

**Northeast Acupuncture and Herbs, LLC**  
**501 Riverway Place**  
**Bedford, NH 03110**  
**Ph: (603) 647-0600 F: (603) 647-0633**

Dear New Patient,

Welcome! Thank you so much for your interest in acupuncture and Oriental medicine. At Northeast Acupuncture and Herbs we do our best in every way possible to assure that you receive the best quality care. Services are now being offered at the Northeast Center for Holistic Medicine. We want you to know that everyone on our staff is trained to:

- Make sure that our customer service always meets the highest standards.
- Make sure that any questions you have about your care are answered in a way that you can understand.
- Make sure that your phone calls are returned promptly.
- Make sure that your private health care information is kept secure and private.

Enclosed you will find several forms that we'd like you to fill out and bring with you to your first appointment. If you have any questions about these forms, please call us at (603) 647-0600 and any one of us will be happy to help you.

Again, welcome to Northeast Acupuncture and Herbs. You have taken an important step on the road to more vibrant health. We look forward to serving you.

Yours sincerely,

Alyson Adams, L.Ac  
Northeast Acupuncture and Herbs, LLC



6. Do you have any reason to believe you may be pregnant?                    Y            N

If so, how far along are you? \_\_\_\_\_

7. Do you have any infectious diseases?    Y            N            If yes, please identify: \_\_\_\_\_

8. <b>Family History:</b>	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
Check those applicable:						
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Height:** \_\_\_\_\_    **Weight:** Currently: \_\_\_\_\_    Past Maximum: \_\_\_\_\_    When? \_\_\_\_\_

10. **Blood Pressure:** What is your most recent blood pressure reading? \_\_\_\_\_ / \_\_\_\_\_    When was this reading taken? \_\_\_\_\_

11. **Childhood Illness** (please circle any that you have had):

- Scarlet Fever    Diphtheria            Rheumatic Fever            Mumps            Measles            German Measles            Chicken Pox

12. **Immunizations** (please circle any that you have had):

- Polio            Tetanus            Rubella/Mumps/Rubella            Pertussis            Diphtheria            Hib            Hepatitis B

Others: \_\_\_\_\_

13. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____

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15. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings                  Nervousness                  Mental Tension

16. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue                  Slow Wound Healing                  Chronic Infections                  Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision                  Eye Pain/Strain                  Glaucoma                  Glasses/Contacts                  Tearing/Dryness  
Impaired Hearing                  Ear Ringing                  Earaches                  Headaches                  Sinus Problems  
Nose Bleeds                  Frequent Sore Throats                  Teeth Grinding                  TMJ/Jaw Problems                  Hay Fever

18. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia                  Frequent Common Colds                  Difficulty Breathing                  Emphysema  
Persistent Cough                  Pleurisy                  Asthma                  Tuberculosis  
Shortness of Breath                  Other Respiratory Problems: \_\_\_\_\_

19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease                  Chest Pain                  Swelling of Ankles                  High Blood Pressure  
Palpitations/Fluttering                  Stroke                  Heart Murmurs                  Rheumatic Fever                  Varicose Veins

20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers                  Changes in Appetite                  Nausea/Vomiting                  Epigastric Pain                  Passing Gas                  Heartburn  
Belching                  Gall Bladder Disease                  Liver Disease                  Hepatitis B or C                  Hemorrhoids                  Abdominal Pain

21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease                  Painful Urination                  Frequent UTI                  Frequent Urination                  Heavy Flow  
Kidney Stones                  Impaired Urination                  Blood in Urine                  Frequent Urination at Night

22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles                  Breast Lumps/Tenderness                  Nipple Discharge                  Heavy Flow  
Vaginal Discharge                  Premenstrual Problems                  Clotting                  Bleeding Between Cycles  
Menopausal Symptoms                  Difficulty Conceiving                  Painful Periods

23. **Menstrual/Birthing History:**

1. Age of First Menses: \_\_\_\_\_
2. # of Days of Menses: \_\_\_\_\_
3. Length of Cycle: \_\_\_\_\_
4. Birth Control Type: \_\_\_\_\_
5. # of Pregnancies: \_\_\_\_\_
6. # of Miscarriages: \_\_\_\_\_
7. # of Abortions: \_\_\_\_\_
8. # of Live Births: \_\_\_\_\_

