healing house

Princeton Healing House
463 Prospect Ave.
Princeton, NJ 08540
609.759.0881

NEW PATIENT INTAKE FORM

Patient Name:			Date:
Birthdate:	Age:	Height:	Weight:
Home Address:			
City:		State:	Zip:
Preferred Phone:		E-mail:	
How did you hear about this office?		Occupation:	
Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Partnership			Number of Children:
Emergency Contact:		Phone:	
Primary Care Physician:		Phone:	
Have you received acupuncture therapy before? ☐Yes ☐No If yes, when? ________			
If yes, Whom?			
For what condition?			
What are the main issues for which you are seeking treatment today?			
Is this injury work-related? ☐Yes ☐No			
Is this injury due to an auto accident? ☐Yes ☐No			
Have you had the same or similar symptoms in the past? ☐Yes ☐No			
If yes, please state when and indicate prior treatment information (i.e. provider, type of treatment, etc.)			

Please list any medications and supplements you are currently taking.

Medicine	Dosage	Reason	How Long?	Prescribed By	Last Check Up

Please list any accidents, surgeries or hospitalizations.

EVENT	YEAR

Please indicate the use and frequency of the following:

	YES	NO	HOW MUCH?	HOW OFTEN?	MOST EVER USED?
Coffee/Tea					
Recreational drug					
Tobacco					
Alcohol					
Water					
Soda					
Refined Sugar					

Please indicate the use and frequency of the following:

	TYPE (S)	FREQUENCY
Exercise		
Hobbies		

Describe your dietary/nutritional habits (what do you eat?)

List any allergies, food sensitivities or cravings that you have:

Please check the appropriate box if you experience sensitivity to any of the following items		
Perfume		**Please Describe**:
Insecticides		
Fabrics		
Other Chemicals		
Do you currently work with or around chemicals? Yes ☐ No ☐		
If yes, please describe:		

How do you feel about the following areas of your life?				
	GOOD	AVERAGE	POOR	COMMENTS
Significant other				
Family				
Diet				
Sex				
Self				
Work				
Exercise				
Spirituality				

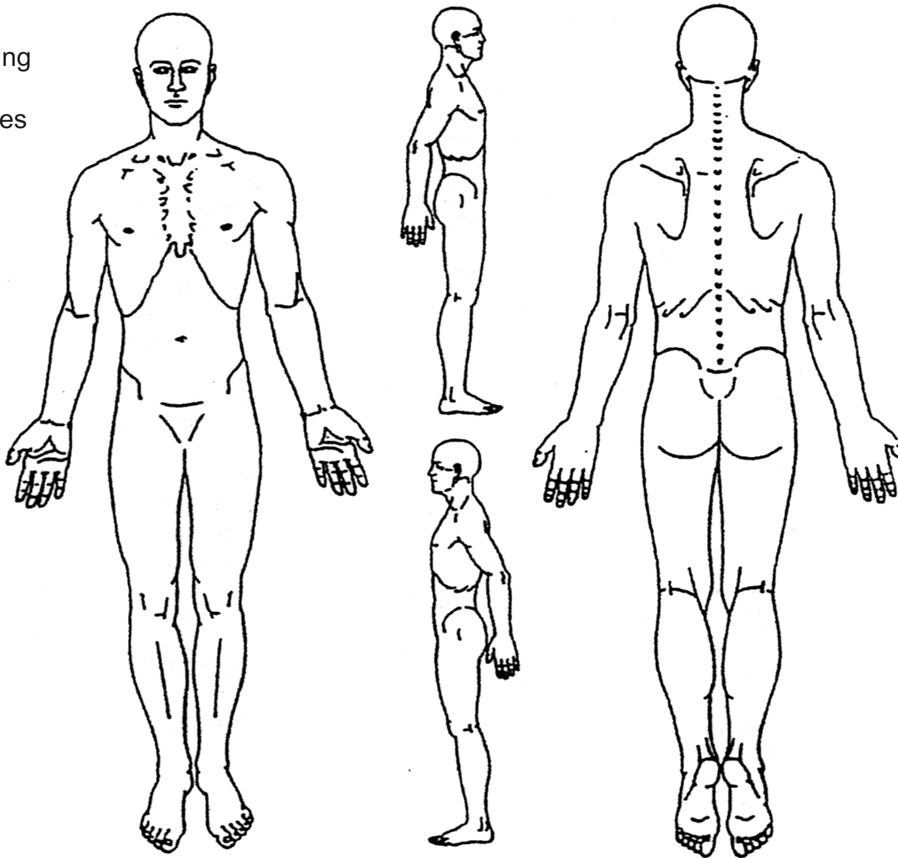
Please rate how your primary complaint affects the following aspects of your health.						
	NO PROBLEM	OCCASIONAL PROBLEM	MILD PROBLEM	MODERATE PROBLEM	SEVERE PROBLEM	NOT APPLICABLE
Energy Level	1	2	3	4	5	NA
Appetite	1	2	3	4	5	NA
Sleep Patterns	1	2	3	4	5	NA
Pain	1	2	3	4	5	NA
Digestion	1	2	3	4	5	NA
Elimination	1	2	3	4	5	NA
Emotions	1	2	3	4	5	NA
Using the scale above, how would you rate the intensity of your primary complaint						

