# Goshorn Acupuncture

721 Ridge Road, Webster, NY 14580
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*Traditional Chinese Medicine is based on the principle of balancing an individual's body, mind, emotions, and spirit. The following confidential questionnaire is a detailed and invaluable source of information about you. It provides Allison with a complete sense of you as a unique individual as opposed to a collection of symptoms.*

Date: ______________

Name: ___________________________________

Address: _________________________________

________________________________________

City State Zip

Sex: □ M □ F Age: ____ Birthdate __________

□ Single □ Married □ Significant Other
□ Widowed □ Separated □ Divorced

Patient SS #: __________________________

Occupation: ____________________________

Employer: _____________________________

Spouse/Partner's Name: ___________________

Whom may we thank for referring you?

___________________________________

**Phone Numbers:**

Home: ___________________________

Work: ____________________________

Cell: ______________________________

Best time & place to reach you: _____________

________________________________________

**In case of emergency, contact:**

Name:___________________________________

Relationship:_____________________________

Phone: __________________________________

**Insurance:**

Who is responsible for this account? __________

Relationship to patient: ___________________

Insurance Company: ______________________

Group #: _______________________________

Is patient covered by additional insurance?

□ Yes □ No

Subscriber's Name: __________________

Birthdate: ___________ SS#: ______________

Relationship to patient ___________________

Insurance Co.: __________________________

Group #:_______________________________

## Present Health Concerns:

*Please list your most important health concerns in order of their significance*

**1.**_______________________________ Approximate date of Onset: ______________
Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation
Other therapies tried: □ Medications □ Surgery □ Chiropractic □ PT □ Other _______

**2.**_______________________________ Approximate date of Onset: ______________
Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation
Other therapies tried: □ Medications □ Surgery □ Chiropractic □ PT □ Other _______

**3.**_______________________________ Approximate date of Onset: ______________
Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation
Other therapies tried: □ Medications □ Surgery □ Chiropractic □ PT □ Other _______

Please list all **medications** that you are currently taking with dosages:
1. _____________________________ 4. __________________________
2. _____________________________ 5. __________________________
3. _____________________________ 6. __________________________

Please list any **vitamins, minerals, herbs, or homeopathic remedies** that are you presently taking
1. _____________________________ 4. __________________________
2. _____________________________ 5. __________________________
3. _____________________________ 6. __________________________

**Past medical history:** Please list past injuries, broken bones, surgeries and hospitalizations, with approximate dates:

____________________________________________________________________________

____________________________________________________________________________

**Personal Habits:**
□ Tobacco packs/day: ______
□ Alcohol drinks/wk: ______
□ Coffee/Tea cups/day: _______
□ Recreational drugs times/wk: _______

Work Activity:
□ Sitting % of time: _______
□ Standing % of time: _______
□ Light labor % of time: _______
□ Heavy labor % of time: _______

□ High Stress Level Reason: __________________________________________

Do you follow any diet regimens/restrictions?
□ Yes □ No
If yes, describe: __________________

Exercise:
Do you exercise regularly? □ Yes □ No
If yes, describe & tell how often:
____________________________

## Family Information:

Do you have children: □ Yes □ No If yes, how many? ______________ Ages: ___________

Are you, or could you be currently pregnant? □ Yes □ No Due date: ______________________

**Please check if you have had (in the last three months)**

### General:

□ Poor appetite
□ Heavy appetite
□ Changes in appetite
□Weight loss/gain
□ Cravings
□ Strong thirst
□ Fever/chills
□ Sweat easily
□ Localized weakness
□ Bleed/bruise easily
□ Sudden energy drop (time?)
□ Tremors
□ Poor sleeping
□ Heavy sleeping
□ Dream disturbed sleep
□ Night sweating
□ Dizziness

### Skin and hair:

□ Rashes/hives
□ Itching
□ Dry skin
□ Dandruff
□ Ulcerations
□ Eczema/Psoriasis
□ Loss of hair
□ Pimples/Acne
□ Fungal infections
□ Changes in hair or skin textures
□ Other hair or skin concerns
__________________________

### Head, eyes, ears, nose, and throat:

□ Concussions
□ Glasses/Contacts
□ Eye strain/pain
□ Red eyes
□ Itchy eyes
□ Excessive tearing
□ Poor/blurry vision
□ Night blindness
□ Cataracts/Glaucoma
□ Spots in front of eyes
□ Earaches/infections
□ Ringing in ears
□ Poor hearing
□ Sinus problems
□ Post nasal drip
□ Excessive phlegm
□ Nose bleeds
□ Recurrent sore throats
□ Swollen glands
□ Sores on lips/tongue
□ Dry mouth
□ Excessive saliva
□ Teeth problems
□ Gum problems
□ TMJ disorder
□ Grinding teeth
□ Headaches (location, triggers, severity?):

### Cardiovascular:

□ High blood pressure
□ Low blood pressure
□ Chest pain
□ Irregular heartbeat
□ Palpitations
□ Fainting
□ Cold hands/feet
□ Swelling of hands
□ Swelling of feet
□ Blood clots

Other heart or blood vessel concerns:

### Respiratory:

□ Cough
□ Coughing blood
□ Wheezing
□ Asthma
□ Bronchitis
□ Pneumonia
□ Pain with deep breath
□ Shortness of breath
□ Tight chest
□ Production of phlegm – color? ______ Is it □ thick or □ thin?