24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties      Prostrate Problems      Testicular Pain/Swelling      Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain      Muscle Spasms/Cramps      Arm Pain      Upper Back Pain      Mid Back Pain

Low Back Pain      Leg Pain      Joint Pain (if so, where?): \_\_\_\_\_

26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness      Paralysis      Numbness/Tingling      Loss of Balance      Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid      Hypoglycemia      Hyperthyroid      Diabetes Mellitus      Night Sweats      Feeling Hot or Cold

28. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia      Cancer      Rashes      Eczema/Hives      Cold Hands/Feet

Is there anything else we should know? \_\_\_\_\_

\_\_\_\_\_

29. **Lifestyle:**

a. Do you typically eat at least three meals per day?      Y      N      If no, how many? \_\_\_\_\_

b. Exercise routine: \_\_\_\_\_

c. Spiritual practice: \_\_\_\_\_

d. How many hours per night do you sleep? \_\_\_\_\_      Do you wake rested?      Y      N

e. Level of education completed:      High School      Bachelors      Masters      Doctorate      Other

f. Occupation: \_\_\_\_\_      Employer: \_\_\_\_\_      Hours/Week: \_\_\_\_\_

Do you enjoy work?      Y/N      Why/Why not? \_\_\_\_\_

g. Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_

h. Have you experienced any major traumas?      Y      N      Explain: \_\_\_\_\_

\_\_\_\_\_

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? \_\_\_\_\_

j. Television habits: \_\_\_\_\_      Reading habits: \_\_\_\_\_

k. Interests and hobbies: \_\_\_\_\_

How did you hear about us? _____
Would you like to receive our email newsletter? _____

# Northeast Acupuncture and Herbs, LLC

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## Consent for Purposes of Treatment, Payment and Health Care Operation

*By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at Northeast Acupuncture and Herbs. I understand that acupuncturists practicing in the state of New Hampshire are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners. I consent to the use of disclosure of my identifiable health information by Northeast Acupuncture and Herbs, LLC for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations.*

**Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

**Direct Moxibustion:** I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

**Chinese Herbs:** I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Chinese Medical Clinic as soon as possible.*

**Acupressure/Massage:** I understand that I may also be given acupressure/massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

**Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that I have the right to review the Northeast Acupuncture and Herbs, LLC Notice of Privacy Practices prior to signing this document. This notice describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the Northeast Acupuncture and Herbs, LLC.

Northeast Acupuncture and Herbs, LLC reserves the right to change information contained in the notice of Privacy Practices at any time. I may obtain revised Notice of Privacy Practices at any time by requesting the most current notice in writing or in person at the time of my office visit.

### Payment

Payment is expected in full at time of service. We accept checks, cash, Visa, Master Card and American Express

- We are currently unable to bill insurance. Upon request, an invoice can be produced which may be submitted to insurance companies for reimbursement by the patient. Please ask for this invoice at time of payment.
- Northeast Acupuncture and Herbs, LLC does not guarantee reimbursement by the patient's insurance company.
- I understand that it is not the responsibility by the Northeast Acupuncture and Herbs, LLC to research whether reimbursement may occur, to submit forms for reimbursement, or to follow-up with my insurance company regarding reimbursement.

**Cancellation Policy**

Northeast Acupuncture and Herbs, LLC requires at least 24 hours notice of cancellation in advance of the scheduled appointment time. Missed appointments without notification will be charged the full fee visit. Cancellations with less than 24 hours notice will be billed 50% of the visit fee.

- I agree to pay for services rendered at time of service. I acknowledge that I may request the fees for various procedures before they may occur and include that information in my decision regarding healthcare.
- I understand that this office requires notice of cancellation at least 24 hours in advance of the scheduled appointment time.
- I consent to treatment as agreed upon between the practitioner and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any problems in my care with the practitioner.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and relationship to patient

\_\_\_\_\_  
Date of Birth