When was your last physical exam? (month/year)	
Please list your doctor's name	
When did you last have lab (blood) work done?	
Were there any significant findings	

Are you experiencing discomfort in any area of your body? Yes ☐ No ☐

If yes, using the models below, please indicate the appropriate location of the discomfort by using the symbol that best describes the feeling:

+++ Sharp/Stabbing
vvv Dull/Aching
ooo Pins & Needles
/// Numbness



THE PAIN INDICATED ABOVE IS

Mild ☐ Moderate ☐ Severe ☐

Please check the appropriate square to describe your present limitations in function due to the pain indicated above

ACTIVITY	NORMAL	MILDLY LIMITED	MODERATELY LIMITED	SEVERELY LIMITED
Lifting	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Running	☐	☐	☐	☐
Resting in bed	☐	☐	☐	☐
Intercourse	☐	☐	☐	☐
Data entry/typing	☐	☐	☐	☐

Does your condition interfere with your normal work, household or recreational activities? Yes ☐ No ☐

If yes, please explain:

Please check the symptoms/illness you have experienced within the past six months

EARTH ELEMENT	METAL ELEMENT	WATER ELEMENT	WOOD ELEMENT	FIRE ELEMENT	MISCELLANEOUS
☐ Clammy hands	☐ Bronchitis	☐ Swollen ankles	☐ Anemia	☐ Angina pains	☐ Dry skin
☐ Lack of appetite	☐ Cough	☐ Burning with urination	☐ Bitter taste in mouth	☐ Anxiety	☐ Water retention or swelling
☐ Low blood sugar	☐ Chest Congestion	☐ Frequent urination	☐ Difficulty digesting oily or fatty foods	☐ Frequent crying	☐ High energy
☐ Sweet Cravings	☐ Shortness of breath	☐ Frequent urination at night	☐ Difficulty making plans or decisions	☐ Heat intolerance	☐ Fatigue or tendency to faint
☐ Loose Stool or undigested food	☐ Decreased sense of smell	☐ Urine retention	☐ Easily angered or agitated	☐ Nervousness	☐ Tendency to be hot
☐ Afternoon slump	☐ Feeling of claustrophobia	☐ Painful urination	☐ Eye problems (tearing, itching, blurred vision)	☐ Nightmares	☐ Tendency to be cold
☐ Nausea	☐ Fever	☐ Kidney stones	☐ Gall stones	☐ Poor memory	☐ Weight loss: ______ (#lbs/time frame)
☐ Drowsiness	☐ Frequent sore throats	☐ Cold intolerance	☐ Hemorrhoids	☐ Irregular heart-rate	Weight Gain: ______ (#lbs/time frame)
☐ Tendency to be "obsessive"	☐ Asthma	☐ Decreased sex drive	☐ Hepatitis	☐ Pressure in chest	☐ Sweating when not exercising or hot out
☐ Fatigue after a meal	☐ Nasal problems	☐ Hair loss	☐ High cholesterol	☐ Easily excitable	
☐ Food Sensitivity	☐ Recent use of antibiotics	☐ Knee problems	☐ Impatience	☐ Mental confusion	
☐ Easily bruised	☐ Frequent colds	☐ Night sweats	☐ Depression	☐ Insomnia	
☐ Indigestion	☐ Chills	☐ Fearful	☐ Light colored stool	☐ Palpitations	
☐ Vomiting	☐ Constipation	☐ Ringing in ears	☐ Pain under ribs	☐ Restlessness	
☐ Tendency to worry	☐ Blood in stool	☐ Burning hands or feet	☐ Soft/brittle nails	☐ Sore on tip of tongue	
☐ Bloating	☐ Skin problems type ______	☐ Blood in urine	☐ Spasm or twitching muscles	**6 @CC8**	
☐ Gurgling in stomach	☐ Inhalation of toxic chemicals	☐ Low blood pressure	☐ Stiff neck/shoulders	☐ Dizziness	
☐ Prolapsed Organs (Diagnosed)	☐ Swollen lymph glands	☐ Salt craving	☐ Tightness in ribs	☐ See floating black spots	
☐ Hemorrhoids	☐ Allergies	☐ Stress	☐ Varicose veins	**DAMPNESS**	
☐ Over-Thinking	☐ Infections	☐ Sleeplessness	☐ Anger	☐ General feeling of heaviness	
	☐ Chronic Illness	☐ Dizziness	☐ High blood pressure	☐ Swollen hands or feet	
	☐ Sweating without exercise	☐ Dark circles under eyes	☐ Fever Blisters	☐ Chest congestion	
	☐ Intolerant to weather changes	☐ Low back pain	☐ Frequent Sighing	☐ Nausea	
	☐ Nasal Discharge	☐ Hearing impairment		☐ Snoring	
	☐ Sadness	☐ Afternoon fever		☐ Mental sluggishness, or fogginess	
	☐ Melancholy	☐ Edema			
	☐ Frequent Yawning	☐ Infertility			