Other lung related concerns:

## Gastrointestinal:

- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Gas/bloating
- □ Hiccups
- □ Belching
- □ Bad breath
- □ Blood in stool
- □ Black stools
- □ Mucus in stools
- □ Acid regurgitation
- □ Abdominal pain
- □ Itchy anus
- □ Burning anus
- □ Hemorrhoids/fissures

History of chronic laxative use?

Other concerns with your general digestion:

## Gentio-urinary:

- □ Pain on urination
- □ Frequent urination
- □ Blood in urine
- □ Urgency to urinate
- □ Unable to hold urine
- □ Decrease in flow
- □ Bedwetting
- □ Kidney stones
- □ Impotency
- □ Increased libido
- □ Decreased libido
- □ Premature ejaculation
- □ Nocturnal emissions
- □ Sores on genitals
- □ Frequent urinary tract infections
- □ Chronic yeast infection

If you wake to urinate, how often?

Other concerns with genitals or urinary system:

## Musculoskeletal:

- □ Neck pain
- □ Upper back pain
- □ Lower back pain
- □ Hand/wrist pains
- □ Muscle pains
- □ Muscle weakness
- □ Cramps/spasms
- □ General joint pain/stiffness
- □ Shoulder pain
- □ Knee pain
- □ Foot/ankle pain
- □ Hip pain
- □ Joint with limited range of motion: ____________________________

Other muscle, joint or bone concerns:

## Neuro-psychological:

- □ Seizures
- □ Loss of balance
- □ Areas of numbness
- □ Tics
- □ Lack of coordination
- □ Memory loss
- □ Concussion
- □ Depression
- □ Anxiety
- □ Irritability
- □ Easily susceptible to stress
- □ History of emotional/physical abuse

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Other neurological or psychological concerns:

## Gynecology:

Age of first menses: ______ If no longer menstruating, approximate date ceased: __________

First day of last menses: ______ Length between menses: _____days Duration of period: ____days

□ Unusual flow (□ heavy or □ light)
□ Painful periods
□ Irregular periods
□ Clots in flow
□ Vaginal discharge- color ________
□ Vaginal odor
□ Vaginal dryness
□ Vaginal sores
□ Hot flashes
□ Breast lumps/soreness

Changes in body or psyche prior to menstruation ("PMS")?: ___________________________

Date of last PAP: _________________ Results were: normal abnormal unsure

If you use birth control, what type and for how long?

Have you ever used hormonal methods for contraception or period regulation?
(i.e. the pill)

Other gynecological concerns:

## Pregnancy History:

Number of pregnancies ________ Births _______ Miscarriages _______ Abortions ______

Were your births relatively normal? Explain:

Other related concerns:

**Comments:** Please let me know of any other concerns you would like to address:

## Family History:

Please fill in the boxes for each condition that applies to one of your family members

| | Yes | Who | Comments |
|---|---|---|---|
| Addiction (alcohol/drugs) | | | |
| Cancer | | | |
| Cardiac disorders (heart disease, high blood pressure, stroke) | | | |
| Diabetes | | | |
| Digestive/Gastro- intestinal disorders | | | |
| Immune disorders (hepatitis, HIV, etc.) | | | |
| Mental Illness | | | |
| Respiratory disorders (asthma, allergies, etc) | | | |
| Skin disorders (eczema, psoriasis, etc) | | | |
| Seizure disorders | | | |

**Please Note**: 24 Hour Notice is required for cancellation to avoid a $35 service fee.
Payment is due at time of service. If payment is not made a $15 fee will be incurred.

**Disclosures:** Please read carefully the following disclosure statements as well as the attached HIPPA Privacy Policy. Sign the corresponding agreements and acknowledgements of consent.

## Consent for Treatment:

I, ___________________________, voluntarily consent to receive Acupuncture Treatment by Allison Goshorn of Goshorn Acupuncture, who is certified by the state of New York and are certifed by the National Certification Commission of Acupuncture and Oriental Medicine to practice Acupuncture. I understand her training is in Acupuncture and Oriental Medicine and that she is not, nor claims to be, a medical docor. I understand that the evaluation, diagnosis, and the treatment I receive are not a replacement for allopathic (Western) medical care.

I have provided a full and accurate medical history and undersytand the ongoing need to communicate my complete medical status with my provider. I understand that no guarantee has been made concerning the effects of Acupuncture and I may cease treatment at any time. I understand that treatment consists of the insertion of fine, sterile needles, with or without electro-stimulation, through the skin, and/or the application of heat therapy to the skin. I acknowlesge that, although rare, certain side effects may result, including, but not limited to, minor bruising, minor pain at needle site, dizziness or fainting. I am choosing Acupuncture and/or Chinese Herbal Medicine treatment as an exercise of my right to freedom of choice in the healing arts.

_________________________________      ___________________

Signature of Patient      Date

## Insurance Agreement:

I understand and agree that health insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the Acupuncturist's office will prepare any necessary claims and forms to make collections from the insurance company on my behalf. However, I clearly understand that all services rendered me are charged accordingly and that I am personally responsible for payment should insurance coverage fail to pay for any reason. I also understand that if I suspend or terminate, any fees due will be immediately payable.

_________________________________      ___________________

Signature of Patient      Date

## HIPPA Compliance Policy:

Please read the attached packet and sign below to confirm your consent and understand of the policy.

_________________________________      ___________________

Signature of Patient      Date

## Further Information:

Our office does not process Worker's Compensation and No-Fault claims. If this is a Worker's Compensation or No-Fault case, the patient is responsible for full payment of treatment at the time of service to Goshorn Acupuncture.

_________________________________      ___________________

Signature of Patient      Date