Anat Raz - Acupuncture & Chinese Herbal Medicine

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name _____ Sex M ___ F___ Date _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Place of birth _____ Age _____

Telephone: Home ( ) _____ Work ( ) _____ Cell ( ) _____
*Please check the best number to reach you.

Email: _____ (Will be used for appointment confirmation only)

_____ Single _____ Married _____ Divorced _____ Widowed _____ Living with

Education _____ Occupation _____

Referred by: _____

Reason for visit today _____

Other problems _____

How long have you had this condition? _____ Have you ever experienced this before? _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother your Sleep ___Work ___other (what?) _____

FAMILY HISTORY - Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	self	mother	father	sibling	spouse	children
cancer or tumors						
diabetes						
blood or bleeding disorders/anemia						
seizures						
high blood pressure/heart disease						
allergies						
stroke						
drug abuse						
depression or mental illness						
age of death						
hepatitis						
kidney disorders						
thyroid disorders						
musculo-skeletal disorder						
blood transfusion (if before 1985)						

PERSONAL LIFESTYLE HABITS (how much, how many, or how often)

Cigarettes (packs) _____ Coffee/Tea (cups) _____ Alcohol (drinks per week) _____

Marijuana _____

Other recreational drugs _____

Vitamins & herbs _____

Dietary restrictions _____

Food cravings _____

Diet: What might you eat on a typical day?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Exercise _____ How often? _____

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.) _____

_____

MEDICINES:

Prescription drugs you are currently taking: For what condition?

_____ _____
_____ _____
_____ _____
_____ _____

Over-the-counter medication you are currently taking: For what condition?

_____ _____
_____ _____
_____ _____

MAJOR HOSPITALIZATIONS If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

Date of last physical examination: _____

Name & address of physician _____

Phone number of physician _____

Have you ever been treated with acupuncture &/ or Chinese herbal medicine before? Yes No

GYNECOLOGY

Age of first menses: _____ Date of last menstrual period: _____ Duration of flow _____

Blood clots: yes no When: _____ Length of cycle _____

Color of menstrual blood: pale bright red dark red brown other _____

Texture of menstrual blood: thick thin watery normal

Pain: yes no When: _____

Irregular periods (describe): _____

PMS (please describe): _____

Current method of contraception: _____ Past method of contraception: _____

Are you currently pregnant? Yes No

Number of pregnancies:

Number of live births:

Number of miscarriages:

Number of abortions:

Any premature births:

Breast (lumps, cysts, tenderness, etc.): _____

Urinary tract infections: _____ How frequent? _____

Vaginal infections/ discharges (describe color): _____

Pain/itching of genitalia: _____

Pap smear: normal abnormal Date of last Pap smear: _____

Uterine fibroids: _____ Endometriosis: _____ Other: _____

Menopause (date of onset): _____ Symptoms: _____

_____

Any bleeding since? _____

Are you currently on Hormone Replacement Therapy (HRT)? Yes No Dose: _____

How long have you been on HRT? _____ Any side effects? _____

Other: _____

_____

_____

_____

Please put a **"C"** if the condition is current or a **"P"** if you had it in the past

General
__ Insomnia
__ Dreams/ nightmares
__ Irritability
__ Depression
__ Mood swings
__ Fatigue
__ Poor memory
__ Strongly like cold drinks
__ Strongly like hot drinks
__ Recent weight loss/gain
__ Cold hands & feet
__ Chills
__ Fever

Head & Neck
__ Headaches
__ Migraines
__ Stiff neck
__ Dizziness
__ Fainting
__ Swollen glands

Ears
__ Ringing
__ Hearing loss
__ Infections
__ Earache
__ Hearing aids
__ Vertigo

Eyes
__ Glasses/ contact lenses
__ Blurred vision
__ Poor night vision
__ Spots or floaters
__ Eye inflammation
__ Double vision
__ Glaucoma
__ Cataracts

Nose, Throat & Mouth
__ Sinus infection
__ hay fever/ allergies
__ Frequent sore throat
__ difficulty swallowing
__ Mouth & tongue ulcers
__ Frequent colds
__ Nosebleed
__ Dry nose
__ Nasal congestion
__ Loss of voice
__ Thirst
__ Excessive phlegm
__ TMJ
__ Facial pain
__ Gum problems
__ Dry mouth

Skin
__ Hives
__ Rashes
__ Eczema/ psoriasis
__ Night sweating
__ Excess sweating
__ Dry skin
__ Easy bruising
__ Changes in moles, lumps
__ Itching

Respiratory
__ Difficulty breathing
__ Difficulty breathing when lying down
__ Wheezing
__ Asthma
__ Chronic cough
__ Wet cough
__ Dry cough
__ Coughing up phlegm
__ Coughing up blood
__ Shortness of breath
__ Tight chest
__ Pneumonia

Cardiovascular
__ High blood pressure
__ Low blood pressure
__ Chest pain or tightness
__ Palpitation
__ Rapid heart beat
__ Irregular heart beat
__ Poor circulation
__ Swollen ankles
__ Phlebitis
__ Anemia
__ History of heart attack

Gastrointestinal
__ Nausea
__ Indigestion
__ Stomach pain
__ Diarrhea
__ Constipation
__ Poor appetite
__ Excessive hunger
__ Vomiting
__ Gas
__ Hiccups
__ Acid regurgitation
__ Bloating
__ Bad breath
__ Laxative use
__ Bloody stool
__ Mucus in stool
__ Hemorrhoids
__ Gall Bladder disorder