For Females Only

Age began Menstruating: ______________________

If post-menopausal, age of menopause onset and completion: ________________________________

Are your periods regular? ☐ YES ☐ NO ☐ N/A

Number of days between cycles: __________________

Number of days of flow: _________________________

Type of flow ☐ Light ☐ Medium ☐ Heavy ☐ Clots

Color of Blood ☐ Red ☐ Bright Red ☐ Dark Red ☐ Brown ☐ Purplish

Last period began on (date): ______________________

Have you ever had an abnormal PAP result? ☐ YES ☐ NO ☐ N/A

If Yes, when & class, if known: _______________________

Have you had a mammogram(s)? ☐ YES ☐ NO

If yes, when (date)?: ______________________________

Any abnormalities? ☐ YES Date: _______ ☐ N/A

Do you do breast self-exams? ☐ YES ☐ NO

If yes, how often? _____________________________

If yes, any abnormalities? _________________________

Check the corresponding box if you have ever had any of the following:

☐ Yeast Infections
☐ Non-yeast vaginal infection
☐ Ovarian cysts
☐ Breast lumps
☐ Genital herpes
☐ Hysterectomy
☐ Chlamydia infection
☐ Irregular periods
☐ Genital burning
☐ Scanty bleeding/spotting
☐ Anal fissures
☐ Vaginal warts
☐ Urinary tract infection
☐ Menstrual cramping
☐ Clotting during period
☐ Endometriosis
☐ Infertility
☐ Fibroids
☐ Hot flashed
☐ Decreased sex drive
☐ Pelvic inflammatory disease

☐ Sexually transmitted disease(s)
__Genital herpes
__Chlamydia
__HIV/ARC
__Gonorrhea
__Syphilis

☐ Premenstrual Syndrome (PMS)
__ Breast Tenderness/Swelling
__Sugar cravings
__Salt cravings
__Fat/oil cravings
__Insomnia
__Mood Swings
__Diarrhea
__Constipation
__Irritability/frustration
__Headaches
__Abdominal bloating
__Ravenous Appetite
__Poor Appetite
__Increased Libido
__Decreased Libido

Obstetrical History

Are you currently pregnant? ☐ YES ☐ NO

Pregnancies	#	AGE		#	AGE
Live births			Miscarriages		
Vaginal deliveries			Still births		
Caesarian deliveries			Abortions		

For Males Only

Check the corresponding box and sub-categories if you have ever had any of the following:

☐ Testicular swelling/pain
☐ Premature ejaculation
☐ Nocturnal emissions
☐ Weak or slow urine stream
☐ Dribbling urination
☐ Burning urination
☐ Discharge from penis
☐ Rectal/anal pressure

☐ Sexually transmitted diseases
__HIV/ARC
__Genital herpes
__Chlamydia
__Gonorrhea
__Syphilis

☐ Impotence
☐ Decreased sex drive
☐ Increased sex drive
☐ Low sperm count

Is there anything else you would like to explain regarding your condition?

How did you hear about our services?

CANCELLATION POLICY

Appointments must be canceled or changed within 24 hours of your appointment time. Without notice, the full cost of the visit will be incurred.

I understand the above cancellation policy. ______________________________

Signature

Pamela Strum - L.Ac., MSTOM

Acupuncture - Herbalist - Oriental Medicine

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).

____

Print Patient Name

has been advised by Pamela Strum to consult a physician regarding the condition(s) for which they are seeking acupuncture treatment.

____

Patient Signature ***Date***

____

L.Ac., MSTOM Signature ***Date***

Pamela Strum - L.Ac., MSTOM
Acupuncture - Herbalist

New Jersey State Licensed Acupuncturist
Princeton Healing House | 463 Prospect Ave. Princeton, NJ 08540
www.princetonhealinghouse.com | 609.759.0881

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 authorites if you are a member of the armed forces of the United States.

New Jersey State law provides additional protection for information regarding HIV/ AIDS. We will continue to follow New Jersey 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 acknowledgment of receipt as we are required under law to show that we gave you this information.

Acknowledgment 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: