Name:_____Street Address:_____
City, State, Zip:_____❑ Male ❑ Female ❑ Other
Ht_____Wt_____Age:_____Birthdate:_____ Marital Status: ❑ Married ❑ Single ❑ Divorced
Phone #:_____Wk Phone #:_____ Occupation:_____
E-Mail:_____ Website: _____
Emergency Contact:_____ Relation: Phone #:
Have You Had Acupuncture Before? ❑ Yes ❑ No Did It Help? ❑ Yes ❑ No ❑ Unsure

The Following Questions Are Designed To Provide Your Clinician With Information To Help You.
(Please Do Not Answer Any Question You Don't Wish To.)

(Use the back of this sheet if there is not enough space to write your reply.)

1.) Please describe your reason for seeking an acupuncturist's help._____

_____

_____

2.) What do you hope for from this & other treatments?_____

_____

_____

3.) Describe the location, onset & duration of the discomfort that you would like help with. (Use the diagram on the next page if useful.)_____

_____

Include anything which changes your symptoms. What makes it better? _____
_____What makes it worse?_____

Have you received a medical diagnosis for this problem? If so, what is it?_____

Physician's Name: _____ Phone: _____

If there is pain, (Circle any description that applies.)

Tingling Sharpness Burning Achy Dullness Deep/Superficial Pain Numbness Pressure

Rate pain/discomfort on a 1-10 scale, with 10 being the worst. **1 2 3 4 5 6 7 8 9 10**

4.) Who referred you, or how did you find us?_____

5.) Describe a normal Breakfast for you:_____

Lunch:_____

Dinner:_____

Snacks:_____

6.) Do you crave any specific foods and or flavors? (Describe)_____

_____

7.) Rate these tastes on a scale of 1 to 5. (Place the 5 with the item most preferred and a 1 with the one you least like.)

Sweet_____Spicy_____Sour_____Salty_____ Bitter_____

8.) What do you drink on a regular basis? (Include quantities.)

Glasses/day of: Tea_____Coffee_____Water_____Juice_____Alcohol_____Soda_____Other____

9.) Are you thirsty often?_____Do you prefer cold or hot beverages? (circle)

10.) What is your first conscious memory? Age?_____

_____

_____

11.) How is your digestion and appetite? _____

_____

_____

(Circle any that apply)

Bloating Gas Discomfort Belching Flatulence Excessive Appetite No/Reduced Appetite
Nausea Vomiting Acid Reflux Ulcers Heartburn Tired After Eating Eating After 9pm

12.) How often do you have bowel movements?_____x/Day/Week. Are they? (Circle all that applies.)

Fully Formed Hard Loose Dry Diarrhea Bloody Constipation Very Odorous Burning

Painful Movement Hemorrhoids Use Laxatives Undigested Food In Stool Itchiness
What color are they?_____Do they float?_____
13.) How often do you urinate?_____x/Day. What color is it?_____Is there ever?
(Circle) Discomfort Burning Dribbling Interrupted Stream Urgent Need Urinating At Night
14.) Are you sexually active? (If so, at what age do this start.)_____Use protection or birth control?_____
What type?_____Do you experience physical discomfort?_____
Have you ever contracted an STD?_____If so, describe._____When?_____

For Women -Questions 15-17

15.) How old were you when you began menstruating? _____What is the duration?_____Days
Where are you in your cycle now?_____How many days for a full cycle?_____
Describe the color._____ Last Menses_____
Length of Period _____ (Circle any that applies.) Endometriosis PID Ovarian Cysts
Cramps Bloating Irritability Breast Soreness/Distension Odor Menopausal (or Pre)
Spotting(between) Vaginal Itching Discharge Light or Heavy Flow Clots Miscarriage(s)
Abortion(s)_____# of Pregnancies_____
16.) Are you presently trying to conceive?_____
17.) When was your last breast exam/ObGYN_____What was the outcome?_____

