Acupuncture Health History Questionnaire

Name: _____
Today's Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Email Address: _____
Phone Home: _____ Work: _____
Cell: _____ Birth Date: _____ Age: _____
Ht: _____ Wt: _____ Sex: M/F Marital Status: _____
# of Children: _____ Occupation: _____
Emergency Contact Name: _____
Cell Phone: _____ Home Phone:_____

Occupation: _____ if retired what you did previously:_____

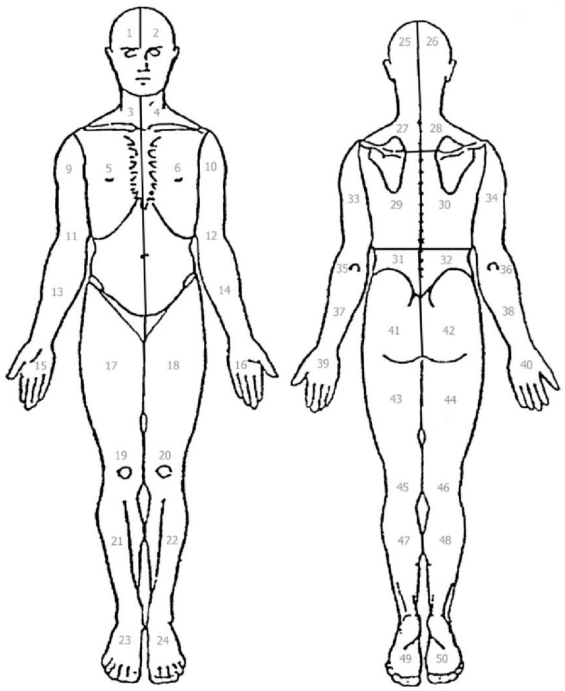
IF UNDER 18, PARENT/GUARDIAN NAME:
Mother:_____ Father:_____
Guardian:_____ Phone:_____

Primary Care Practitioner:
_____
Is this your first time getting acupuncture? Y / N
How did you hear about us? _____
Goals: What would you most like to achieve with acupuncture treatments?
_____
_____
_____
Major Symptoms: Please list in order of importance what symptoms are of concern to you. List most concerning to least concerning along with duration of symptoms:
_____
_____
_____
What type of treatments have you tried? Has it helped? _____
_____
_____
_____

Are you experiencing pain/discomfort in any area of your body? Y / N

Please rate your pain level: 1 2 3 4 5 6 7 8 9 10

Use the illustration at left to indicate painful or distressed areas.
Indicate the location of the discomfort by using the symbol that best describes the feeling:
XXX = Sharp/ Stabbing
PPP = Pins & Needles
DDD = Dull/Aching
NNN = Numbness
TTT = Tightness/Spasms



Medical History

Do you have, or have you ever had any of the following conditions?
If yes, please indicate the date of your diagnosis.

Diagnosis	Date Diagnosed		Diagnosis	Date Diagnosed
Cancer			High Blood pressure	
Diabetes			Hypothyroid	
HIV			High Cholesterol	
Heart disease			Hyperthroid	
Depression/anxiety			Stroke	
Heart attack			Other	

Please list surgeries or major illnesses with date:

_____

_____

_____

_____

Please list any medications or supplements you have taken in the past 2 months:

_____

_____

_____

_____

Do you have a pacemaker or any metal devices in your body: Y / N

Family History

Please indicate close family members with any of the following: Family Members Family

Diagnosis	Family member	Diagnosis	Family member
Cancer: Type_____		Heart Attack	
High Cholesterol		Diabetes	
Heart Disease		High Blood Pressure	
Stroke		Other _____	

Lifestyle Habits

Do you have an exercise routine? Please describe: _____

How many hours per night do you sleep on average? _____ Do you wake rested? Y / N

Nicotine Use: _____ Alcohol Use (# of drinks/wk & type): _____

Caffeine Use (# of drinks/day and type):_____

Water Intake (how much/day):_____

Dietary habits (# of meals/day and type of food):_____

_____

Please check all that apply :

__ Fatigue	__Knee Pain	___Painful Urination	__Bleeding gums	__Stressed
__ Allergies (Specify) _____	__Back Pain	__Frequent UTI	__Mouth Sores	__Anxiety

__ Chronic Fatigue Syndrome	__Leg pain	__Urinary Frequency	__Chronic Sinus congestion	__Depression
__ Thyroid Problems	__Hip/ Pelvic pain	__ Urinary Urgency	__Dry Mouth	__Irritability
__ Edema/ Swelling	_Numbness/ tingling	__Dry eyes	__ Bad Breath	__ Poor memory
__ Tendency to catch colds	__Muscle weakness	__ Blurred vision	__Headaches	__Difficulty making decisions
__ Anemia	__Arm Pain	__Ringing in the ears	__dizziness/ Vertigo	__Nightmares
__ Neck pain	__Finger pain	__Hearing difficulty	__Increased thirst	__Difficulty falling asleep
__Shoulder pain	__ Joint pain	__Teeth grinding/TMJ	__ Mood swings	__Difficulty Staying asleep
__Muscle spasm/ Cramps	__Foot pain	__Sore Throat	__Difficulty Concentrating	__Insomnia
__Changes in appetite	__ Shortness of breath	__Irregular Menstrual Cycle	_Ammenorhea	__Decreased Libido
__Nausea/Vomiting	__Asthma	__Heavy Flow	__Painful Periods	__Prostate Enlargement
__Gas/ Bloating	__Chest pain	__Menstrual Clots	__Uteterine Fibroids	__Premature ejaculation
__Diarrhea	__Palpitation	__Breast Tenderness	__Hot flashes	__Hernia
__Constipation	__Poor circulation	__PMS	__Night Sweats	__Groin Pain
__Hemorrhoids	__Chronic cough	__Breast Lumps	__Excessive Sweating	
__Acid Reflux	__Wheezing	__Abnormal discharge	__No Sweating	

