

EAST MOUNTAIN ACUPUNCTURE PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers will remain confidential.

WHERE DID YOU HEAR ABOUT THE EAST MOUNTAIN ACUPUNCTURE?

IDENTIFICATION DATA Please fill in completely & print clearly.

| | |
|-------------------------------|---------------------------|
| Name _____ | Date _____ |
| | Place of birth _____ |
| | Date of birth _____ |
| | Age _____ |
| Address _____ | |
| | Home Phone _____ |
| | Work Phone (parent) _____ |
| | Cell phone (parent) _____ |
| Child's level in school _____ | |
| Parents' Occupation(s) _____ | |

FAMILY HEALTH 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.

| | Patient | Mother | Father | Sibling |
|-------------------------------------|---------|--------|--------|---------|
| Cancer or tumors | | | | |
| Diabetes | | | | |
| Blood or bleeding disorders/ anemia | | | | |
| seizures | | | | |
| high blood pressure/ Heart Disease | | | | |
| allergies | | | | |
| stroke | | | | |
| drug abuse/ alcohol abuse | | | | |
| depression or mental illness | | | | |
| age at death | ----- | | | |
| Hepatitis | | | | |
| Kidney disorder | | | | |
| thyroid disorder | | | | |
| musculo-skeletal disorder | | | | |
| blood transfusion (if before 1985) | | | | |

PERSONAL LIFESTYLE HABITS

Use of tobacco: yes____ Cigarettes per day____(packs per day) no____ age started____
Use of marijuana yes____ How much per day?____ no____ age started____
Use of alcohol yes____ How many drinks per week?____ no____ age started____
Use of caffeine yes____ Colas per day____ Coffees per day____ Teas per day____
Use of crack/cocaine yes____ How often?____ no____
Use of other recreational drugs yes____ what drug(s)?____
how often?____ no____

MEDICINES:

Please list any medications, vitamins, or herbs the patient is currently taking, how often and what conditions they are for. _____

Was the patient immunized?_____ Which immunizations were given?_____
How recently? _____

DIET:

What is the typical daily diet like? (be honest)
BREAKFAST: _____
LUNCH: _____
DINNER: _____
SNACKS: _____
Was/ is the baby breast-fed? _____ How long? _____
At what age was solid food introduced? _____
What foods were they? _____

What is a typical weekday schedule like for the patient? _____
How much time is spent at home, in school, in day care, etc.? _____

What does the patient do for fun? _____

MAJOR HOSPITALIZATIONS Has the patient ever been hospitalized?

| YEAR | OPERATION or ILLNESS |
|------|----------------------|
| | |
| | |
| | |

Any emotional traumas or transitions? (i.e., parent divorce, loss of loved one, moving, changing schools, difficulties in school, strained relationships with parents, etc.) Please give dates if appropriate.

Date of Last Physical Examination: _____
Name and address of Doctor _____
Phone number of Doctor _____

Has the patient been treated with acupuncture &/ or Chinese herbal medicine before? ____yes
____no

What other treatments have been tried for the patient's condition?

WHAT IS THE MAIN HEALTH ISSUE FOR WHICH THE PATIENT IS SEEKING ORIENTAL MEDICAL TREATMENT?

PLEASE PUT A **C** IF THE CONDITION IS CURRENT OR A **P** IF IT IS A PAST CONDITION:

HEAD & NECK

- dizziness
- fainting
- neck stiffness
- enlarged lymph glands
- headaches
- head or neck injury

EARS

- infection
- ringing
- decreased hearing or deafness
- vertigo
- discharge
- pain

EYES

- blurred vision
- visual changes
- spots or floaters
- eye inflammation
- eye discharge
- double vision
- contact lenses/ glasses
- year of last eye exam

NOSE, THROAT, & MOUTH

- sinus infection
- hay fever/ allergies
- frequent sore throats
- hoarseness
- difficulty swallowing
- changes in sense of smell or taste
- mouth or tongue ulcers
- frequent colds
- nosebleeds

SKIN

- hives
- rashes
- eczema / psoriasis
- night sweating
- excess sweating
- dry skin
- easy bruising
- changes in moles, lumps, hair

RESPIRATORY

- chronic cough
- coughing up blood
- coughing up phlegm
- difficulty breathing
- wheezing/ asthma
- frequent colds