Musculoskeletal
__ Joint pain/disorder
__ Sore muscles
__ Weak muscles
__ Difficulty walking
__ Neck/shoulder pain
__ Upper back pain
__ Lower back pain
__ Rib pain
__ Limited range of motion
__ Other (describe)

Neurological
__ Seizures
__ Tremors
__ Numbness or tingling
__ Pain
__ Paralysis
__ Poor coordination
__ Other (describe)

Genito-urinary
__ Pain on urination
__ Frequent urination
__ Urgent urination
__ Blood in urine
__ Unable to hold urine
__ Incomplete urination
__ Bedwetting
__ Wake to urinate
__ Increased libido
__ Decreased libido
__ Kidney stones
__ Impotence
__ Premature ejaculation
__ Nocturnal emission
__ Pain/itching of genitalia
__ Lumps in testicles

Infection Screening
__ HIV risks: self or partner
__ TB: self or household
__ Hepatitis risk: self or partner
__ History of sexually transmitted disease: self or partner
__ Gonorrhea
__ Chlamydia
__ Syphilis
__ Genital warts
__ Herpes: oral/ genital

Other

CONSENT FORM

I, _____ hereby consent to be treated by Anat Raz L.Ac., with acupuncture &/ or Oriental medical procedures, which may include acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, or nutritional and lifestyle counseling.

I understand that acupuncture is performed by the insertion of pre-sterilized acupuncture needles through the skin, with or without the addition of heat or electrical stimulation, to certain points on the body, with the intent of improving bodily function, relieving pain, and treating certain diseases or bodily dysfunctions.

I have been informed that acupuncture, when performed by qualified licensed practitioners, is a safe method of treatment, but rarely, some side effects do occur. The most common of these are bruising or tingling near the needling sites for a few days, fatigue or temporary aggravation of pre-existing symptoms. Other possible though extremely rare side effects may be fainting, or pneumothorax. If I experience any symptom I believe may be the result of treatment, I've been advised to contact my acupuncturist promptly for guidance.

I understand that I should also inform my acupuncturist prior to being treated if I believe that I might be pregnant.

I accept the fact that no guarantee is made concerning the outcome of my acupuncture or herbal medicine treatment and that I may stop treatment at any time.

I have been advised by ANAT RAZ, L.Ac., to consult a physician regarding the condition or conditions for which I am seeking acupuncture/herbal medical treatment.

PATIENT'S NAME _____

PATIENT'S SIGNATURE _____

ACUPUNCTURIST SIGNATURE _____

DATE _____

Anat Raz, M.S., L.Ac.
Acupuncture & Chinese Herbal Medicine
25 East Main Street
Mount Kisco, NY 10549
Phone: (914) 244-0569
Fax: (914) 244-3353

Office Policy

1) Cancellations must be made at least 24 hours in advance, or full fee will be charged.

2) Cancellation fee will not be applied if appointment is cancelled due to bad weather or a sick child.

3) Arrival to the office more than 15 minutes after the scheduled appointment time may result in less than the full consultation and/or acupuncture treatment.

4) Pre payment is required for all custom granules and other specially ordered items.

5) Herbs and supplements you have been prescribed may not always be in stock. Please call at least one week before you will run out so that we have time to order them if necessary.

6) While in the waiting room, please keep in mind that loud voices, cell phones, and strong odors from food or perfume can be disruptive to those receiving treatment.

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Notice of privacy practices

Our office is dedicated to providing respectful and confidential service. Protecting your privacy and healthcare information is fundamental to our practice, and is also mandated by law.

Pleased be advised that we may gather personal and health information about you in several ways:
✳Directly from you, our patient
✳From other healthcare providers
✳From third party payers (i.e., insurance companies)

Note that we may use and disclose medical information about you (without your specific consent or authorization) for the following reasons *only:*
✳To confer with other healthcare practitioners to better understand the optimal course of treatment
✳To facilitate payment from insurance companies for the treatment and services you receive from us
✳To share our findings with your referring primary care practitioner.

We may disclose your medical information to any other medical practitioners, friends, or family only with your written consent. You may request a medical information disclosure consent form from our office.

Communication:
We routinely communicate with patients over the phone to schedule appointments or to address concerns or answer questions. If we leave a message, we will identify ourselves by name and mention we are from Anat Raz's office. *If you prefer to only be contacted at work, home or other phone number, please write that number here:* _____

Patient Rights:
✳Upon written request, you have the right to access, review or receive copies of your healthcare records.
✳Upon written request, you have the right to request that we place restrictions on the disclosure of your protected health information. In your request, you must indicate what information you want to limit. We are not required to agree to this request.
✳You are entitled to a copy of this notice.
✳Upon written request, you have the right to a summary of what we have disclosed about you and to whom.

Complaints:
If you have questions or complaints, please contact Anat Raz at 914-244-0569. If you are not satisfied with how this office handles your complaints, you may submit a formal complaint to:

DHHS (Office of Civil Rights)
2000 Independence Avenue, S.W. Room 509F HHH Building, Washington, D.C. 20201

*By signing below, I acknowledge that I have read, reviewed, understood and agreed to the statement of Privacy Policy for healthcare services with Anat Raz Acupuncture and Herbal Medicine. I also confirm that this office has attempted to provide me with a copy of the statement of privacy policies.

(Patient signature) (Date)