THE PEOPLE'S ACUPUNCTURE CLINIC

"health for the people... by the people."

REGISTRATION FORM

Name			D.O.B / /	Age
Address			Time of birth: : am/pm	
City	State	Zip	Sex: Male Female	
Tel. (H.)	Cell		Ht.	Wt.
Email		Primary Care Physician:		
Occupation:		Company:		
Emergency Contact:			Relationship:	
Address			Tel.	

How did you learn about our clinic? Doctor Friend Website Other:_______________________________

*Please lets us know if someone referred you! We would like to thank them! Referred by:*_______________________________

Consent to Treatment

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 of The People's Acupuncture Clinic, Inc. I understand that acupuncturists practicing in the state of Massachusetts 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.

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.

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 effects 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 People's Acupuncture Clinic Inc. as soon as possible.*

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 give my permission and consent to treatment.

Signature: _______________________________ **Date:** ____________________

(If under 18 years of age a parent or legal guardian must sign.)

Printed Name: _______________________________ **Date of Birth:** ____________________

NOTICE OF PRIVACY POLICIES

We love our small town of Amherst, MA, and are thrilled to provide wellness care to the community. We understand that medical information about you and your health is personal. Yet, living in a small town means that we may bump into you in the grocery store, the farmers market or at a restaurant on any given night. Protecting your privacy and healthcare information is fundamental in the course of our relationship, and we employ a strict policy not to discuss health concerns outside of the clinic.

For HIPPA laws, we must let you know that we keep on file non-public personal information such as:

- Your patient record, including diagnostic information, as well as the care and services you receive.
- Your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversation to our office.
- Your financial transactions, however we do not store credit card numbers.

Your Rights

When it comes to your health information, you have certain rights, including the following:

- Upon written request, get an electronic or paper copy of your medical records
- Ask us to limit what we use or share
- Upon written request, get a list of those with whom we've shared information
- Get a copy of this privacy notice
- File a complaint if you feel your rights are violated, by:
    - Contacting us using the information below
    - Sending a written complaint to the U.S. Department of Health and Human Services (address at bottom of page)
- We will not retaliate against you for filing a complaint

Marketing

We will never share or sell your information for any reason. We will use phone, text, or e-mail to contact you or confirm appointments.

Disclosure of Information

In order to maintain the level of service that you expect from our office, we may need to share limited information for treatment, payment and healthcare operations. We typically use or share your health information in the following ways:

- We can use your health information and share it with other professionals treating you
- We can use and share your health information to run our practice, improve your care, and contact you when necessary
- We can use and share your health information to bill and get payment from health plans or other entities.

NOTICE OF PRIVACY POLICIES

- We will also share information about you if state or federal laws require it, to comply with law enforcement and other government requests, and to respond to lawsuits and legal actions.

Our Responsibilities
We are required by law to maintain the privacy and security of your protected health information. We will let you now promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it for review. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.
If you have questions, complaints or want more information, contact:

DHHS (Office of Civil Rights)
p200 Independence Ave S.W. Room 509 F HHH Building, Washington, DC 20201

Effective 01/01/2019

I understand I have the right to read and discuss the Notice of Privacy Policies form of The People's Acupuncture Clinic Inc. before I sign this consent form regarding the use and disclosures of my protected health information.

I have the right to revoke this consent, in writing, at any time except to the extent that the The People's Acupuncture Clinic Inc. has acted in reliance on this consent.

I have read, reviewed, understand and agree to the Notice of Privacy Policies for healthcare services at The People's Acupuncture Clinic Inc.

Print Name: ____

Patient / Representative Signature: ______________________________ Date: _______________

THE PEOPLE'S ACUPUNCTURE CLINIC

228 Triangle Street Amherst, Massachusetts 01002

Name: ______________________

Date: _____ / _____ / _______

WOMEN'S HEALTH HISTORY

MAIN COMPLAINTS

Please write in your top 3 health concerns in order of importance. Circle the items that make it better or worse and mark the severity of the condition on the scale from 1-10. (0=No symptoms, 10=worst ever)

#1. ______________________________

When did this start? ________________ ago.

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise/activity:	better	no change	worse

0 |------------------|------------------|10

#2. ______________________________

When did this start? ________________ ago.

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise/activity:	better	no change	worse

0 |------------------|------------------|10

#3. ______________________________

When did this start? ________________ ago.

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise/activity:	better	no change	worse

0 |------------------|------------------|10

MEDICAL HISTORY

Please check off any that apply to **you**.

- ❑ Cancer
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Stroke
- ❑ Seizure
- ❑ Thyroid
- ❑ Asthma
- ❑ Pacemaker
- ❑ Osteoporosis
- ❑ Herpes
- ❑ Auto-immune Disease
- ❑ AIDS/HIV
- ❑ STD
- ❑ Rheumatic Fever
- ❑ Alcoholism
- ❑ Mental Illness
- ❑ Kidney Disease
- ❑ Anemia
- ❑ Glaucoma
- ❑ Tuberculosis
- ❑ Allergies *type(s):* ________________

CURRENT MEDICATIONS

Please note what prescription medications, over-the-counter medications, herbs, or supplements you take regularly.

