

Significant Trauma (physical or emotional)

Birth History (prolonged labor, forceps delivery, complications, etc.)

Surgeries (please include date of procedure)

Allergies (chemical, environmental, food, drugs, etc.)

Exercise: # of days per week Length of workout Type of Activity

Diet: <i>Please list usual foods for each meal or snack</i>	<i>Type, Amount, & Frequency</i>
Breakfast:	Snacks:
Lunch:	Alcohol:
Dinner:	Caffeine:

Tobacco: Cigarettes Cigars Pipe Chew

Amount/Frequency:

Recreational Drugs

What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days, etc.)

Personal History

Please check any conditions or symptoms you have now.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Elevated Blood Cholesterol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> Diverticulitis/IBS |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Raynaud's Disease |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Imbalance | <input type="checkbox"/> Respiratory Allergies |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Chronic Pain Condition | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Gastritis/Pancreatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Infertility | <input type="checkbox"/> Emphysema |

Family Medical History

Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- | | | | |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> Diabetes ___ | <input type="checkbox"/> Seizures ___ | <input type="checkbox"/> Heart Disease ___ | <input type="checkbox"/> Stroke ___ |
| <input type="checkbox"/> High Blood Pressure ___ | <input type="checkbox"/> Allergies ___ | <input type="checkbox"/> Cancer ___ | <input type="checkbox"/> Asthma ___ |
| <input type="checkbox"/> Other _____ | | | |

Please **star** if you have had any of these items listed below **in the last year**

Put a **check** on the box if you had this in the past but do not any longer.

General

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sweats Easily | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Bleed/Bruise easily | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Peculiar tastes/smells | <input type="checkbox"/> Dental/gum problems |
| <input type="checkbox"/> Muscle weakness/fatigue | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Strong thirst (hot or cold drinks) | |

Skin and Hair

- | | | | |
|---|--------------------------------------|--|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Face flushing |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Warts | <input type="checkbox"/> Fungal Infection | <input type="checkbox"/> Weak or ridged nails |

Head, Eyes, Ears, Nose and Throat

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Migraines | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night Blindness |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Jaw clicks/locks | <input type="checkbox"/> Headaches |

Cardiovascular

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Varicose/spider veins | <input type="checkbox"/> Pressure in chest | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Spontaneous sweating | <input type="checkbox"/> Dizziness | |

Respiratory

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight sensation in chest | <input type="checkbox"/> Difficult inhale/exhale |
| <input type="checkbox"/> Difficulty breathing when lying down | | <input type="checkbox"/> Production of phlegm... what color? _____ | |

Gastrointestinal

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bloating/Edema | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Loose stools (>2 per day) | <input type="checkbox"/> Abdominal pain/cramps |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid reflux/GERD | <input type="checkbox"/> Hernia | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Significant thirst | <input type="checkbox"/> IBS/Crohn's Disease | |

Genito-Urinary/Reproductive

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Scanty urine flow | <input type="checkbox"/> Copious urine flow |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Sores on genitals | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Burning urination |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Pain in testicles | <input type="checkbox"/> Herpes | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Night urination... What time? _____ How often? _____ | | | <input type="checkbox"/> Excessive libido |
| <input type="checkbox"/> Difficult/Painful intercourse | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Age of first menses _____ | |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Date of last menses _____ | |
| <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Date of last PAP/Pelvic _____ | |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Fibrocystic breast tissue | <input type="checkbox"/> Number of pregnancies _____ | |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Polycystic Ovarian Disease | <input type="checkbox"/> Number of ectopic pregnancies _____ | |
| <input type="checkbox"/> Irregular menstruation | <input type="checkbox"/> PMS | <input type="checkbox"/> Number of live births _____ | |
| | <input type="checkbox"/> Painful menstruation | <input type="checkbox"/> Number of miscarriages _____ | |
| | | <input type="checkbox"/> Number of abortions _____ | |

Do you practice birth control? _____

What type? _____ How long? _____

Musculoskeletal

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Back pain Low__ Middle__ Upper__ | | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Rotator Cuff |
| <input type="checkbox"/> Soreness/weakness in lower body (back, knee, hip, ankle, foot) | | | |

Neuropsychological

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety/Panic attacks | <input type="checkbox"/> Bad temper/irritable | <input type="checkbox"/> Easily susceptible to stress | <input type="checkbox"/> Seasonal Affective Disorder |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Manic Depression | |

Have you ever been treated for emotional problems?

Yes No

Have you ever considered or attempted suicide?

Yes No

Have you ever been treated for substance abuse?

Yes No

Comments: Please inform me of any other conditions or concerns that you would like to discuss.

Acupuncture Consent to Treatment & Care

I hereby request and voluntarily consent to the performance of acupuncture treatments and other Asian medicine procedures on me (or on the patient named below, for which I am legally responsible) by Neil Pregozen, L.Ac., and/or another licensed acupuncturist who is serving as back up for Neil Pregozen.

