Notice, you will be informed at your next office visit after such a change has been made.

Patient Comments:

_____ _____

Patient Signature Date

This Notice is effective 15 June 2015