KEREN BAR-NIR ACUPUNCTURE CLINIC- CONFIDENTIAL INTAKE FORM

DATE: _____

PATIENT INFORMATION

Name: _____ Gender: _____

Age: _____ Date of Birth: _____

Home Address: _____

_____

Home Phone: _____ Cell: _____ Work Phone: _____

Email: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone number: _____

Primary Care Physician (PCP): _____ PCP Phone: _____

Date of last medical examination: _____

Occupation: _____

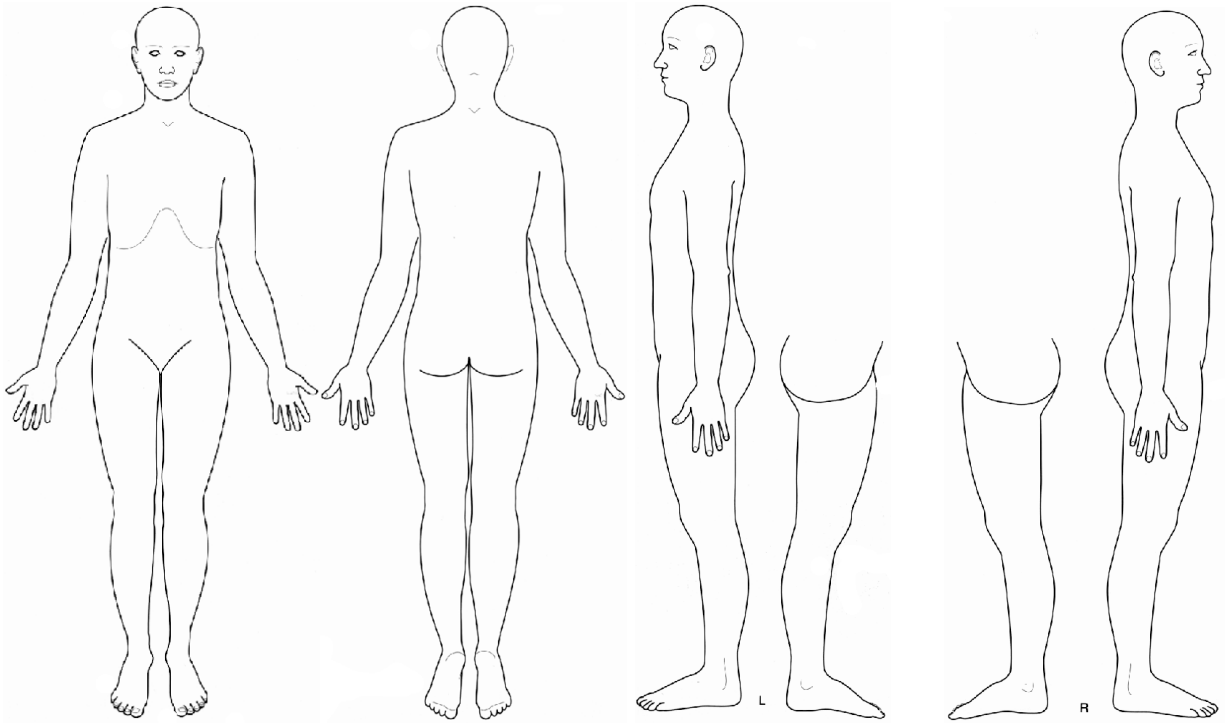
I. DESCRIPTION OF MAJOR COMPLAINTS, SYMPTOMS, DIAGNOSIS, DURATION, ETC.

1. **Have you seen a physician (or other primary care provider) for your Primary Complaints? If yes, when and what diagnosis did you receive?**

2. **Other Care: what other therapies are you doing/ have you done to manage your Primary Complaints, e.g. physical therapy, medication, chiropractic, etc.? Did these/ are these other therapies helping?**

3. **Please describe your goals for Acupuncture treatment, both physically and emotionally:**

B. On the diagram, please shade in the areas where you feel symptoms associated with your complaints. PLEASE NUMBER THE COMPLAINTS (Primary Complaint = #1; Secondary Complaint = #2):



II. MEDICATIONS, SUPPLEMENTS AND HERBS

Please list all medications, (prescriptions and over-the-counter drugs) supplements and/or herbs you are **CURRENTLY** taking:

Medications, supplements, or herbs:	*Indication/For treatment of:*
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____
7. _____	7. _____
8. _____	8. _____
9. _____	9. _____
10. _____	10. _____

LIST ANY ALLERGIES (to medications, supplements, herbs):

_____

III. PERSONAL MEDICAL HISTORY

II. **BIRTH:** Describe anything significant/traumatic about your birth:

III. **VACCINATION HISTORY:** Any unusual reaction? Any unusual vaccination?

IIII. **CHILDHOOD ILLNESSES (0-12 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:

AGE:

AGE:

IIV. **ADOLESCENCE ILLNESSES (13-17 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:

AGE:

AGE:

IV. **ADULTHOOD ILLNESSES (18 – 35 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:

AGE:

AGE:

IVI. **ADULTHOOD ILLNESSES (36 & up):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:

AGE:

AGE:

AGE:

AGE:

IV. FAMILY MEDICAL HISTORY

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

MOTHER_____
FATHER_____
SIBLINGS_____
MATERNAL GRANDPARENTS_____
PATERNAL GRANDPARENTS_____

V. SYMPTOM OVERVIEW BY SYSTEM

Please check all symptoms that you are CURRENTLY experiencing AND/OR experience FREQUENTLY. Please indicate (by circling) if the symptom is acute, chronic or experienced frequently.

- A = Acute (under 3 months)
- C = Chronic (over 3 months—experience at some point most days)
- F = Experience frequently (on & off)

MUSCULOSKELETAL

A C F Joint clicking
A C F Limitation of movement
A C F Stiffness
A C F Spasms or cramps
A C F Swelling
A C F Weakness
A C F Pain: Full body
A C F Pain: Facial (e.g. jaw)
A C F Pain: Neck
A C F Pain: Upper Back
A C F Pain: Mid Back
A C F Pain: Low Back
A C F Pain: Shoulder
A C F Pain: Elbow
A C F Pain: Wrist
A C F Pain: Hand
A C F Pain: Hip
A C F Pain: Knee
A C F Pain: Ankle
A C F Pain: Foot
A C F OTHER (Please list)

_____
_____

EYES, EARS, NOSE & THROAT

A C F Loss of vision
A C F Eye pain
A C F Tearing or eye dryness
A C F Eye discharge
A C F Eye redness
A C F Ear discharge
A C F Ear itching
A C F Ear pain &/or infections
A C F Loss of hearing
A C F Ringing or buzzing in ears
A C F Problems with balance (vertigo)
A C F Olfaction (sense of smell) impaired
A C F Nose obstruction (stuffiness)
A C F Nose bleeds
A C F Sinus pain, pressure &/or infections
A C F OTHER (Please list)

_____
_____

RESPIRATORY

A C F Chest pain &/or tightness
A C F Bluish discoloration of skin
A C F Cough
A C F Coughing up blood (hemoptysis)
A C F Shortness of breath (dypsnea)
A C F Sore throat
A C F Sputum production
A C F Voice changes
A C F Wheezing
A C F OTHER (Please list)

_____
_____

CARDIOVASCULAR

A C F Changes in skin temperature & color
A C F Chest pain &/or pressure
A C F Edema
A C F Fainting (syncope)
A C F Fatigue
A C F Palpitations
A C F Skin ulceration
A C F Swelling of the ankles &/or legs
A C F OTHER (Please list)

_____
_____

DIGESTIVE

A C F Abdominal distention/bloating

A C F Abdominal mass
A C F Abdominal pain
A C F Acid regurgitation &/or Heartburn
A C F Alternating constipation/diarrhea
A C F Rectal bleeding
A C F Constipation
A C F Diarrhea
A C F Gas
A C F Eating disorder
A C F Indigestion
A C F Jaundice (yellow tint to skin &/or eyes)
A C F Nausea
A C F Vomiting
A C F OTHER (Please list))

_____
_____

UROGENITAL

A C F Difficulty with urine flow
A C F Incontinence
A C F Painful urination (dysurea)
A C F Rashes
A C F Red urine
A C F Urinary tract infection (UTI)
A C F OTHER (Please list)

_____
_____

NEUROLOGICAL

A C F Changes in consciousness
A C F Confusion
A C F Difficulty concentrating
A C F Dizziness
A C F Dysphasia (impaired ability to speak)
A C F Gait disturbance
A C F Headache
A C F Numbness and/or tingling
A C F Loss of consciousness
A C F Paralysis
A C F Post shingles pain
A C F Problems coordinating movements
A C F Severe forgetfulness
A C F Tremor
A C F Visual disturbance
A C F Weakness
A C F OTHER (Please list)

_____
_____

INTEGUMENTARY (SKIN)

A C F Changes in hair
A C F Changes in nails
A C F Changes in skin color
A C F Itching (prurites)
A C F Never sweat
A C F Rash and/or skin lesion
A C F Unusual sweating
A C F Wounds that will NOT heal
A C F OTHER (Please list)

_____
_____

PSYCHOLOGICAL

A C F Feelings of grief
A C F Feeling of sadness
A C F Feeling fearful/anxious/ nervous
A C F Difficulty managing anger
A C F Feeling manic
A C F Feeling worried or overly pensive
A C F Feelings of panic
A C F Feeling overwhelmed
A C F Extreme mood swings
A C F Extreme lack of emotion
A C F OTHER (Please list)

