

New England Acupuncture and Integrative Therapies

Health History and Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. If this form does not address something related to your health, please note it in the *Comments* section or bring it to the attention of the acupuncturist.

Name: _____ Date of Birth: _____ Age: _____
Address: _____ Height: _____ Weight: _____ Sex: _____
City: _____ State: _____ Zip Code: _____
Email: _____ Phone: (H) _____ (W) _____
Employer: _____ Occupation: _____
Marital Status: _____ Spouse's Name: _____
Physician: _____ Referred to this office by: _____
In Emergency, notify: _____ Relationship: _____ Phone: _____

Insurance Information - Please complete if this office is submitting claims

Name of insurance company: _____ Member ID: _____
Name of policy holder: _____ Date of Birth: _____
Effective date: _____ Policy holder's SSN: _____
Address of policy holder: _____
City: _____ State: _____ Zip Code: _____
Phone: (H) _____ (W) _____
Policy holder's place of employment: _____ City: _____
State: _____ Zip Code: _____
Client relationship to policy holder: self spouse child other

Secondary Insurance Information - Please complete this section if you have secondary health insurance coverage.

Name of insurance company: _____ Member ID: _____
Name of policy holder: _____ Date of Birth: _____
Effective date: _____ Policy holder's SSN: _____
Address of policy holder: _____
City: _____ State: _____ Zip Code: _____
Phone: (H) _____ (W) _____
Policy holder's place of employment: _____ City: _____
State: _____ Zip Code: _____
Your relationship to policy holder: self spouse child other

New England Acupuncture and Integrative Therapies

Current Medical Condition

Main problem you would like help with: _____

When did the problem begin (mm/dd/ yyyy): _____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)? _____

Does this problem cause you to miss work? No yes if so, how often? _____

Have you been given a diagnosis for the problem? If so, what? _____

What kind of treatments have you tried? _____

Other concurrent therapies: _____

Past Medical History – please note dates:

Cancer: _____ HIV/AIDS: _____ Thyroid Disease: _____

Diabetes: _____ High Blood Pressure: _____ Lyme Disease: _____

Hepatitis: _____ Heart Disease: _____

Surgeries (types & dates): _____

Significant Traumas: _____

Significant Dental Work: _____

Birth History (prolonged labor, forceps, etc.): _____

Allergies (drugs, chemicals, foods, etc.) _____

Occupational Stress (chemical, physical, psychological) _____

New England Acupuncture and Integrative Therapies

Family Medical History

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

Medications

List all medications and supplements you are currently taking _____

Are you currently taking an anticoagulant medication (blood thinner)? yes no

Have you had any courses of antibiotics recently? None 1 or 2 many

Social History

Do you have a regular exercise program? Please describe: _____

Are you or have you been on a restricted diet? What kind and why?

Do you have a close friend or a loved one that you can 'lean' on? yes no

Do you have any spiritual or religious affiliations? yes no

Please indicate usage per day or per week:

Tea _____ per _____ Coffee _____ per _____

Soft Drinks _____ per _____ Sugar/Candy _____ per _____

Alcohol _____ per _____ Cigarettes _____ per _____

Drugs _____ per _____ Other _____ per _____

Please describe yesterday's diet:

Morning: _____

Afternoon: _____

Evening: _____

Snacks: _____

Liquids: _____

New England Acupuncture and Integrative Therapies

General

- Recurrent Infections**
- Night Sweats
- Strong thirst (prefer hot or cold?)
- Fatigue
Time of day _____
- Sudden energy drops
Time of day _____
- Poor Sleep
 - Difficulty falling a sleep
 - Difficulty staying a sleep
 - Dream disturbed
- sleep
 - Vivid dreams

Head/Eyes/Ears/Nose/Throat

- Headaches
- Migraines
- Dizziness
- Glasses
- Eye styes
- Eye Pain
- Spots in front of eyes
- Blurry vision
- Excessive Tearing
- Night blindness
- Ringing in ears
- Vertigo
- Loss of balance
- Poor hearing
- Nasal discharge
- Blocked nose
- Nose bleeds
- Grinding teeth
- Snoring
- Hoarseness
- Frequent/recurrent sore throat
- Swollen glands
- Sores on lips/mouth/tongue
- Teeth problems
- Other _____

