Kristin Grey Apple, LAc
66 Lawrenceville Pennington Road, Lawrenceville, NJ 08648
Phone: 908-599-0436 Email: info@applepuncture.com

Dear New Patient,

Thank you for your interest in acupuncture and your own wellbeing. Welcome to Applepuncture! It is an honor to treat you and to work with you. Let it be known that it is my deepest pleasure to ensure proper care for my patients. Beyond my expertise in acupuncture, I aim to:

- Make sure that any questions you have about your care are answered in a way that you can understand.
- Guarantee that your phone calls or emails are returned within 24 hours.
- Safeguard your private healthcare information.

Enclosed you will find several forms that I'd like you to fill out and bring with you to your first appointment. If you have any questions about these forms, please call me at 908-599-0436.

Again, welcome to Applepuncture. You have taken an important step on the road to more vibrant health. I look forward to serving you.

Yours sincerely,

Kristin Grey Apple, Licensed Acupuncturist

Kristin Apple

Confidential Intake Form

Name: ____ Date: ______/______/______
(first) (middle) (last)

Address: ____

____

Phone: ____________________________________ Email: ________________________________

Emergency Contact: ____________________________Phone:________________________________

Date of Birth: _______/_______/_______ Age: _______ Gender: M/F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. Please describe in your own words the primary reason for your visit:

Secondary:

2. What other care are you currently receiving? And what regular activities do you do to self-treat your condition?

3. When and where did you last receive healthcare?

For what reason?

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

____

____

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking. Please include start date:

____

____

____

____

____

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you?____

7. Do you have any infectious diseases? Y N

If yes, please identify: ______________________________

8. **Height:** __________ **Weight:** Currently: __________ Past Maximum: _________ Past Minimum ________________

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9. **Blood Pressure:** What is your most recent blood pressure reading? _______/_______ When was this reading taken? ________

10. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles

Chicken Pox Other:____

11. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib

Hepatitis B

Others: ____

12. **Hospitalizations and Surgeries:**

Reason	When	Reason	When

13. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When

14. **Family History:**

Check those applicable:

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_______	________	________	________	________	_______
Health (G=Good, P=Poor)	_______	________	________	________	________	_______
Cancer	_______	________	________	________	________	_______
Diabetes	_______	________	________	________	________	_______
Heart Disease	_______	________	________	________	________	_______
High Blood Pressure	_______	________	________	________	________	_______
Stroke	_______	________	________	________	________	_______
Mental Illness	_______	________	________	________	________	_______
Asthma/Hay fever/Hives	_______	________	________	________	________	_______
Kidney Disease	_______	________	________	________	________	_______
Age (at death)	_______	________	________	________	________	_______
Cause of Death	_______	________	________	________	________	_______

15. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Anxiety Depression Feelings of Fear

Feelings of Panic Feelings of Hopelessness Feelings of Anger Feelings of Grief Feelings of Euphoria

16. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

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18. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema
Persistent Cough Pleurisy Asthma Tuberculosis
Shortness of Breath Other Respiratory Problems: ____

19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure
Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn
Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow Kidney Stones
Impaired Urination Blood in Urine Frequent Urination at Night

22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

23. **Menstrual/Birthing History:**

1. Age of First Menses: _______ 4. Birth Control Type: ________ 7. # of Abortions: ________

2. # of Days of Menses: _______ 5. # of Pregnancies: ________ 8. # of Live Births: ________

3. Length of Cycle: _______ 6. # of Miscarriages: ________

24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain

Mid Back Pain Low Back Pain Leg Pain

Joint Pain (if so, where?): ____

26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

28. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

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Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know?

____

29. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N

b. If no, how many? ___________________

c. Exercise routine: ____

d. Spiritual practice: ____

e. How many hours per night do you sleep? ________ Do you wake rested? Y N

f. Level of education completed: High School Bachelors Masters Doctorate Other

g. Occupation: ________________________________ Employer: ______________________ Hours/Week: _______

Do you enjoy work? Y/N Why/Why not?

____

h. Nicotine/Alcohol/Caffeine Use:

____

i. Have you experienced any major traumas? Y N Explain:

____

____

j. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

k. Interests and hobbies:

How did you hear about us? ____

Would you like to receive monthly emails of our educational videos?__________________

Informed Consent: Acupuncture Clinical Services

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at Applepuncture. I understand that acupuncturists practicing in the state of New Jersey and Pennsylvania are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioner.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that if I receive direct moxibustion as part of therapy, there is a slight risk of burning from its use. Moxibustion produces smoke, which may irritate susceptible individuals. I understand that I may refuse these therapies. I understand that there are no guarantees concerning the use of these therapies and that I am free to stop treatment at any time.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: minor electrical shock and pain or discomfort. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature (Legal Representative for patients under 18):

____

Printed Name: ____**Date:**______________________________
Date of Birth: __________________

Address:

____

City: __________________________ **State:** _____________ **Zip Code:** ______________

Phone: ________________________

Applepuncture Protects Your Health Information and Privacy

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 being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information 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, workman's comp and your employer, and other third part administrators (*e.g*. requests for medical records, claim payment information).

In certain cases, 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 1-908-599-0436.

Yours truly,

Kristin G. Apple, Licensed Acupuncturist
Applepuncture
66 Lawrenceville Pennington Road
Lawrence, NJ 08648

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS
NOTICE OF PRIVACY PRACTICES

NAME ____
BIRTHDATE ___________________ **SOCIAL SECURITY #** ______________

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

____

____

Patient:
X______________________________ ________ ________________________
Patient Signature or Legal Representative **Date** **Witness Signature**

Office Use Only:
Accepted ________________________ __________ _________
Denied Signature Title Date

EMAIL COMMUNICATION CONSENT FORM

- When we send you a regular email, or you send us an email, the information that is sent is not encrypted. Though security systems are in place and it is very unlikely, a third party may be able to gain access to the information included.
- Because email is very convenient and is a commonly used form of communication, the federal government has had to modify the HIPAA act. This information is available on the U.S. Department of Health and Human Services website.
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

I understand the risks of unencrypted email and do hereby give permission to Applepuncture to send me personal health information via unencrypted email.

Signature___________________________ Printed Name____________________

Date __________________ Email Address_________________________

Payment Policy

- We accept all major credit cards (American Express, MasterCard, Visa), cash, and checks.

- Payment is expected in full at the time the service is rendered.

- We require 24 hours notice for cancellations. A fee of $75 will be billed to patients who do not provide 24 hours notice for appointment cancellations or who do not show for a scheduled appointment.

I have read the above policies and agree to abide by them.

Signature:__________________________Date:__________