

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 _____

Phone _____ E-mail _____

Emergency Contact _____ Phone _____

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.

Symptom Survey

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
NO MARK () = NEVER EXPERIENCE CHECK MARK (√) = SOMETIMES EXPERIENCE
PLUS SIGN (+) = FREQUENTLY EXPERIENCE

lack of appetite excessive appetite loose stool or diarrhea
 digestive problems, indigestion vomiting belching, burping
 heartburn/ reflux feeling the retention of tendency to become obsessive
food in stomach in work, relationships ...

insomnia, difficulty sleeping heart palpitations cold hands and feet
 nightmares mentally restless laughing for no apparent
reason
 angina pains abdominal pains chest pain
 sciatic pain headaches pain or coldness in the genital
area

cough shortness of breath decreased sense of smell
 nasal problems skin problems feeling of claustrophobia
 bronchitis colitis or diverticulitis constipation
 hemorrhoids recent use of antibiotics eye problems
 jaundice (yellowish eyes or skin) difficulty digesting oily foods gall stones
 light colored stool soft or brittle nails easily angered or agitated
 difficulty in making plans/decisions spasms or twitching of muscles
 low back pain knee problems hearing impairment
 ear ringing kidney stones decreased sex drive
 hair loss urinary problems fatigue
 edema blood in stool black tarry stool
 easily bruised difficult to stop bleeding asthma
 tendency to catch colds easily intolerance to weather changes allergies
 hay fever dizziness tendency to faint easily
 high cholesterol levels sudden weight loss

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