_____
_____

SLEEP

A C F Difficulty falling asleep
A C F Dream disturbed sleep
A C F Wake up & cannot fall back asleep
A C F OTHER (Please list)

_____
_____

MISCELLANEOUS

A C F Extremely low energy/fatigue
A C F OTHER (Please list)

_____
_____

FOR WOMEN ONLY

A C F Abnormal vaginal bleeding
A C F Changes in hair distribution
A C F Fertility concerns
A C F Irregular menstruation
A C F Menopausal symptoms
A C F No menses
A C F Pain with menses (dysmenorrhea)
A C F Pain during or after sexual relations
A C F Pelvic pain
A C F Premenstrual symptoms
A C F Sexual dysfunction
A C F Unusual discharge
A C F OTHER (Please list)

_____
_____

Are you pregnant OR trying to become pregnant?
YES NO

Have you ever been pregnant? YES NO If yes, how many pregnancies: _____

Births _____
Miscarriages _____
Abortions _____

FOR MEN ONLY

A	C	F	Fertility concerns
A	C	F	Prostate problems
A	C	F	Sexual dysfunction
A	C	F	Unusual discharge
A	C	F	OTHER (Please list)

_____
_____

VII. MEDICAL DISEASES/CONDITIONS. **Please check all that apply AND indicate (by circling) if it is chronic or if you had the problem in the past, but is now resolved.**

- C = Current condition
- P = Past condition, but is now resolved.

C P AIDS/HIV
C P Alcoholism &/or substance addiction
C P Allergies (If yes, pls indicate diagnosis & history)
_____
_____

C P Anemia
C P Asthma
C P Bell's Palsy
C P Blood clotting disorder (If yes, pls indicate diagnosis & history)
_____
_____

C P Bipolar disorder
C P Cancer (If yes, pls indicate diagnosis & history)
_____
_____

C P Chron's Disease &/or colitis
C P Chronic Fatigue Syndrome (CFIDS)
C P Depression (Major)
C P Diabetes
C P Eczema
C P Endometriosis
C P Fibroids
C P Infertility
C P Lung disease, e.g. COPD (If yes, pls indicate diagnosis & history)
_____
_____

C P Fibromyalgia
C P Gallstones
C P Heart disease (If yes, pls indicate diagnosis & history)
_____
_____

C P Hepatitis A / B / C
C P Hernia
C P Herpes
C P Hypertension
C P Hypoglycemia
C P Irritable Bowel Syndrome (IBS)
C P Joint Replacement (If yes, pls indicate diagnosis & history)
_____
_____

C P Kidney Stones and/or Disease (If yes, pls indicate diagnosis & history)
_____
_____

C P Lupus
C P Lyme Disease
C P Lymph node removal
C P Mitral valve prolapse
C P Mood Disorder
C P Mononucleosus
C P Multiple Sclerosis
C P Organ removal or transplant (If yes, pls indicate diagnosis & history)

_____

_____

C P Osteoarthritis
C P Osteoporosis
C P Pacemaker (heart or stomach)
C P Parkinson's Disease
C P Pelvic Inflammatory Disease
C P Polio
C P Psoriasis
C P PTSD (Post-Traumatic Stress Disorder)
C P Reflux esophagistis (GERD)
C P Rheumatic fever
C P Rheumatoid arthritis
C P Scarlet Fever
C P Schizophrenia
C P Scoliosis
C P Seizures and /or epilepsy
C P Shingles
C P Sleep Disorder
C P Stroke
C P Schizophrenia
C P Thyroid disease (If yes, pls indicate diagnosis & history)

_____

_____

C P Ulcer
C P Trigeminal Neuralgia
C P Tuberculosis
C P Vascular disease (e.g. phlebitis) (If yes, pls indicate diagnosis & history)

_____

_____

C P OTHER (pls list)

_____

_____

VI. LIFESTYLE INFORMATION

A.Stress, Energy Level & Sleep

1. Do you think that stress, including recent major life changes, is contributing to your main complaints and/or negatively impacting any other aspect of your physical or mental health? If yes, briefly describe:

2. Do you have any problems with your energy level? If yes, please briefly describe:

3. Do you have any problems with sleep? If yes, please briefly describe:

4. Do you have any problems with your sexual drive? If yes, please briefly describe:

B. Smoking, Alcohol & Drugs

1.Do you smoke tobacco? YES NO If yes, do you believe that this is a problem for you?

2.Do you drink alcohol? YES NO If yes, do you believe that this is a problem for you?