For Men - Question 18

18.) Have you had your prostrate checked?_____When?_____Outcome?_____
(Circle if applies) Painful Ejaculation Premature Ejaculation Impotence Delayed Ejaculation Discharge
19.) How is your energy?_____After eating?_____
Most energetic?_____Least?_____
20.) What type of exercise do you do?_____
How often?_____ x/week. For how long(historically and # of minutes)?_____
21.) How do you feel emotionally?_____
_____(Circle all that apply.)
Excessive (or lack): Anger Sadness Nervousness Anxiety Panic Attacks Depression Joy
How do you feel about your relationship(s)?_____
Your work?_____
22.) How is your sleep?_____How many hours?_____How do you feel when you awake?_____ Bedtime? _____ (Circle all that apply.) Trouble Falling Asleep
Dream Disturbed Insomnia Night Sweats Snoring Waking At Night(include time)_____
23.) Do you smoke tobacco(other)?_____How long?_____Quantity?_____ /Day
24.) Do you use any prescription, non-prescription, OTC drugs?(Describe dosage, reasons for use and if their use is effective.)_____
_____
25.) Circle any medical conditions or history that applies:
AIDS/HIV Alcoholism/Addiction Allergies Arthritis Asthma Atherosclerosis Birth Trauma(Own)
Blackouts Cancer Chronic-Fatigue Diabetes Dizziness Emphysema Fibromyalgia Headaches
Heart Disease Hepatitis(A, B, C) Herpes Joint Pain Latex Allergy Lymph-Nodes Removed Lupus
Lyme Disease Malaria Migraines Multiple Sclerosis Neuropathy Osteoporosis Pacemaker
Polio Respiratory Problems Rheumatic Fever Scarlet Fever Seizures Skin Irritation(s) Strep
Throat Tendonitis Tuberculosis Vaccinations (Reactions) Other?_____
_____When was your last complete physical?_____
_____Findings?_____
26.) Describe any significant injuries, surgery or trauma._____
_____
_____Any hospitalizations?_____
27.) How is your respiratory condition? (Please describe.) Include ears, throat, nose, gums, mouth, tongue, or any other related areas as appropriate._____
_____

(Circle any that apply.) Coughing Wheezing Shortness of Breath Asthma Emphysema Phelgm Nose Bleed Allergies Short Inhalations Pain Runny Nose Bloody Gums Clogged Ears Loss of Hearing Sore Throat Ringing In Ears Ulcerations(Mouth) Cold Sores Dry Mouth Frequent Colds

28.) How is/are your vision/eyes? (Describe)_____

_____

(Circle any that apply.) Dry Eyes Irritations Near or Far-Sighted Spots In Vision Greyouts

29.) How is your cardio-vascular condition? List **any** pertinent information. Have you ever had an EKG?

_____

_____

Blood Pressure:_____(Circle any that apply.)

Chest Pain Fast/Slow Heartbeat Throbbing Pulses Arrythmia Heart Disease Cold Hands/Feet Swelling Palpitations (Fluttering) High Cholesterol

30.) What is your family medical history? Parents? Grandparents? Children?_____

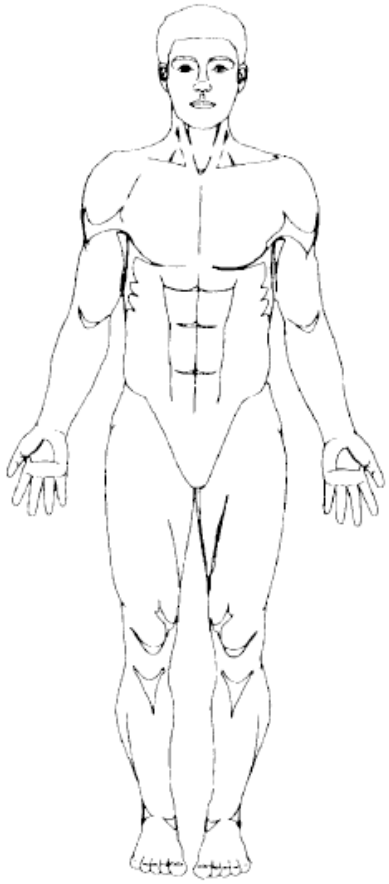
_____

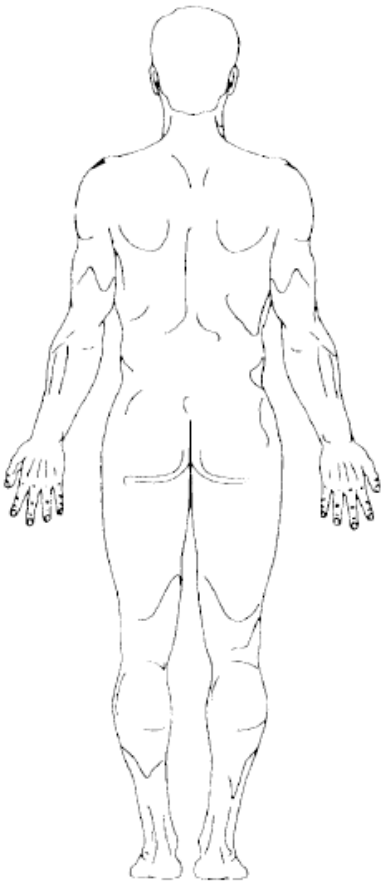
_____

_____

_____

Shade In Or Pen Notes Below In Any Areas Which Need Addressing.





INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatment by **Peter Doyle LAc.** I understand that acupuncture therapy is not a substitute for medical examination and diagnosis, and it is recommended that I see a medical doctor for any ailment for which I seek acupuncture treatment. I also understand that acupuncture may involve the insertion of sterilized and disposable needles into the skin and realize bruising, soreness and superficial bleeding may accompany this therapy. I furthermore understand I should inform the practitioner if I am, or become pregnant and should decline treatment under these circumstances. Having read and understood all of the above, I voluntarily consent for acupuncture treatment and hereby release the above named practitioner from liability for any results that may occur from known or unknown risk.

_____ _____

Signature Date

CONSENT FOR ACUPUNCTURE TREATMENT AND CARE FOR MINOR

I, the parent or guardian of the below named minor, hereby consent to all the above terms and conditions implied in the above document. I give permission for my minor child to undergo acupuncture treatments for_____.

_____ _____

Date Parent/Guardian Signature

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I the undersigned, hereby authorize the release of all medical records pertinent to my case to Peter Doyle L.Ac. from _____.This shall include all records pertinent to my treatment. You are hereby authorized to provide this information as of this date:_____

_____

Signature

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I the undersigned, hereby authorize the release of all medical records pertinent to my case to my physician and insurance carrier. This shall include all records pertinent to my treatment. You are hereby authorized to provide this information as of this date:_____

_____

Signature

HIPAA Receipt Materials Acknowledgement

I the undersigned, hereby affirm I have received the following information from Peter Doyle L.Ac: ***Notice of Privacy Practice, Uses and Disclosures.*** I fully understand the policies and forms and/or have had any questions answered by my treatment provider.

_____ _____

Signature Date

QG Cancellation/Rescheduling Policy

In order to continue to provide the best possible care to all of my clients, and to manage my schedule so that I am able to most effectively facilitate the health and healing of everyone who wishes to utilize my services, I am revising my rescheduling/cancellation policy as of April 15th, 2008. Any changes to scheduled appointment times must be made with a minimum of 3-day (72 hour) notice. Without such notice, the client is responsible for the full cost of any missed session.

Having read and understood the above I _____
Agree to abide by said policy and will pay for all charges for these instances.

Credit Card # _____

Expiration _____

Code _____

Type _____

_____
Signature

_____
Date

Assignment of Benefits

I authorize payment to be made directly to Peter C. Doyle, LAc. I understand I am responsible for charges not covered by this assignment.

_____
Signature

Authorization To Release Information

I authorize the release of any information requested to process this claim.

_____
Signature

Consent For QiGardener Newsletter by Email

I consent/request the monthly newsletter from Pete Doyle, LAc, QiGardener.

_____
Signature

Informed Consent to Herbal Treatment

I consent to herbal treatments associated with Traditional Chinese Herbology by Peter C. Doyle, L.Ac. I have discussed the nature and purpose of my treatment with said practitioner.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that are recommended are traditionally considered safe in the practice of Chinese herbology, although some may be toxic in large doses. I understand that herbs should not be taken during pregnancy. Some possible side-effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be prepared and the tea or pills consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify the practitioner of any unanticipated or unpleasant effects associated with the consumption of the herbal teas, pills or powders or liniment used.

I will notify the practitioner who is caring for me if I become pregnant.

I do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner to exercise judgment during the course of treatment, as the practitioner deems appropriate and in my best interest, based upon the facts then known.

I understand that all my records will be kept confidential and will not be released to anyone without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of treatment, and have had an opportunity to ask questions concerning the above. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment. I understand that I have the option to discontinue treatment at any time.

Please note that if you are having any untoward side effects or concerns after treatment, in addition to calling Peter Doyle at (917) 836-6834, you must call your primary care provider and/or visit the emergency room

_____	_____
Signature of Patient	*Signature of Practitioner*
_____	_____
Date	*Date*

Notice of Privacy Practices (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Respect for patient privacy is highly valued. As required by law, I will protect the privacy of your health information that may reveal your identity and provide you with a copy of our notice which describes the health information privacy procedures when providing health care services.

REQUIRED PERMISSION TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

I will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment for that treatment, and conduct the day to day operations. This general written consent will be obtained the first time I provide you with treatment or services. This general written consent is a broad permission that does not have to be repeated each time I provide treatment or services to you.

HOW I MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Uses and Disclosures

I use health information about you for the treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. I may use your health information of share it with others in order to conduct our day to day operations. For example I may share it with third party insurers.

I may disclose identifiable health information about you without your authorization in these situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

Your Rights: In most cases, you have the right to look at or get a copy of health information about you.. You also have the right to receive a list of certain types of disclosures of your information that I have made. If you believe that information in your record in incorrect, you have the right to request that I correct the existing information.

Our Legal Duty: I am required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice and seek your acknowledgment of receipt of this notice. Before I make a significant change in policy, I will change the notice and post the new notice in the waiting area. You can also request a copy of said notice at any time. For more information about privacy practices, contact the person listed below.

Complaints: If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the U.S. Department of Health and Human Service. I can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:

Peter Doyle