Skin

- Changes in hair/skin
- Oozing
- Recent changes in moles
- Pimples
- Dry skin/scalp
- Bleed or bruise easily
- Spontaneous sweating
- Rashes
- Eczema
- Psoriasis
- Itching
- Other _____

Respiratory

- Difficulty breathing
- Pain with breathing
- Shortness of breath
- Chronic cough
- Recurrent lung infections
- Production of phlegm
- Other _____

Digestion

- Bad breath
- Belching
- Gas
- Recent weight loss
How much _____wk or mo?
- Recent weight gain
How much _____wk or mo?
- Change in appetite
- Frequent heartburn
- Craving of particular food
What? _____
- Nausea
- Vomiting
- Hemorrhoids
- Strong smelling stools
- Bloody stools
- Pain with passing stools
- Constipation
- Loose Stools

Musculoskeletal

- Neck
- Shoulder pain
- Elbow/Forearm pain
- Hand/Wrist pain
- Back pain
- Knee pain
- Foot/Ankle pain
- Kidney stones
- Joint/Bone problems
- Muscle weakness
- Bone pain

Neurological

- Seizures
- Nerve damage
- Coordination loss
- Poor memory
- Difficulty in concentrating
- Other _____

Cardiovascular

- Pacemaker
- High Blood Pressure
- Low Blood Pressure
- Heart Palpitations
- Chest discomfort/pain
- Swelling of hands or feet
- Blood Clots
- Spider veins
- Cold hands or feet
- Fainting
- Other _____

New England Acupuncture and Integrative Therapies

Reproductive

- Pain on urination
- Urgency with urination
- Frequent urination
- Do you wake at night to urinate?
How many times? _____
- Blood in urine
- Decrease in urinary flow
- Difficulty holding or dribbling urine
- Changes in sexual drive
- Hernia
- Infertility
- Sexually transmitted diseases
- Nipple discharge
- Other _____

Women only

- Date of last menses

- Date of last pap exam

- Do you do self breast exam
 yes no
- Irregular periods
- Number of days in cycle _____
- Do you have pain with your cycle?
 yes no
- Tender breasts
- Heavy periods
- Endometriosis
- Fibroids
- Clotting
- Number of pregnancies

- Number of births _____
- Number of children _____
- Age of menopause

- Are you pregnant now?
 yes no
- Do you practice birth control?
 yes no

Men only

- Prostate problems
- Erectile Dysfunction
- Fertility Issues
- Date of last physical exam

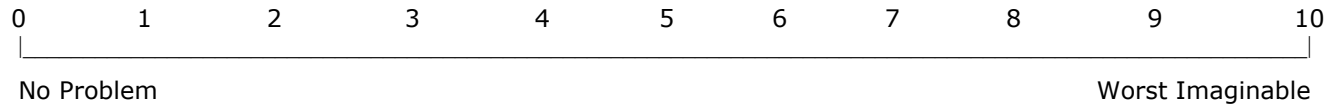
Emotional

- PMS
- Moody
- Lose control of emotions
- Easily susceptible to stress
- Aggressive/Bad temper
- Anxiety
- Panic Attacks
- Depression
- Fears or phobias
- Substance abuse
- Anorexia nervosa
- Bulimia
- Physical abuse
- Emotional abuse
- Have you ever considered or attempted suicide?
 yes no

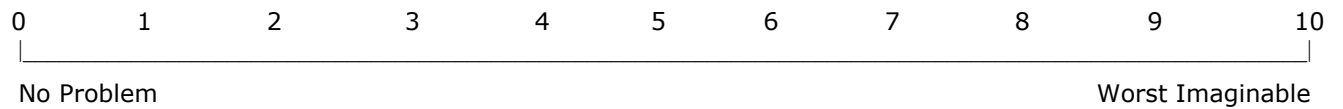
New England Acupuncture and Integrative Therapies

