

**Newport Acupuncture & Herbal Medicine**  
**850 Aquidneck Ave., Middletown, R.I. 02842**  
**(401)849-0514**

**HEALTH HISTORY QUESTIONNAIRE**

Name: _____	Date: _____
Address: _____	Date of Birth: _____
City: _____ State: _____ Zip: _____	Occupation: _____
Phone: (H) _____ (W) _____	Marital Status: _____
E-Mail: _____	Spouse's Name: _____
Referred by: _____	Previous Acupuncture Care? _____
Emergency Contact: _____	Phone #: _____

**Primary Care Physician:** \_\_\_\_\_

**Reason for your visit today:** \_\_\_\_\_

**Secondary reason(s):** \_\_\_\_\_

**Are you currently under a doctor's care, other than your primary care physician, for these specific conditions?** \_\_\_\_\_

**TODAY'S VISIT**

At the time of your first visit to Newport Acupuncture, we will achieve the most thorough understanding of your health as possible. We will do this by asking you detailed questions about your health, looking at your tongue, and reading your pulse. You will also receive a treatment during this visit.

Upon your second visit to Newport Acupuncture, you will receive our Report of Findings. This report will include our assessment of your condition based on the principles of Traditional Chinese Medicine (TCM). We will tell you what we believe is happening in regards to your health, what our recommendations are for diet and lifestyle according to your individual diagnosis, and what we recommend as a course of treatment with acupuncture and/or Chinese Herbal Medicine to achieve your health goals.

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Optimal health can be achieved! At Newport Acupuncture, we believe that disease prevention and optimal health are a possibility for everyone. By getting to know you, we can help you in achieving your health goals. We would like to be your guide in learning how to use Chinese medicine as a tool in leading a healthier and more enjoyable life. Please take your time in filling out this paperwork. If you have any questions, do not hesitate to ask.**

**SURGERIES, HOSPITALIZATIONS, AND SIGNIFICANT TRAUMAS**

\_\_\_\_\_  
\_\_\_\_\_

**CURRENT MEDICATIONS/HERBS/VITAMINS/OTHER SUPPLEMENTS**

\_\_\_\_\_  
\_\_\_\_\_

**DIET** Meals per day: \_\_\_\_\_ Snacks per day: \_\_\_\_\_ Caffeinated drinks per day: \_\_\_\_\_ Alcohol per week: \_\_\_\_\_  
Typical daily diet: \_\_\_\_\_

**EXERCISE** Days per week: \_\_\_\_\_ Duration of work out: \_\_\_\_\_  
Types of Exercise: \_\_\_\_\_

**PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU CURRENTLY HAVE,  
OR HAVE HAD IN THE PAST**

- |                                       |  |   |  |  |
|---------------------------------------|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV     | <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke            | <input type="checkbox"/> Measles           |
| <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Chicken Pox       |
| <input type="checkbox"/> Allergies    | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Tuberculosis      | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gout          | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Typhoid Fever     | <input type="checkbox"/> Whooping cough    |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Ulcers            | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Hepatitis     | <input type="checkbox"/> Polio              | <input type="checkbox"/> Herpes            | <input type="checkbox"/> Rheumatic Fever   |

**GENERAL:**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Poor appetite               | <input type="checkbox"/> <u>Weakness in limbs</u> | <input type="checkbox"/> Night sweats           | <input type="checkbox"/> Fever              |
| <input type="checkbox"/> Heavy appetite              | <input type="checkbox"/> Bodily heaviness         | <input type="checkbox"/> Muscle cramps          | <input type="checkbox"/> Chills             |
| <input type="checkbox"/> Recent weight loss/gain     | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Vertigo or dizziness   | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> <u>Poor sleep, insomnia</u> | <input type="checkbox"/> Peculiar taste in mouth  | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Poor circulation   |
| <input type="checkbox"/> Heavy sleep                 | <input type="checkbox"/> <u>Facial edema</u>      | <input type="checkbox"/> Dream disturbed sleep  | <input type="checkbox"/> Intense thirsty    |

**HEAD, EYES, EAR, NOSE AND THROAT:**

- |   |   |   |  |  |
|---|---|---|--|--|
| <input type="checkbox"/> Glasses              | <input type="checkbox"/> Cataracts            | <input type="checkbox"/> <u>Poor night vision</u> | <input type="checkbox"/> Sinus problems        | <input type="checkbox"/> Earaches        |
| <input type="checkbox"/> Eye strain           | <input type="checkbox"/> Teeth problems       | <input type="checkbox"/> Sensitive to light       | <input type="checkbox"/> Excessive phlegm      | <input type="checkbox"/> Headaches       |
| <input type="checkbox"/> Eye pain             | <input type="checkbox"/> Teeth grinding       | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Migraines       |
| <input type="checkbox"/> Red eyes             | <input type="checkbox"/> TMJ                  | <input type="checkbox"/> Sores on lips or tongue  | <input type="checkbox"/> Swollen glands        | <input type="checkbox"/> Concussions     |
| <input type="checkbox"/> Itchy eyes           | <input type="checkbox"/> Facial pain          | <input type="checkbox"/> Dry mouth                | <input type="checkbox"/> Lumps in throat       | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> <u>Spots in eyes</u> | <input type="checkbox"/> Gum problems         | <input type="checkbox"/> Excessive saliva         | <input type="checkbox"/> Enlarged thyroid      | <input type="checkbox"/> Poor hearing    |
| <input type="checkbox"/> Nose bleeds          | <input type="checkbox"/> <u>Blurry vision</u> |   |  |  |

**RESPIRATORY:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> <u>Difficulty breathing</u> | <input type="checkbox"/> Tight chest            | <input type="checkbox"/> <u>Chronic cough</u> | <input type="checkbox"/> Coughing blood          |
| <input type="checkbox"/> <u>Shortness of breath</u>  | <input type="checkbox"/> <u>Asthma/wheezing</u> | <input type="checkbox"/> Excess phlegm        | <input type="checkbox"/> Frequent colds and flus |

**CARDIOVASCULAR:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Fast heart rate           |
| <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Chest pain          | <input type="checkbox"/> <u>Heart palpitations</u> |
| <input type="checkbox"/> Blood clots         | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Phlebitis                 |

**MUSCULO-SKELETAL:**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Neck/Shoulder pain | <input type="checkbox"/> Upper back pain      | <input type="checkbox"/> <u>Knee, hip or ankle pain</u> | <input type="checkbox"/> <u>Rib or breast pain</u> |
| <input type="checkbox"/> Muscle pain        | <input type="checkbox"/> <u>Low back pain</u> | <input type="checkbox"/> Other joint pain               | <input type="checkbox"/> Other                     |

**SKIN AND HAIR:**

- |                                       |                                   |   |  |
|---------------------------------------|-----------------------------------|---|--|
| <input type="checkbox"/> Rashes/Hives | <input type="checkbox"/> Acne     | <input type="checkbox"/> Hair loss              | <input type="checkbox"/> <u>Weak fingernails</u> |
| <input type="checkbox"/> Ulcerations  | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Fungal infections      |  |
| <input type="checkbox"/> Psoriasis    | <input type="checkbox"/> Itching  | <input type="checkbox"/> Change in skin texture |  |

**NEUROPSYCHOLOGICAL:**

- |                                   |   |  |   |
|-----------------------------------|---|--|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> <u>Poor memory</u> | <input type="checkbox"/> <u>Irritability, Crankiness</u> | <input type="checkbox"/> Considered Suicide |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> <u>Depression</u>  | <input type="checkbox"/> Easily stressed                 | <input type="checkbox"/> Seeing a therapist |
| <input type="checkbox"/> Tics     | <input type="checkbox"/> <u>Anxiety</u>     | <input type="checkbox"/> Abuse survivor                  | <input type="checkbox"/> Other              |

**GENITOURINARY:**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Pain on urination  | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Increased libido      | <input type="checkbox"/> Nocturnal emission |   |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Incomplete urine     | <input type="checkbox"/> Decreased libido      | <input type="checkbox"/> Kidney stones      | <input type="checkbox"/> <u>Wake to urinate</u> |
| <input type="checkbox"/> Urgent urination   | <input type="checkbox"/> Venereal disease     | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Impotence          |   |
| <input type="checkbox"/> Blood in the urine | <input type="checkbox"/> Urinary infection    | <input type="checkbox"/> <u>Genital pain</u>   | <input type="checkbox"/> Bedwetting         |   |

**DIGESTION:**

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Painful digestion | <input type="checkbox"/> Loose stools                    | <input type="checkbox"/> Weight gain  |
| <input type="checkbox"/> Bloating          | <input type="checkbox"/> Hard stools                     | <input type="checkbox"/> Gas/Belching |
| <input type="checkbox"/> Nausea            | <input type="checkbox"/> <u>Nausea with bitter taste</u> |                                       |

**OBSTETRICS-GYNECOLOGY**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal sores          | <input type="checkbox"/> # of pregnancies ____ |
| <input type="checkbox"/> PMS               | <input type="checkbox"/> <u>Clots in menses</u> | <input type="checkbox"/> # of terminations     |

**GENERAL APPEARANCE:**

- |   |   |
|---|---|
| <input type="checkbox"/> <u>Sallow complexion</u> | <input type="checkbox"/> <u>Dark/dull facial complexion</u> |
| <input type="checkbox"/> <u>Under eye circles</u> | <input type="checkbox"/> <u>Spider or Varicose veins</u>    |

**OTHER:**

- |  |   |
|--|---|
| <input type="checkbox"/> <u>Symptoms are better with steroidal medications</u> | <input type="checkbox"/> <u>Symptoms are related to menstrual cycle</u> |
| <input type="checkbox"/> <u>Symptoms are better with thyroid medications</u>   | <input type="checkbox"/> <u>Symptoms are worse with hunger</u>          |
| <input type="checkbox"/> <u>Symptoms are worse with stress</u>                 |   |

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**850 Aquidneck Ave., Middletown RI 02842**  
**(401)849-0514**

**INFORMED CONSENT**

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxabustion, cupping, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff or any unanticipated or unpleasant effects associated with the consumptions of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness and fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxabustion and cupping. I understand that while the document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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. **By signing this consent form I accept full responsibility for payment of the services rendered. If I choose to seek third party reimbursement for these services it is still my responsibility to pay for these services, out-of-pocket, should their reimbursement not be rendered in a timely manner.**

PATIENT SIGNATURE X \_\_\_\_\_  
DATE \_\_\_\_\_

OFFICE SIGNATURE X \_\_\_\_\_

## Newport Acupuncture & Herbal Medicine

THIS NOTICE DESCRIBES HOW MEDICAL AND ACUPUNCTURE RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS CAREFULLY AND SIGN IF YOU AGREE TO THESE CONDITIONS.

In the course of your care as a patient at Newport Acupuncture and Herbal Medicine, we may use or disclose personal and health related information about you in the following ways:

- ❖ Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- ❖ Your health care records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- ❖ Your name, contact information and health care records may be used to contact you regarding appointment reminders or other health related information that be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you.

Under federal law, we are also permitted or required to use or disclose you health information without your consent or authorization in these following circumstances:

- ❖ If we are providing health care services to you based on the orders of another health care provider or if we provide health care services to you in an emergency.
- ❖ If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- ❖ If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created, or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities,, you should direct your complaint to the staff of Newport Acupuncture. Complaints can also be made to the Office of Civil Rights at 1-800-368-1019.

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

If you would like further information about our privacy policies and practices please contact our privacy officer Dr. Seth Bock at:

**Newport Acupuncture & Herbal Medicine - (401) 849-0514  
850 Aquidneck Ave., Middletown RI 02842**

**Your signature indicates your authorization of this activity.**

\_\_\_\_\_  
**Name (printed)**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**MEDICAL INFORMATION RELEASE FORM**  
**Newport Acupuncture & Herbal Medicine**

We would like your permission to notify your primary care physician (or other health care provider) of your acupuncture and Chinese medicine treatment plan. You are not required to sign this release to receive treatment from us. However, signing this will help us provide you with comprehensive care.

Date: \_\_\_\_\_

I, \_\_\_\_\_, authorize:

Newport Acupuncture & Herbal Medicine  
850 Aquidneck Ave.  
Middletown, RI 02842  
Tel: 401-849-0514 Fax: 401-324-6858

to receive information from: \_\_\_\_\_

**OR**

to release information to: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Fax: \_\_\_\_\_

Concerning:

\_\_\_\_\_

**Specific expiration date or timeframe for expiration**

I understand that this authorization is subject to revocation at any time, except to the extent that the individual or entity that is to make the disclosure has already taken action in reliance upon it. I also understand and agree that this authorization will terminate only upon the execution of my written statement indicating my intent to revoke this authorization and that without such written revocation; this authorization shall remain in full force and effect as specified in the expiration timeframe.

Signature of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_