Laith Naayem L.Ac.
(845) 674-7639
www.LANacupuncture.com

Health History Questionnaire

Please help in providing you with the best care by taking the time to fill out this questionnaire. *All of your answers will be held absolutely confidential.* If you have any questions, please ask. Please include in the "Comments" section anything or any problems that you would like to discuss that are not included in this form.

Date: _____

Name:	Gender: M / F	Age:	Height:	Weight:
Address:		Date of Birth:		
		Place of Birth:		
Home phone:	Cell phone:	Work phone:		
Best number to contact you?	Email:			
Name of emergency contact (local):	Contact phone:	Relationship:		
Occupation:	Physician:			
How did you hear about Laith Naayem L.Ac.?				

Have you ever been treated with acupuncture or Oriental medicine before? Yes / No Where?
Main problem(s) you would like help with:
When did the problem(s) begin? Please be specific.
To what extent does the problem(s) interfere with your daily activities, such as work, sleep, recreation, sex?
How would you like the problem(s) to change?
Have you been given a diagnosis for this problem? If so, what?
What other types of treatment have you tried?
How would you rate the overall stress level in your life? ___Low ___Moderate ___High Please explain.

Medical History

Allergies (drugs, foods, chemical/ environmental):
Medications/ supplements/ vitamins (in the last two months):
Past medical history (including childhood illnesses):

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Surgeries/procedures (and dates):			
Significant injuries/trauma (auto accidents, falls, etc.):			
Significant diagnoses (please check any that apply):			
Blood disorder/ bleeding problems		Rheumatoid arthritis	
Diabetes		Other arthritis	
Heart disease		Hepatitis/ liver disease	
High blood pressure		HIV/AIDS	
Stroke		Tuberculosis	
Thyroid problems		Sexually transmitted diseases	
Kidney disease		Epilepsy/ seizures	
Gastrointestinal problems (reflux, IBD, ulcerative colitis, Crohn's disease)		Neurological disease (multiple sclerosis, Parkinson's disease, etc.)	
Respiratory problems		Depression/ other mental illness	
Cancer [type(s) and date(s)]:		Chemical dependency (alcohol, drugs)	
Other (please describe):			
Family Medical History (please circle all applicable) Asthma Allergies Diabetes Cancer Heart disease Stroke High blood pressure Seizures Thyroid disease Other:			
Please describe any use of drugs for non-medical purposes.			
Do you have a regular exercise program? Yes / No (Please describe)			
Do you smoke? If yes, how much?		Do you drink alcoholic beverages? How much per week?	
How much fluids (including water) do you drink per day?			
How much caffeinated coffee, tea, colas do you drink per week?			

Please describe your average daily diet

Morning	Afternoon	Evening	Snacks

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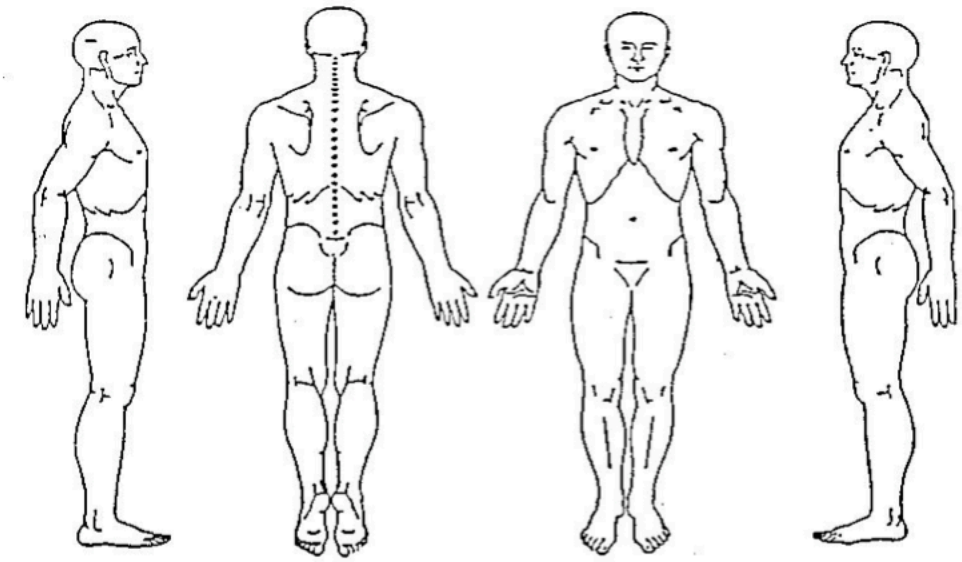
Please indicate any painful or distressed areas by circling the area.



Please check any symptoms you have had in the past six months:

General

Feeling hot/ fevers	Cravings	Peculiar tastes or smells
Sweats easily	Change in appetite	Fatigue
Afternoon / night sweats	Weight loss	Sudden drop in energy
Feeling cold/ chills	Weight gain	Poor sleep
Bruise or bleed easily		

Skin & Hair

Rashes /hives	Eczema	Recent moles
Itching	Loss of hair	
Dandruff	Warts	
Ulcerations/ unhealed sores	Pimples	
Change in hair or skin texture		
Any other hair or skin problems?		

Head, eyes, ears, nose and throat

Glasses/ contacts	Ear aches/ pain	Sinus problems
Poor vision	Dizziness	Nose bleeds
Cataracts	Ringing in ears	Facial pain
Eye strain	Grinding teeth	Jaw clicks/ locks
Eye pain	Gum or teeth problems	Concussions
Color blindness	Sores on lips, gums, tongue	Migraines
Night blindness	Loss of smell/ taste	Headaches (where, when?)
Blurry vision	Bitter taste in mouth	
Spots/floaters	Recurrent sore throat	
Poor hearing	Sneezing	
Sensation of something stuck in throat		
Any other head or neck problems?		

Respiratory

Bronchitis
Pneumonia
Cough
Coughing blood
Asthma
Difficulty inhaling/exhaling
Wheezing
Shortness of breath
Pain with a deep breath
Pulmonary embolism
Difficult breathing when lying down

Production of phlegm: ___loose ___thick/ sticky What color?
Any other lung/breathing problems?

Cardiovascular

Chest pain
Irregular heartbeat
High blood pressure
Low blood pressure
Fainting
Colds hands or feet
Swelling of feet/ legs
Swelling of hands
Blood clots
Phlebitis
Varicose /spider veins
Peripheral artery disease

Any other heart or blood vessel problems?

Gastrointestinal

Bad breath
Bleeding gums
Nausea
Vomiting
Indigestion/ acid reflux
Gall stones
Abdominal pain or cramps
Gas
Bloating
Belching
Diarrhea/ loose stool
Undigested food in stool
Constipation
Blood in stools
Black stools
Rectal pain
Hemorrhoids
Incomplete bowel movements

Any other stomach or intestinal problems?

Urinary

Frequent urination
Urgent urination
Unable to hold urine
Dribbling
Pain on urination
Blood in urine
Decrease in urine flow
Kidney stones
Falling (prolapsed) bladder

Do you wake up to urinate? Yes / No How often?
Urine color: ___ light or clear ___ amber ____ cloudy ____other (specify):
Any other problems with your urinary system?

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Female reproductive

Are you pregnant? Yes / No **LMP** _____ Duration of menses _____
Is it possible you are pregnant? Yes / No Time between of menses: _____
Menopause? Age: _____
Age of first menses: _____
Pregnancies? #_____ Miscarriages #_____
Live births #_____
Premature births #_____

Irregular periods	Sores on genitals	Breast lumps
Painful periods	Sexually transmitted disease	
Clots	Infertility	
Vaginal discharge	Western fertility treatments	

Menstrual flow (heavy / moderate / light)
Premenstrual symptoms?
Do you practice birth control? Type and for how long?
Any other reproductive problems?

Male reproductive

Impotence	Premature ejaculation	Testicular pain/ injury
Prostatitis	Spermatorrhoea	Testicular cancer
Prostrate cancer	Low sperm count	Sores on genitals
Enlarged prostrate	Low motility	

Any other reproductive problem?

Musculoskeletal

Neck pain	Knee pain	Muscle cramping
Shoulder pain	Foot/ ankle pain	
Hand/ wrist pain	Muscle pain	
Hip pain	Muscle weakness	

Back pain: upper/ middle /lower
Any other muscle, joint or bone problems?

Neurological

Seizures	Dizziness	Areas of numbness
Stroke	Loss of balance	Poor memory
Concussion	Lack of coordination	Tremors (where?)

Any other neurological problems?

Psychological

Depression	Easily angered	ADD/ ADHD
Anxiety	Easily susceptible to stress	Bipolar disorder
Panic attacks	Easily over worried	Post traumatic stress
Poor concentration	Seasonal affective disorder	disorder (PTSD)

Have you ever been treated for emotional problems?
Have you ever considered or attempted suicide?

Patient Advisory To Consult A Physician

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 _____ (THE PATIENT) HAS BEEN ADVISED BY LAITH NAAYEM L.AC. TO CONSULT A PHYSICIAN REGARDING THE CONDITIONS FOR WHICH SUCH A PATIENT SEEKS ACUPUNCTURE TREATMENT.

_____ Date: _____
Patient's signature

_____ Date: _____
Laith Naayem L.Ac.

Financial Agreement

Assignment of Benefits and Release of Information for Insurance
I authorize payment of benefits be directly to this healthcare provider and I understand I am responsible for charges not covered by this assignment. If insurance sends payments to me for services incurred in this office, I agree to send or bring those payments to this office upon receipt. However, if I pay for visits in full, the assignment will not be provided by this provider and any payment will be sent directly to me. I also authorize this office upon request from insurance carrier the release of any medical or other information necessary to process the claim.

Payment Arrangements
We require that you pay a co-pay on each visit. Your full portion of the balance is expected to be paid when payment is received from your insurance carrier.

Returned Check Policy
All returned checks will be subject to an additional charge of $25.00

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 momentum of effect from the treatment plan will be maintained.
All scheduled appointments require a 24 hour cancellation notice or the patient will be charged for a full office visit.

I acknowledge that I have read the above financial policies and will be responsible for all charges stated above.

_____
Patient's signature Date

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices Regarding Disclosure of Health Information describes how health information about you may be used and disclosed. It also describes how you can gain access to your health information. Please review this information carefully.

Understanding Your Health Record:
A record is made each time you visit our office for treatment. This record includes symptoms, clinical observations, diagnosis, and treatment. The record may also contain other pertinent information provided by you or another of your health care practitioners with whom we may have communicated.

Your Health Information Rights:
Your health record is owned by the clinic, however, the content is always available to you for your review. You have the right to request a review of your file and to obtain copies of documents contained in your file. You also have the right to request that amendments be made to your record. In addition, you may request that the use of your information be restricted from certain uses and disclosures and to request a list of individuals or entities to whom your information has been disclosed. You may revoke any authorizations you have given regarding disclosure of your health information at any time. This revocation must be provided to us, in writing.

Our Responsibilities:
We are required to maintain the privacy of your health information and to provide you with a copy of this notice upon request. We will follow the terms of this notice and advise you if we are unable to comply with a request you may make regarding the use of your health information. We reserve the right to amend our privacy policies and we use our best efforts to notify you of such amendments. Other than for reasons stated in this notice, we will not use or disclose your health information without your consent.

I, _____ have read and understand this Notice of Privacy Practices Regarding Disclosure of Health Information. I understand my health information will be treated in accordance with this notice.

Patient/Guardian Name: _____(please print)

Signature: _____ Date: _____