

Arbor Vitae Acupuncture, P.C.  
 Margarita Borisova, MSTOM, L.Ac.  
 (917) 664-6786  
 needles@arborvitaeacu.com

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have any questions, please ask. Thank you.

**Personal Information**

Name \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Occupation \_\_\_\_\_ Person responsible for your account \_\_\_\_\_

Who should we thank for referring you to this office? \_\_\_\_\_

Sex: Male \_\_\_ Female \_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_

Marital Status: Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Number of children \_\_\_\_\_

Have you received acupuncture therapy before? Yes \_\_\_ No \_\_\_

When? \_\_\_\_\_ With whom? \_\_\_\_\_

Please indicate any significant illness you or a blood relative (grandparent, parent or sibling) have had:

Illness	You	Your relative	Approx. date	Illness	You	Your relative	Approx. date
Cancer	_____	_____	_____	Diabetes	_____	_____	_____
Hepatitis	_____	_____	_____	Heart Disease	_____	_____	_____
High blood pressure	_____	_____	_____	Seizures	_____	_____	_____
Rheumatic Fever	_____	_____	_____	Emotional Disorders	_____	_____	_____
Infectious Disease	_____	_____	_____	Tuberculosis	_____	_____	_____

Sexually Transmitted Diseases: Gonorrhea \_\_\_ Syphilis \_\_\_ AIDS \_\_\_ HPV \_\_\_ Chlamydia \_\_\_  
 Herpes \_\_\_ Date \_\_\_\_\_

List any medications and supplements you are currently taking (continued on back if necessary)

Medicine and Dosage	Reason	How long?	Prescribed by	Date of last check up

(Attach separate page if necessary.)

Arbor Vitae Acupuncture, P.C.

Please indicate the use and frequency of the following:

	Yes	No	How much?
Coffee/black tea	_____	_____	_____
Non-medical drugs	_____	_____	_____
Tobacco	_____	_____	_____
Alcohol	_____	_____	_____
Water intake	_____	_____	_____
Soda drinks	_____	_____	_____

What are the main health problems for which you are seeking treatment?

---

What other forms of treatment have you sought?

---

List any other health problems you now have.

---

List any allergies, food sensitivities or food cravings that you have.

---

List any accidents, surgeries, or hospitalizations (include date).

---

Lab Results (please include copies)

---

How do you feel about the following areas of your life? (please check the appropriate spaces and indicate any problems you may be experiencing)

	Great	Good	Fair	Poor	Bad
Significant other	_____	_____	_____	_____	_____
Family	_____	_____	_____	_____	_____
Diet	_____	_____	_____	_____	_____
Sex	_____	_____	_____	_____	_____
Self	_____	_____	_____	_____	_____
Work	_____	_____	_____	_____	_____
Exercise	_____	_____	_____	_____	_____
Spirituality	_____	_____	_____	_____	_____
Your Comments:					

---

Arbor Vitae Acupuncture, P.C.

**Women**

Age of first period (menarche) \_\_\_\_\_ Age of last period (menopause) \_\_\_\_\_  
Number of days between periods \_\_\_\_\_ Number of days of flow \_\_\_\_\_  
Color of flow \_\_\_\_\_ Clots? Yes \_\_\_ No \_\_\_ Color \_\_\_\_\_  
Average number of pads you use per day:  
1st day \_\_\_\_\_ 2nd day \_\_\_\_\_ 3rd day \_\_\_\_\_ 4th day \_\_\_\_\_ + days \_\_\_\_\_  
Have you been diagnosed with: Fibroids \_\_\_\_\_ Fibrocystic Breasts \_\_\_\_\_  
Endometriosis \_\_\_\_\_ Ovarian cysts \_\_\_\_\_ PID \_\_\_\_\_ Other \_\_\_\_\_  
Location of pain: Lower abdomen \_\_\_\_\_ Lower back \_\_\_\_\_ Thighs \_\_\_\_\_ Other \_\_\_\_\_  
Nature of pain (please indicate before, during or after menses):  
Cramping \_\_\_\_\_ Stabbing \_\_\_\_\_ Burning \_\_\_\_\_  
Aching \_\_\_\_\_ Dull \_\_\_\_\_ Bloating \_\_\_\_\_  
Constant \_\_\_\_\_ Intermittent \_\_\_\_\_  
Bearing down sensation \_\_\_\_\_  
Other symptoms related to menses:  
Discharge \_\_\_\_\_ Vaginal Dryness \_\_\_\_\_ Headache \_\_\_\_\_  
Nausea \_\_\_\_\_ Constipation \_\_\_\_\_ Diarrhea \_\_\_\_\_  
Swollen Breasts \_\_\_\_\_ Mood swings \_\_\_\_\_ Ravenous appetite \_\_\_\_\_  
Poor appetite \_\_\_\_\_ Hot flashes \_\_\_\_\_ Night sweats \_\_\_\_\_  
Increased libido \_\_\_\_\_ Decreased libido \_\_\_\_\_ Insomnia \_\_\_\_\_  
Are you pregnant? Yes \_\_\_ No \_\_\_ # of pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_  
# of abortions \_\_\_\_\_ # of miscarriages \_\_\_\_\_  
Date of last: Gynecologic exam \_\_\_\_\_ Pap smear \_\_\_\_\_ Mammogram \_\_\_\_\_  
Bone Density scan \_\_\_\_\_ Results \_\_\_\_\_

**For Men**

Date of last prostate check up \_\_\_\_\_ PSA results \_\_\_\_\_  
Manual prostate exam results \_\_\_\_\_  
Lab Results:  
Frequency of Urination: daytime \_\_\_\_\_ Nighttime \_\_\_\_\_  
Color of urine: clear \_\_\_\_\_ murky \_\_\_\_\_ Odor: \_\_\_\_\_  
Symptoms related to prostate:  
Prostate problems \_\_\_ Delayed stream \_\_\_ Dribbling \_\_\_  
Rectal Dysfunction \_\_\_ Incontinence \_\_\_ Retention of Urine \_\_\_  
Back pain \_\_\_ Increased Libido \_\_\_ Decreased Libido \_\_\_  
Premature Ejaculation \_\_\_ Impotence \_\_\_ Groin pain \_\_\_  
Testicular pain \_\_\_ Other: \_\_\_\_\_



Arbor Vitae Acupuncture, P.C.  
Margarita Borisova, MSTOM, L.Ac.  
(917) 664-6786  
needles@arborvitaeacu.com

**PATIENT ADVISORY TO CONSULT A PHYSICIAN AND INFORMED CONSENT TO ACUPUNCTURE AND ORIENTAL MEDICINE TREATMENT AND CARE**

To comply with Article 160, Section 8211(b) of New York State Education Law, I request that you read and sign the following statement:

We, the undersigned, do affirm that \_\_\_\_\_ (Patient) has been advised by Margarita Borisova, L.Ac., to consult a physician regarding the conditions for which the patient seeks acupuncture treatment.

I hereby request and consent to the performance of the procedures which are within the scope of practice of acupuncture and oriental medicine, including, but not limited to, acupuncture, moxibustion, cupping, electroacupuncture, acupressure, herbology, various modes of bodywork, on me (or the patient for whom I am legally responsible), by the acupuncturists named above and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named above, including those working at the clinic or office listed above or any other treatment location, whether signatories to this form or not.

I have had the opportunity to discuss with the acupuncturist named above and/or with other office/clinic personnel the nature and purpose of acupuncture, moxibustion, cupping, electroacupuncture, acupressure, herbology, and other procedures. I understand that the results are not guaranteed.

I understand and am informed that there are some risks to acupuncture and oriental medicine treatment, including, but not limited to, slight bruising, tingling near the needled sites that last a few days, nausea, infection and blisters. There have been instances reported of fainting, infections and scarring. There have been instances reported of spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform the acupuncturist. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

\_\_\_\_\_  
(Signature of Patient or Patient Representative)

Margarita Borisova, MSTOM, L.Ac.

\_\_\_\_\_  
Print Name of Patient/Representative

\_\_\_\_\_  
Date

Arbor Vitae Acupuncture, P.C.  
Margarita Borisova, MSTOM, L.Ac.  
(917) 664-6786  
needles@arborvitaeacu.com

Notice of Privacy Practices for HIPAA Regulations

This note describes general office practices regarding confidentiality of your medical information.

Office Practices:

- All information regarding patients, their treatments, diagnosis and appointments is kept strictly confidential within the confines of the practitioner and office assistant. Patient chart and financial data will be seen only by practitioner and office assistant.
- Electronic data transfer from this office is limited strictly to electronic claims filing for insurance reimbursement.
- For treatment purposes, information will be provided to another practitioner only after your written consent is given.
- Discussion of treatment is confined to the consultation room or the treatment room, and will never be held in the presence of other individuals.

Communication:

- We routinely communicate with patients over the phone to schedule and confirm appointments. While the names "Arbor Vitae Acupuncture", "Margarita Borisova" are given in messages, no reference to medical services is made. Occasionally, we call to give instructions or to notify you that herbs and supplements you ordered are in the office.
- If you prefer to be contacted ONLY at work, home, mobile, or other phone number, please provide that information below.

---

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how medical information may be used and disclosed in this office and have been informed on how I may gain access to and control this medical information.

---

Signature of Patient or Patient Representative

---

Print Name of Patient or Patient Representative

---

Description of Personal Representative

---

Date

Arbor Vitae Acupuncture, P.C.  
Margarita Borisova, MSTOM, L.Ac.  
(917) 664-6786  
needles@arborvitaeacu.com

## FINANCIAL AGREEMENT

### Assignment of Benefits for Insurance

I authorize payment of benefits be made directly to the above-named healthcare provider and I understand I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process claims in conjunction with my treatment(s) by this provider.

### Cancellation Policy

Please be respectful of the time set aside for your treatment. If you need to change or cancel an appointment, be sure to make up the missed appointment within a week so that the effects from the treatments are not interrupted.

**All scheduled appointments require a 24 hour cancellation notice, otherwise the patient will be charged a FULL office visit fee.**

### Returned Check Policy

All returned checks will be subject to an additional charge of \$ 25.00.

By signing this agreement, I am acknowledging that I have read the above financial policies and will be responsible for ALL charges stated above.

---

Patient Signature

Date