HIPAA AUTHORIZATION FORM

I, _____, hereby authorize the use or disclosure of my protected health information as described below:

1. AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Just Enjoy Life Acupuncture and Wellness Center is authorized to disclose the following protected health information to _____ of _____, _____ _____.

2. DESCRIPTION OF INFORMATION TO BE DISCLOSED

The health information that may be disclosed is:

Medical records
All treatment records
Other: _____

All past, present, and future periods of health care information may be shared.

3. PURPOSE OF THE USE OR DISCLOSURE

The purpose of this use or disclosure is _____.

4. VALIDITY OF AUTHORIZATION FORM

This Authorization Form is valid beginning on _____ and expires on December 31, 2029.

5. ACKNOWLEDGMENT

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

By: _____ Date: _____ _____

JUST ENJOY LIFE ACUPUNCTURE AND WELLNESS CENTER
JENNIFER MUILENBURG, L.Ac.
2500 ROUTE 347 UNIT 6D
STONYBROOK, NY 11787
631-675-1895

PATIENT BILLING ACKNOWLEDGEMENT

I, _____, being a patient of Jennifer Muilenburg, L.Ac. located at Stony Brook Medical Park, 2500 Nesconset Highway Unit 6D, Stony Brook, NY 11790, do hereby acknowledge that I have been informed in advance of receiving treatment that my health insurance benefits will/or may not cover acupuncture treatment. Upon signing this form, I acknowledge that I have chosen to undergo treatment and acknowledge that I am, therefore, solely finacially responsible for the payment of services rendered to me

_____
Patient name (Print)

_____ _____
Patient Signature Date

_____ _____
Witness Date

_____

Name of Insured:_____≠_____

Address of Insured:_____
street city
zip code

Insured Phone Number:_____ _____
home cell

Insurance Plan:_____ ID#:_____

Group #:_____ Insurcance #:_____

Relationship to the Insured:_____

Insured DOB:_____ Insured Employer:_____

2500 Route 347 Unit 6D
Stony Brook, NY 11790
Phone: (631)675-1895
Fax: (631)675-1896
https://www.justenjoylifeacupuncture.com/

Just Enjoy Life
Acupuncture and
Wellness Center

Dear Patient:

We would like your permission to notify you of your next appointment via email/text message.

If you are **IN AGREEMENT,** please provide us with your email address: _____ and / or

Your cell phone number: _____

Please Initial here: _____.

OR

If you are **NOT IN AGREEMENT** and prefer a telephone message,

Please Initial here _____.

Print Name: _____

Your Signature: _____

Date: _____

THANK YOU!

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JENNIFER MUILENBURG, L.Ac.
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PATIENT ADVISORY TO CONSULT A PHYSICIAN

I, Jennifer Muilenburg, L.Ac. and Just Enjoy Life Acupuncture and Wellness Center (Clinic), am commited to your health and well being. I believe that while Oriental Medicine has a great deal to offer as a health care system, it can not totaly replace the resources available through biomedical physicians. Consequently, I recommend that you consult a licensed 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:
I, THE UNDERSIGNED, DO AFFIRM
THAT_____(PATIENT) HAS BEEN ADVISED BY JENNIFER MUILENBURG, L.AC. TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

_____
_____
PATIENT SIGNATURE DATE

_____
_____
ACUPUNCTURIST SIGNATURE DATE

I hereby request and consent to acupuncture treatments and other procedures associated with the practice of Oriental Medicine provided my Jennifer Muilenburg, L.Ac. and Just Enjoy Life Acupuncture and Wellness Center.

I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, and Asian bodywork modalities.

I have been informed that acupuncture is a safe method of treatment, but may have side effects, including bruising, numbness or tingling

near the needling site that may last a few days, and dizziness or 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. Although this site uses sterile, disposable needles and maintains a clean environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes major risks of treatment, other side effects and risks may occur.

I will notify Jennifer Muilenburg,L.Ac.and Just Enjoy Life Acupuncture and Wellness Center, who is caring for me, if I am or become pregnant.

I do not expect Jennifer Muilenburg, L.Ac. and Just Enjoy Life Acupuncture and Wellness Center to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on Jennifer Muilenburg, L.Ac. and Just Enjoy LIfe Acupuncture and Wellness Center to excercise her judgement during the course of treatments which Jennifer Muilenburg, L.Ac. and Just Enjoy Life Acupuncture and Wellness Center thinks at the time, based on facts known to her, is in my best interest.

By voluntarily signing below, I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benfits 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 condition and for any future condition(s) for which I seek treatment.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated).

_____
Date Consent Completed

_____
Print Name of Patient (or patient representative, if applicable)

_____
Signature of Patient or Representative