I understand that methods or treatments may include and are not limited to: acupuncture (insertion of sterile, disposable needles into the skin), gua sha (rubbing of skin with a smooth object), moxibustion (application of heat to the skin by the burning of mugwort herb), cupping (application of heated glass cups to the skin along the meridians of the body), herbal consultations, bodywork, and nutritional consultations. I understand that no guarantees concerning the use and effects of these treatments are given to me, and that I am free to refuse or discontinue any form of treatment at any time.

The treatments offered are generally recognized as safe treatments. I am aware that some risks are possible, as with any treatment. These could include, but are not limited to, brief pain or discomfort, small local bruising, slight bleeding, tingling, dizziness, burning from mugwort herb. Rare instances have been reported of fainting, nausea, spontaneous miscarriage, or pneumothorax. There may be brief and temporary aggravation of symptoms existing prior to treatment.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although as with any consumable, may be toxic in large doses. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastrointestinal reactions to the herbs I will inform the acupuncturist *immediately*.

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 understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _____

initials

I understand that there will be a \$75 charge for missed appointments and appointments canceled with less than 24 hours notice unless the cancellation results from an emergency (a sudden, unexpected situation or set of circumstances). I understand that insurance does not pay for missed appointments or late cancellations, and that I will be personally responsible for the charges. _____

initials

I authorize payment of medical benefits (health insurance or other) to Neil Pregozen, L.Ac.. I agree to pay all charges incurred for services rendered, over and above insurance coverage. _____ (initials)

Patient's Name

Guardian's Name & Relationship (if applicable)

Patient's Signature

Guardian's Signature

Date

Are you pregnant?

**Neil Pregozen, L.Ac.
34 Pomeroy Lane, #5
Amherst, MA 01002
(413) 230-9609**

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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.

USE AND DISCLOSURE OF HEALTH INFORMATION

I may use your health information, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for the purposes of providing you treatment, obtaining payment for you for your care and conducting health care operations.

Treatment – Your health information will be recorded and used to determine the course of treatment that should work best for you. The sharing of your health information may include other health care providers involved in your care within the confines of my practice.

Payment – Your health care information will be used in order to assist you to be able to receive reimbursement payments for services. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.

Health Care Operations – Your health care information will be used as necessary in order to improve the quality and effectiveness of the care and services I provide. For example, with your written consent, I may discuss your case with another health care provider to increase my understanding of your unique situation. In the event of a medical emergency which, for the sake of your welfare, requires information from me about your state of health that is critical to your proper care in a medical setting other than my office, I will communicate with the necessary medical personnel any information that I deem to be appropriate. In signing this disclosure you are giving consent for me to take such an action.

Appointment reminders – I may contact you with appointment reminders.

Treatment alternatives – I may contact you with information about treatment alternatives and other health-related activities that may be of interest to you.

Patient Education – I may contact you to inform you of new services that I offer or of events that I am hosting or attending.

Communications with Family – In an urgent situation, one or more people, a family member, or close personal friend, identified by you, may be given information relevant to your care. This space is available for you to provide names and contact information for those with whom you explicitly authorize me to communicate:

Your Emergency Contact: _____

Contact Information: _____

Research/Education – Your information will be disclosed to researchers or educators upon the assurance that protocols have been established to ensure the privacy of your health information.

Law Enforcement – Your health information will be disclosed when it is required under Federal, State, or Local law.

Other than stated above when applicable, I agree not to use or disclose your health information without your written authorization. Other than activity that has already occurred, you may revoke this authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

Your health record is the physical property of the health care practitioner or facility that compiled it but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information (a copy fee may be requested), and to receive an accounting of the disclosures that have been made of your health information (after the effective date of this Notice) for most purposes other than treatment, payment or health care operations. Other disclosures excluded are direct disclosures to yourself, family or friends involved in your care. You may also request communications of your health information be made by reasonable alternative means or to reasonable alternative locations. You will need to provide details about how to contact you including a valid alternative address. If we are unable to contact you using the information you provide, we may contact you using any information on file. We will not require you to explain why you want this communication. We will honor reasonable requests. However, if we are unable to contact you using the requested ways or locations, we may contact you using any information on file, including an email address given to us by you. You also may want to communicate with us via e-mail. Because e-mail may contain your personal health information and e-mail is not a secure communication, we ask for your specific authorization to communicate with you using this method by signing this form and *initialing here* _____.

All requests must be submitted to me in writing (Neil Pregozen, 34 Pomeroy Lane, #5, Amherst, MA 01002). You have the right to a paper copy of this Notice and may request one at any time by contacting me at 413-230-9609. You have the right to file a complaint with me or the Secretary of Health and Human Services, with no fear of retaliation.

MY RESPONSIBILITIES

I am required by law to maintain the privacy of your health information and to provide you this Notice of duties and privacy practices. I am required to abide by the terms of this Notice and to notify you if I am unable to grant your requested restrictions or desires. I reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that I maintain. If I change this Notice, you will be informed at your next office visit after such a change has been made.

Patient Comments:

Patient Signature

Date

This Notice is effective 29 December 2015