____

____

____

INJURIES / SURGERIES

Please list when & where on the body

____

____

____

LIFESTYLE HABITS

	amount / week	If quit, year?
Coffee/Tea:	________	______
Soda:	________	______
Tobacco:	________	______
Alcohol:	________	______
Drugs:	________	______

EXERCISE

Do you exercise regularly? Yes / No

If so, what & how often?

____

____

____

DIET

Do you follow a special diet? *(Vegetarian, Vegan, Raw, Macrobiotic, etc.)*

____

SLEEP

\# of hours per night =_________

- ❑ Difficulty falling asleep
- ❑ Wake___x/night@____am/pm
- ❑ Wake to urinate ___x/night
- ❑ Disturbing dreams
- ❑ Restless sleep
- ❑ Unrested upon waking
- ❑ ________________

EMOTIONS

Are there emotions you feel more often?

- ❑ Anger
- ❑ Irritability
- ❑ Anxiety
- ❑ Worry
- ❑ Obsessive thinking
- ❑ Sadness Grief
- ❑ Depression
- ❑ Mood swings
- ❑ Joy
- ❑ Fear
- ❑ Timid / Shy
- ❑ Indecision

EYE-EARS-NOSE-THROAT

- ❑ Poor vision
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Floaters
- ❑ Eye pain
- ❑ Poor hearing
- ❑ Ringing in ears
- ❑ Earache
- ❑ Sinus congestion
- ❑ Phlegm
- ❑ Sore Throat
- ❑ Cough
- ❑ Mouth sores
- ❑ Bleeding gums
- ❑ Teeth grinding

Please rate yourself on the scales below and check off any boxes that are appropriate to you.

TEMPERATURE

How warm / cold do you *feel* (not in degrees); relative to other people do you wear more or less clothing, etc.?

COLD |---|---| **HOT**

☐ Cold Hands / Feet	☐ Thirst but no desire to drink	☐ Night sweats	☐ Hot hands, feet, chest
☐ Chills	☐ Absence of thirst	☐ Unusual sweats	☐ Hot flashes
☐ Cold to the bones	☐ Always thirsty	When______ am / pm	☐ Hot in afternoon
☐ Areas of numbness	Desire cold / hot drinks?	Where?____________	☐ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, etc.)?

DRY |---|---| **OILY**

☐ Dry skin	☐ Dry mouth	☐ Rashes / Hives	☐ Oily skin
☐ Dry hair	☐ Dry lips	☐ Itching	☐ Oily hair
☐ Dry eyes	☐ Dry throat	☐ Edema / Swelling	☐ Pimples
☐ Dry brittle nails	☐ Dry nose / nosebleeds	Where?_______________	☐ Weight gain / loss

DIGESTION

DIARRHEA |---|---------------------------------------| **CONSTIPATION**

BM: How often? ____x / every _____day(s)	☐ Belching	☐ Excessive hunger	☐ Dry stool
Are your stools well formed? Yes / No	☐ Poor appetite	☐ Indigestion	☐ Hemorrhoids
☐ Alternating diarrhea & constipation (IBS)	☐ Nausea / Vomiting	☐ Heartburn	☐ Foul smelling stool
☐ Fatigue after BM	☐ Bad breath	☐ Acid reflux	☐ Feels incomplete

ENERGY

LOW |---|---| **HIGH**

☐ Sudden energy drop *Time of day:___am/pm*	☐ Depend on caffeine/stimulants	☐ Hard to concentrate
☐ Energy drop after eating	☐ Wired / Ungrounded feeling	☐ Poor memory
☐ Fatigue	☐ Body / Limbs feel heavy	☐ Dizziness / lightheaded
☐ Shortness of breath	☐ Body / Limbs feel weak	☐ Headaches *How often?*_______
☐ Heart palpitations	☐ Bleed / Bruise easily	☐ Blood pressure High/Low

URINARY

Urination=______x/day *(approx.)*

Color= clear/light yellow/dark

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Burning sensation
- ☐ Urgency to urinate
- ☐ Cloudy urine
- ☐ Blood in urine
- ☐ Dribbling
- ☐ Difficulty starting / stopping
- ☐ Incontinence
- ☐ Incomplete sensation
- ☐ Kidney stones

MENSTRUATION

First period: _____yrs. old	☐ Heavy periods	☐ Fatigue w/menses
Last period:___ /___	☐ Light periods	☐ Fibroids
Duration________days	☐ Painful periods	☐ Ovarian Cysts
Length of cycle: _____days	☐ Irregular periods	☐ Endometriosis
# of pregnancies:____	☐ PMS	☐ Herpes
# of births:____	☐ Cramps	☐ Gonorrhea
Are you sexual active? Y / N	before/1st day /during	☐ Syphilis
Are you pregnant? Y / N	☐ Clots	☐ Yeast infections
Are you on birth control? Y / N	☐ Mid-cycle spotting	☐ Hysterectomy

MENOPAUSE		
	☐ Hot Flashes _____x/day	☐ Vaginal dryness
	☐ Night-sweats ______x/week	☐ Loss of sex drive

Thank you!

We greatly appreciate your time in filling out your health history... it is the first step in enabling us to give you the most appropriate and high quality care that you will expect from our clinic.