CARDIO-VASCULAR

- palpitations
- rapid heart beat
- irregular heart beat
- anemia

GASTROINTESTINAL

- nausea
- indigestion
- stomach pain
- diarrhea
- constipation
- poor appetite
- excessive hunger
- vomiting blood
- blood in stool or black stools
- hemorrhoids
- gall bladder disorder
- food cravings

MUSCLE & JOINT

- joint disorder
- sore muscles
- weak muscles
- difficulty walking
- backache or pain

NEUROLOGICAL

- seizures
- tremors
- numbness or tingling
- pain
- paralysis
- other

MALE

- pain/itching of genitalia
- genital lesions/ discharge
- weak urinary stream
- lumps in testicles
- other

FEMALE

- frequent urinary tract infections
- frequent vaginal infections
- pain/ itching of genitalia
- genital lesions/ discharge
- pelvic inflammatory disease
- abnormal pap smear
- irregular periods
- painful menstrual periods
- pre-menstrual symptoms
- abnormal bleeding
- breast lumps
- other

GENERAL

- insomnia
- frequent dreams/ nightmares
- depression
- agitation
- fatigue
- aversion to cold
- frequent urination
- psychiatric treatment
- diabetes
- other
- history of sexually transmitted disease

OTHER please list

CHILDHOOD ILLNESSES

(ie, Chicken pox, mumps, etc.)
Please list:

DEVELOPMENTAL PROBLEMS:
(Please describe):

EAST MOUNTAIN ACUPUNCTURE

I, _____, hereby consent to be treated by **Ron Hershey, L.Ac.**, with acupuncture &/or other 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 functions, 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, spontaneous miscarriage or pneumothorax. If I experience any symptom I believe may be a result of treatment, or if I have questions or concerns regarding my 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 treatments and that I may stop treatment at any time.

PATIENT'S NAME _____

PATIENT'S SIGNATURE _____

ACUPUNCTURIST'S SIGNATURE _____

DATE _____

I, _____ (patient's or patient's representative's name printed), have been advised by RON HERSHEY, L.Ac. to consult a physician regarding the condition or conditions for which such patient seeks acupuncture/ herbal medical treatment if necessary.

Patients name

Patient's or patient's representative's signature

(Date) _____

EAST MOUNTAIN ACUPUNCTURE

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.

Please 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 East Mountain Acupuncture. *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 Ron Hershey at 914-271-3684. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to:

DHHS (Office of Civil Rights)
200 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 East Mountain Acupuncture. I also confirm that this office has attempted to provide me with a copy of the statement of privacy policies.

(Patient signature)

(Date)

EAST MOUNTAIN ACUPUNCTURE

132 Grand Street, Croton-on-Hudson, NY 10520, 914-271-3684 (office), 914-271-3591 (fax)

A WORD ABOUT SCHEDULING

We strive to make our office run as smoothly as possible and to help make your experience here as satisfying and pleasant as we can.

To do this, we allow plenty of time for your visit. Unlike many physicians' offices that schedule six to eight patients per hour to compensate for those who do not show up, we regularly see only one or two people per hour. For a first visit, an entire hour and a half is set aside just for you.

To enable us to continue this level of individualized attention, however, we must insist that the time we set aside for you is respected. Consequently, should you be unable to keep your appointment, we require notice of at least 24 hours before your appointment time.

If you forget your appointment, if you are running late and cannot make the appointment, if you have transportation difficulties, or if you call to cancel with less than 24 hours notice, we are obliged to charge you the full fee for the visit. Naturally, we will make an exception to this in the event of genuine emergencies, such as acute illnesses or accidents. Also, if another time slot is available the same day as your missed appointment, we will gladly switch your time slot with no penalty. If, however, no other time is available that day, you will still be charged for your missed appointment.

This policy is not intended to be punitive. It simply allows us to keep an appointment schedule that favors longer visits. This means our patients spend less time in the waiting room and more time in consultation and treatment with us.

We are grateful for your cooperation and goodwill in this matter.

Sincerely,

Ron Hershey, L.Ac.

*Please sign below to acknowledge that you have read our scheduling policy and that you accept these terms.
Thank you.*

X