Pain Index

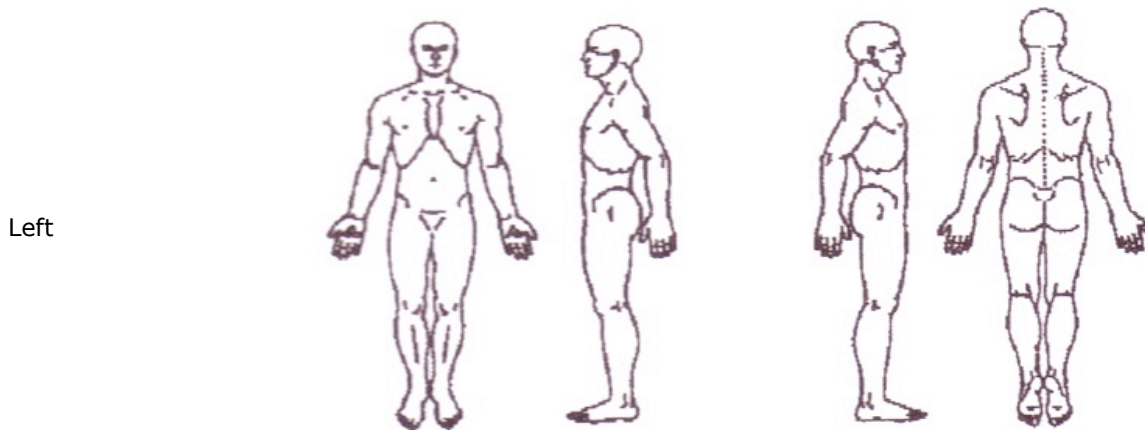
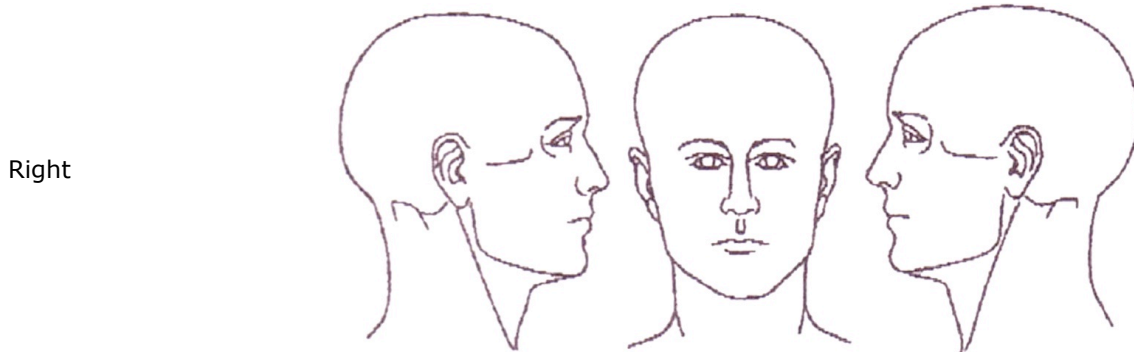
Please note the severity of your problem right now:



Please note the greatest degree of severity of your problem within the last week:



Please indicate areas of pain or distress:



New England Acupuncture and Integrative Therapies

Our Clinic Protects Your Health Information and Privacy

Dear Valued Client,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is protected.

At certain times we may need to share your personal medical information e.g with your insurance company with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workers compensation, your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you e.g. your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 401.596.0167.

_____ Signature

Date _____

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FINANCIAL OBLIGATION AND CANCELLATION POLICY

IMPORTANT INFORMATION FOR CLIENTS WITH INSURANCE. PLEASE READ!

Insurance

We participate with the following insurance companies.

- Health Net
- Pequot
- BCBS

Our network participation does not guarantee that you have acupuncture benefits on your policy. The only way to pre-determine insurance reimbursement is through specific knowledge of your treatment needs. Your first visit will consist of a Chinese diagnosis of your condition and treatment plan. We will then communicate with your insurance company to determine what fees you could be responsible for. You will be charged for the medical evaluation but will NOT have any therapeutic procedures done. This first visit is 1) for medical evaluation and 2) for insurance pre-authorization.

Financial Obligation

The patient is responsible for all fees regardless of insurance coverage. It is customary to pay in full for services when rendered and we offer a discount for those who do. All fees are listed on our website at www.NEacupuncture.com

Cancellations and no-shows

Any missed appointment without 24 hour courtesy notice is considered a no-show.

- No-shows default to the going cash rate for an office visit, no exceptions.

I hereby authorize assignment of benefits to be paid directly to Doctor Borzillo. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered valid as an original. I understand that I am responsible for payment in full for all coinsurance and deductible costs, as well as any Doctor's services which are determined to be non-covered or denied. I authorize my Doctor or her representatives to release any medical information necessary to process my bill.

Signature: _____ Date: _____