

Paul Kempisty L.Ac.
Acupuncture. Chinese herbs. Reiki. Aromatherapy.



Patient Information

Please answer questions to the best of your knowledge

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Other _____ Phone _____

Fax _____ Email _____

Sex: male () female () Height _____ Weight _____ Birthdate ____/____/____ Age _____

Emergency Contact: Name _____ Phone _____

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

Your primary biomedical doctor's contact information:

Name _____

Address _____

Phone _____ Fax _____

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

	You	Relative	When		You	Relative	When
Cancer	()	()	_____	High cholesterol	()	()	_____
Hepatitis	()	()	_____	Seizures	()	()	_____
High blood pressure	()	()	_____	Emotional disorders	()	()	_____
Infectious diseases	()	()	_____	Tuberculosis	()	()	_____
Diabetes	()	()	_____	HIV/AIDS	()	()	_____

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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	<input type="checkbox"/>	<input type="checkbox"/>	_____	Water intake	<input type="checkbox"/>	<input type="checkbox"/>	_____	Soda pop	<input type="checkbox"/>	<input type="checkbox"/>	_____
Non-medical drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

	Good	Average	Poor	Your comments:
Significant other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

What other forms of treatment have you sought?

Please list any other health problems you now have:

Please list any allergies or food sensitivities you may have:

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

Please list any special considerations or circumstances you would like your practitioner to be aware of:

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For Men

Date of last prostate checkup _____/_____/_____ PSA results _____

Manual prostate exam results _____

Frequency of urination: Daytime ____ Night time ____ Color of urine: Clear (). Cloudy (). Red (). Odor ()

Symptoms related to prostate:

Delayed stream (). Dribbling (). Incontinence (). Retention of urine ().
Rectal dysfunction (). Increased libido (). Decreased libido (). Premature ejaculation ().
Impotence (). Groin pain (). Testicular pain (). Back pain ().

Other: ():

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 abortions _____

Number of pads/tampons on heaviest day _____

Number of miscarriages _____

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 (). Nature of pain: Cramping (). Stabbing (). Burning (). Aching/dull (). Constant ().

Intermittent (). Bearing down sensation ().

Discharge (). Nature of discharge: Clear (). White (). Yellow (). Other color (). _____

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

Headache (). Swollen breasts (). Increased libido (). Constipation (). Ravenous appetite ().

Mood swings (). Irritability (). Nausea (). Vaginal Dryness (). Poor appetite ().

Decreased libido (). Hot flashes (). Diarrhea (). Night sweats (). Insomnia ().

Other: ():

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General Symptom Survey (for everyone)

Please check the symptoms you have experienced recently:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Insomnia/difficult sleeping | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Eye problems |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Cold hands & feet | <input type="checkbox"/> Sciatic pain | <input type="checkbox"/> Difficult to |
| <input type="checkbox"/> Loose stools/diarrhea | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Headaches | digest oily foods |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Mentally restless | _____ | <input type="checkbox"/> Gall stones |
| <input type="checkbox"/> Vomit | <input type="checkbox"/> Frequently laughing | | <input type="checkbox"/> Soft brittle nails |
| <input type="checkbox"/> Belching/burping | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Easily irritated |
| <input type="checkbox"/> Heartburn/reflux | _____ | <input type="checkbox"/> Knee problems | <input type="checkbox"/> Easy to faint |
| <input type="checkbox"/> Food sitting in stomach | | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Gas or bloating | <input type="checkbox"/> Cough | <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Muscles spasms |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney stones | or twitches |
| <input type="checkbox"/> Tired after meals | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Bone spurs | <input type="checkbox"/> Dry skin |
| <input type="checkbox"/> Easily bruised | <input type="checkbox"/> Frequently catching colds | <input type="checkbox"/> Decreased sex drive | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Sudden weight loss | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Infertility | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Intolerant to weather changes | <input type="checkbox"/> Sexual dysfunction | concentration |
| <input type="checkbox"/> Colitis or Diverticulitis | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Frequent sighing |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Allergies | <input type="checkbox"/> Urinary problems | |
| <input type="checkbox"/> Pasty taste in mouth | <input type="checkbox"/> Nasal problems | <input type="checkbox"/> Edema | |
| _____ | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Decreased sense of smell | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent yawning | | |
| <input type="checkbox"/> Worrying a lot | <input type="checkbox"/> Recent use of antibiotics | | |
| <input type="checkbox"/> Anxiety | | | |
| <input type="checkbox"/> Easily frightened | _____ | | |
| <input type="checkbox"/> Difficulty in making | | | |
| decisions | <input type="checkbox"/> Fatigue | | |
| <input type="checkbox"/> Often sad | <input type="checkbox"/> Often too cold | | |
| <input type="checkbox"/> Often angry | <input type="checkbox"/> Often too hot | | |
| <input type="checkbox"/> Often crying | <input type="checkbox"/> Very thirsty | | |
| <input type="checkbox"/> Thinking a lot | <input type="checkbox"/> Bitter taste in mouth | | |

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Informed Consent to Acupuncture Treatment

This signed form indicates that the patient named below has been informed of and has consented to acupuncture treatment and other associated and complimentary procedures.

The methods of treatment include but are not limited to Acupuncture, moxibustion, cupping, guasha,

Electro-acupuncture, laser stimulation, Tui Na (Chinese massage), Shiatsu (Japanese massage), essential oil application, Reiki, herbal medicine and nutritional counselling.

The patient has been informed that acupuncture is a safe method of treatment and side effects are generally uncommon. Potential side effects of acupuncture include bruising, numbness or tingling near the needling site that may last a few days. Occasionally dizziness or fainting may occur. 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 patient comfort. Single-use, sterile and disposable needles are used to avoid infection. When moxibustion is applied to acupoints, some burning and/or scarring may occur, depending on the technique used. This form lists the most common risks of acupuncture, but each person may experience different effects.

The herbs and nutritional supplements (derived from plant, animal and mineral sources) which may be recommended are traditionally considered safe, although some may be toxic at high doses. Some herbs are inappropriate for pregnant women. Some possible side effects of herbs include nausea, gas, stomach ache, vomiting, diarrhea, rashes, hives or 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.

The patient has also been advised to inform the practitioner if she becomes pregnant.

Patient Advisory to Consult a Physician

In order to gain the best of both worlds, the patient named below has been advised that for whatever medical conditions they are seeking treatment for by acupuncture and other alternative modalities, they have been advised to check in and consult with their biomedical doctor(s).

In compliance with Article 160, Section 8211.1 (b) of NYS Education Law.....

Print Patient Name

*has been advised by **Paul Kempisty L.Ac.** to consult a physician regarding the condition(s) for which they are seeking acupuncture treatment.*

Patient Signature

Date

L.Ac Signature

Date



New York State Licensed Acupuncturist
73 Spring Street, Suite 201, New York, New York, 10012
www.iloveacupuncture.net 917.657.7246

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.

The privacy of your medical information is important to us. You may be aware that U.S. government regulations established under HIPAA (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 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 of 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.

Obligations That We Have

We are required by law to maintain the privacy of protected health information and to provide individuals 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: