NeuroloQi Acupuncture | Initial Intake Form

Name_____ Age____ DOB____/____/____ Today____/____/____

Address_____ City_____ State____ Zip_____

Phone_____E-mail address_____

Emergency Contact_____Phone_____

Pronouns: _____

Have you had acupuncture before? □ Yes □ No

Do you have Health Insurance? If so, what Company?_____ Plan?_____

How did you hear about Desiree or NeuroloQi Acupuncture?_____

Please list the reasons you are here today

1. _____ 4._____
2. _____ 5._____
3. _____6._____

Please indicate if any of the following pertain to you:

□ Hepatitis □ HIV □ High/ Low Blood Pressure □ Seizures □ Pacemaker

□ Blood-Thinning Medication □ Pregnancy □ Implants □ Herpes Virus

Medication / Supplement	**Why are you taking it?**

Other forms of treatment/therapy?

_____

Please list any surgeries/illnesses / injuries & their dates.

1. _____ 4. _____
2._____ 5._____
3. _____ 6._____

Please circle the conditions that apply to you

Digestion / Elimination

Increased or Decreased appetite	Increased or decreased thirst	Loose stools / diarrhea
Constipation / Dry / Incomplete stools	Gas / Bloating/ Belching	Acid Reflux / GERD
Crohn's/ IBS	Hemorrhoids / Hernia/ Prolapse	Gallstone/ Kidney stone
Liver Disease/ Hepatitis / Cirrhosis	Difficult Urination/Prostate Issue	Urinary Tract Infections

Other _____

How many times a day do you urinate? _____ Is it clear /dark / pale yellow/Cloudy/ Frothy?

How often do you have a bowel movement? _____ day / week. Any remarkable color? _____

Emotion

Worry	Anger	Depression/Sadness	Fear	Grief
Confusion	Poor memory	PTSD	Stress	Anxiety
ADHD	Addiction	Obsession	Compulsion	

Other Psychological Diagnosis: _____

Whole body

Fatigue/ Poor Energy ..... When? Morning/ Afternoon/ Evening/ After meals

Insomnia/ Wake at night	Wake to Urinate	Waking not rested
Night Sweats	Hot Flashes	Chills
Cold Hands/ Feet	Edema (Face/ Legs/Hands)	Low/ High Libido
Dry Skin/ Rashes/ Acne	Other _____	

Cardiovascular / Respiratory

High cholesterol	Heart Attacks	Stents/ Other Operations
Stroke	Cough	Heart palpitations
Shortness of breath	Asthma / COPD/ Emphysema	Chest pain/ Tightness
Poor Circulation	Other _____	

Head/ Face

Ringing in the ears/ Tinnitus	Hearing impairment	Vision Problems

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Allergies Sinus infection/ congestion

Other _____

Musculoskeletal

Lower back pain Arthritis Knee pain/ problems

Joint Pain _____ Muscle Pain_____

Other _____

Gynecology

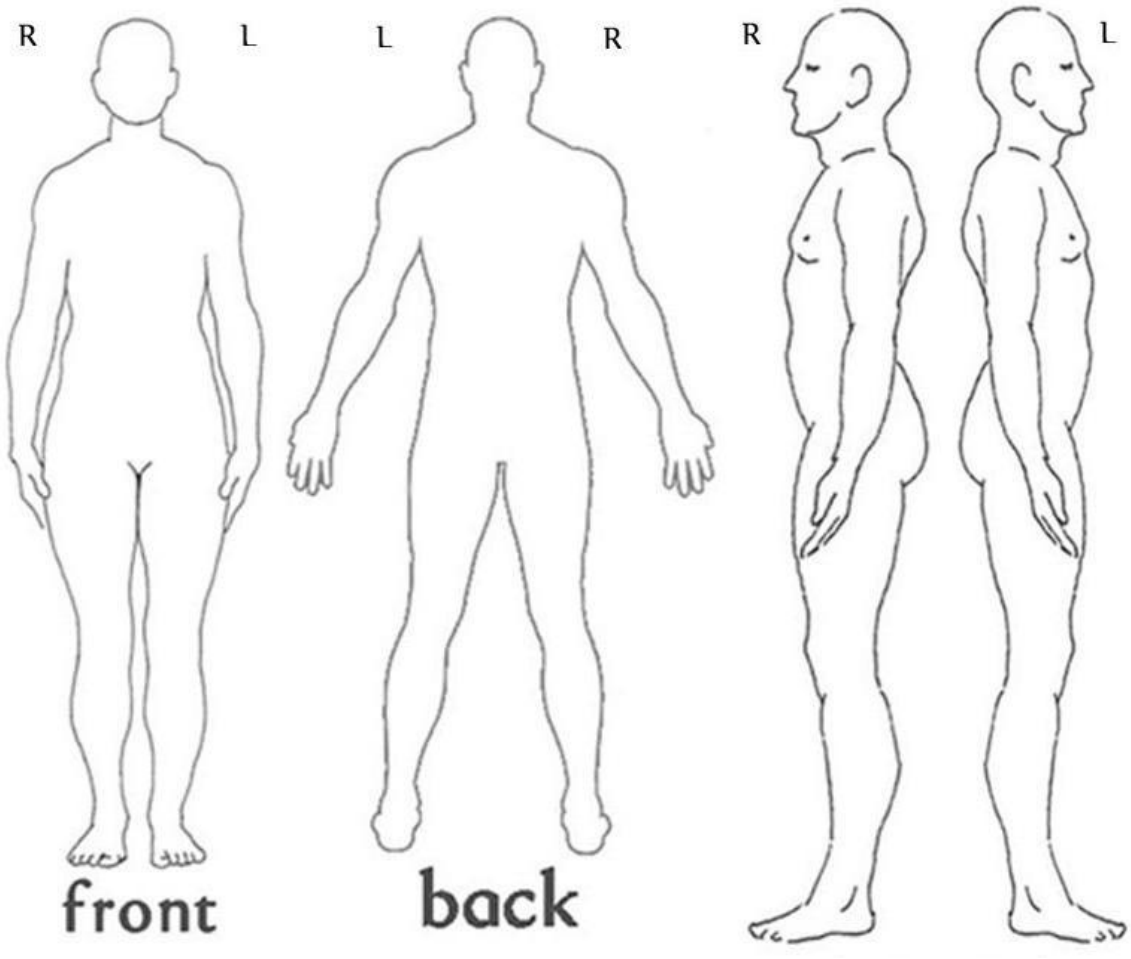
Date of last period__/__ Irregular Period Difficult / Painful Period

Light / Heavy Flow History Miscarriages Fibroids/ Cysts

Hysterectomy (age_____) Age at menopause_____

Other _____

Please circle or fill in the areas you have Pain/ Numbness / Stiffness/ Discomfort etc.



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I consent to receive acupuncture treatment and other associated therapies by Desiree Sale LAc & Stephen Setita LAc. I understand that methods of treatments may include, but are not limited to, Acupuncture, Moxibustion, Cupping, Gua Sha, Electrical Stimulation, use of oils and balms, and Nutritional Counseling.

Acupuncture and its adjunct modalities have the effect of normalizing physiological functions, improving states of pain, and of treating illness by balancing internal disharmony. I understand that Acupuncture is the insertion of thin, sterile needles into designated points along the body's surface. Acupuncture is considered a safe method of treatment. There is occasional bruising, numbness or tingling or other sensations at the site of needle insertion. This is normal and may occur during or after treatment. Gua Sha and Cupping are likely to produce bruising that is part of the healing process and will vanish within a few days. Moxibustion may cause cutaneous burns. Rare side effects include dizziness or fainting, especially if the patient is overdue for a meal. In even more rare circumstances, spontaneous miscarriage and pneumothorax have occurred. I understand that while this document describes the major risks of treatment, other side effects may occur. I also understand that most people experience a sense of well being and relaxation during and after their treatment.

I will promise to notify the acupuncturist if I am or become pregnant since this will affect the course of treatment. I also promise to notify my practitioner if I am following a new diet, prescription drug or supplement regimen, as this too will affect my course of treatment.

I wish to rely on the acupuncturist to exercise their best judgment during the course of treatment. I understand that their diagnoses and treatment are based upon information I have given my practitioner. What my acupuncturist does from there is what they believe is in my best interests. I understand that results are not guaranteed.

I understand that all my records will be kept confidential and will not be released without my written consent. If cases are used for research or publishing purposes, identities, including personal and identifying information will be altered.

In the State of New York Acupuncturists must advise patients to consult a physician for any conditions they are seeing an acupuncturist to treat.

I, the undersigned, do affirm that I have been advised by the Acupuncturist, to consult a physician regarding the condition or conditions for which such a patient seeks acupuncture treatment.

I understand that if my third party payor (insurance company) does not pay for my treatment, then I, the patient, am financially responsible for my care. If this is the case, I will pay the outstanding balance of my care in one lump sum or in installments.

I understand that if I **do not appear for, or cancel my appointment within 24 hours** of the agreed upon time, that I will be charged a **cancellation fee of $25.**

By signing below, I show that I have read or have had read to me this consent to treatment, and have been told about the benefits and risks of acupuncture and adjunct procedures. I have also 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.

_____ _____

Patient or Representative Name (please print) Signature of NeuroloQi Provider/Staff Date

_____

Signature of Patient or Representative Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to us. You may be aware that U.S. government regulations established under HIPAA (Health Information Portability and Accountability Act) govern the protection of health information. This notice describes how it may be used, as well as certain rights you have as a patient.

Use And Disclosure Of Protected Information

All information regarding patients, their treatments, diagnosis and appointments is kept strictly confidential. Patient charts and financial data will be seen only by the practitioner. There is no electronic transfer of your medical data. For treatment purposes, private information will be provided to another practitioner only after your written consent is given. Your medical information may be used, without further notice to you, or specific authorization by you, where required by law: • for public health purposes; • to report child abuse; • in judicial or administrative proceedings; • by a health oversight agency for oversight activities authorized by law; • under law enforcement purposes; • by a coroner or medical examiner; • to avert serious threat to health or safety; • under military authorities if you are a member of the armed forces of the United States. New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information. We may contact you by mail or telephone, at your residence, to remind you of appointment (s). No reference to medical service will be made. Occasionally, we may call to give instructions or to notify you that herbs or supplements are in the office. If you wish for us to make use of alternative methods of communicating with you, please provide that information on the signature sheet.

Rights That You Have

You have the right to inspect and obtain copies of your medical information. A reasonable fee will be charged for copying. You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for the requested amendment. If we disagree with the requested amendment, we will notify you of such disagreement, and we will further notify you of your rights. You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make directly to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or for emergency or notification purposes.

Obligations That We Have

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices. We are required to abide by the terms of this notice as long as it currently is in effect. Please sign the attached acknowledgement of receipt as we are required under law to show that we gave you this information.

Acknowledgement of Receipt of Notice of Privacy Practices

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

_____ _____

Patient or Representative Name (please print) Signature of NeuroloQi Provider/Staff Date

_____

Signature of Patient or Representative Date

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I Understand the Following Covid Protocols:

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of healthcare during a pandemic. Given the current limitations of COVID-19 testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

I attest to the following:

I will cancel an appointment if I test positive for COVID-19. I will continue to practice social distancing. It has been at least 2 weeks since I have Traveled by plane/train or bus. I promise I am not living with a COVID Positive Person and that I have not been in close contact with one. I will cancel my appointment if I experience any of the following symptoms: ● Cough ● Shortness of Breath ● Chills ● Fever ● Loss of Taste. I understand that I will not be charged a cancellation fee if I cancel for any of these reasons.

I understand the following:

I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could include receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. I understand, due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a healthcare office. I also understand that NeuroloQi Acupuncture is doing everything in its power to maintain a clean and sterile environment, and to prevent the spread of infection of any type, including but not limited to COVID-19. I am informed that you and your staff have implemented preventive measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your office(s) to proceed with providing care. I have been offered a copy of this consent form (it may be found online at any time). I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDER IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

_____ _____

Patient/Representative Name (please print) Signature of NeuroloQi Provider/Staff Date

_____

Signature of Patient/Representative Date