3.Do you use recreational drugs and/or prescription medications that your physician does not know about? YES NO Do you believe that this is a problem for you?

C. Diet and Nutrition

1. If applicable, briefly describe any problems you think you have with your eating habits and appetite. Do you believe that your diet has any impact on your complaints? YES NO

2. Are you concerned about your weight and/or appetite (under or overweight, too much or too little appetite)? YES NO

VII.LIFESTYLE COUNSELING OPTION

Would you be interested in developing an acupuncture treatment plan that includes helping you with lifestyle issues?

INFORMED CONSENT: ACUPUNCTURE CLINICAL SERVICES

To All Clients:

Welcome to Keren Bar-Nir's Acupuncture Clinic.

While receiving acupuncture treatment, please feel free to communicate with us what you experience during the needling process, as this will enable us to adjust needles and the points selected to maximize your comfort during treatment. If you experience dizziness, nausea, a cold sweat, shortness of breath, or faintness during treatment, please let us know immediately. This is known as needle shock, and while this occurrence is extremely rare, it helps to let us know if you experience any of these symptoms so that the needles can be removed. These symptoms go away immediately after needles are withdrawn, and are generally caused by anxiety when receiving acupuncture for the first time. Other possible side effects of acupuncture treatment may include local bruising, mild pain in the area treated; brief generalized fatigue, tingling or numbness.

Moxibustion, the burning of moxa, is a traditional method of acupuncture treatment, which is occasionally used in the clinic. Moxibustion produces some smoke, which may irritate sensitive or susceptible individuals.

Other important things to keep in mind regarding acupuncture treatment:

- While the needles are in place, do not change your position or move suddenly.
- Wear comfortable, loose clothing. We provide a gown during treatment if you want one.
- Maintain good personal hygiene.
- Avoid treatment when excessively fatigued, hungry, full, or emotionally upset.
- We are unable to treat patients who are intoxicated and/or are abusing substances.

Everyone responds to treatment differently therefore, we cannot guarantee the outcome of treatment. Some individuals experience total or partial relief of their pain or symptoms after the first few treatments. Others notice steady, gradual improvement. In some cases, no relief is felt at all until after several days go by. Occasionally, some people notice that their pain actually seems to be worse before it gets better. Let us know how you responded to the previous treatment at the time of your follow-up visits, so that your treatment plan can be adjusted accordingly.

Depending on your condition and your goals for treatment, we may require a physician referral in order for you to continue treatment in our clinic. Clients at Keren Bar-Nir's acupuncture clinic are advised to consult a physician regarding the condition or conditions for which they are seeking acupuncture treatment. In addition, clients are responsible for seeking the advice and treatment of a physician should their symptoms change for the worse, or should any new condition arise.

I have been informed that I have a right to refuse any form of treatment. 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 agree to pay the full charge for any missed or forgotten appointments without 48-hour notice of cancellation. _____
initials

From time to time, I understand I may receive emails, updates and contact information from Keren Bar-Nir Acupuncture.
initials _____

Please note that if you are having any untoward side effects or concerns after treatment, in addition to calling **our office (917-596-4856)** you must call your primary care provider and or visit the emergency room.

_____	_____	_____
I have read and understand the above statement	Date	Legal representative (clients under 18)
Signature of Client		
_____		_____
Print name of Client		Signature of Witness (Staff Member)

KEREN BAR-NIR ACUPUNCTURE CLINICAL SERVICES: NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Respect for patient privacy is highly valued at our clinic. As required by law, we will protect the privacy of your health information that may reveal your identity and provide you with a copy of our notice, which describes the health information privacy procedures of our clinic when providing health care services.

REQUIRED PERMISSION TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment for that treatment, and conduct the clinic operations. This general written consent will be obtained the first time we provide you with treatment or services. This general written consent is a broad permission that does not have to be repeated each time we provide treatment or services to you.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

USES AND DISCLOSURES

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. We may use your health information or share it with others in our clinic's operations.

We may disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

YOUR RIGHTS

In most cases, you have the right to look at or get a copy of health information about you at the clinic. You also have the right to receive a list of certain types of disclosures of you information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

OUR LEGAL DUTY

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice and seek your acknowledgement of receipt of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

IF YOU HAVE ANY QUESTIONS OR COMPLAINTS, PLEASE CONTACT:

Keren Bar-Nir
79 Laight Street, Suite 5B
New York, NY 10013
917-596-4856

Keren Bar-Nir Acupuncture Clinic
Notice of Privacy Practices

ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been notified of how health information about me may be used and disclosed by Keren Bar-Nir Acupuncture Clinic listed at the beginning of this notice and how I may obtain access to and control of this information.

By signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me and for the operations of the clinic.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Date

If you have any questions about this notice or would like further information, please contact our office manager.