Riverwalk Physical Therapy, L.L.C.

ACUPUNCTURE HEALTH HISTORY QUESTIONNAIRE

Name: _____Date: _____

Street: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Occupation: _____ Marital Status: _____

Date of Birth: _____ Age: _____ Gender: ☐ M ☐ F Height: _____ Weight: _____

Email: _____ Referred by: _____
(automatic 24hr advance appointment reminders)

Emergency Contact (Name & Phone Number): _____

Family Physician: _____

Insurance Carrier: _____ Policy Number: _____

Is your current condition a result from a work or auto injury?: ☐ Yes ☐ No

CHIEF COMPLAINTS

Have you ever tried acupuncture or Chinese herbal medicine before?: ☐ Yes ☐ No

Would you like to have a chaperone if you required a private room?: ☐ Yes ☐ No

Do you give your full consent for acupuncture needles being inserted into your body?: ☐ Yes ☐ No _____
(initials)

What are your chief complaint(s) you would like to address today? _____

_____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)? _____

_____

How long has it been since you first noticed any symptoms? _____

Have you been given a diagnosis for this issue by a physician or chiropractor?: ☐ Yes ☐ No

If so, what is it? _____

What kinds of treatment or therapy have you tried? _____

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES WHERE POSSIBLE)

- ☐ Allergies:
- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Seizures
- ☐ Rheumatic fever
- ☐ Surgeries
- ☐ Venereal disease
- ☐ Thyroid disease
- ☐ Birth trauma (prolonged labor, forceps delivery, etc.)
- ☐ Other significant illness (describe): _____
  _____
  _____
- ☐ Accidents or significant trauma (describe): _____
  _____
  _____

OTHER RELEVANT MEDICAL HISTORY

_____

_____

FAMILY MEDICINE HISTORY

- ☐ Allergies
- ☐ Diabetes
- ☐ Asthma
- ☐ Cancer
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Seizures
- ☐ Stroke
- ☐ Other

OCCUPATION

Occupational stress factors (physical, psychological, chemical): _____

_____

LIFESTYLE

Do you follow a regular exercise program? _____ If so, please describe: _____

_____

Please describe your average daily diet: _____

_____

Please check any of the following habits that apply. How much and how often do you use them?

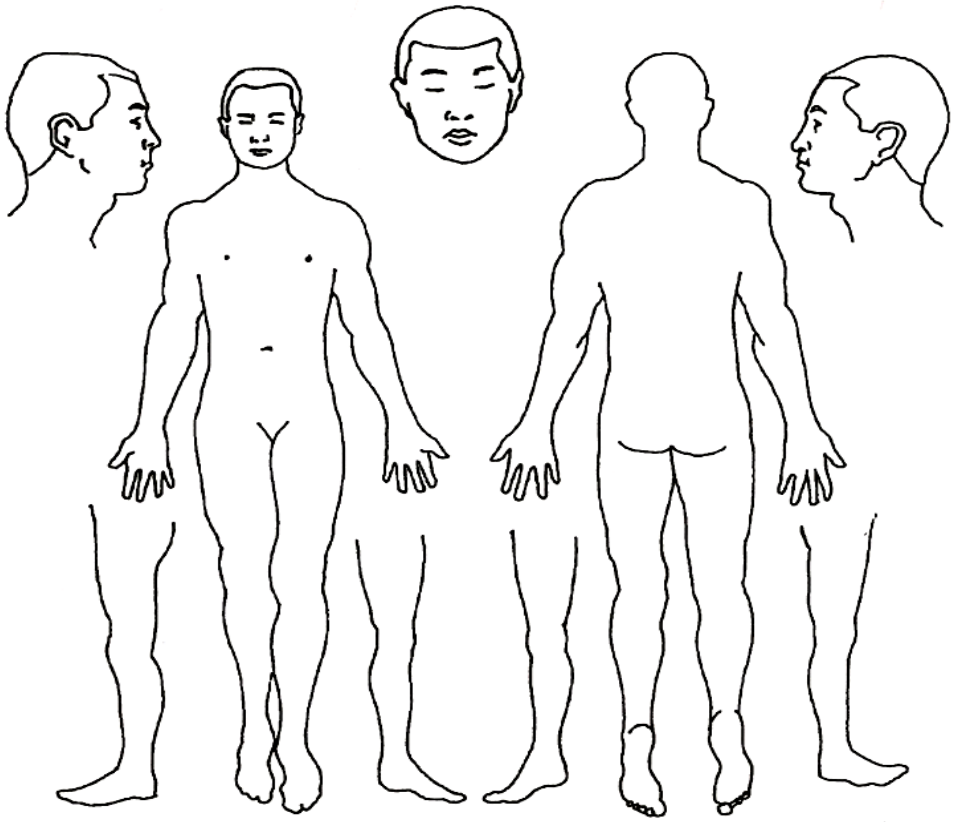
- ☐ Cigarette smoking
- ☐ Coffee, tea or cola
- ☐ Alcoholic beverages

List medications taken within the last two months (vitamins, drugs, herbs, etc.):_____

_____

Please describe any use of drugs for non-medical purposes: _____

PLEASE MARK PAINFUL OR DISTRESSED AREAS BELOW



PLEASE PUT A CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.

GENERAL

- ☐ Poor appetite
- ☐ Insomnia
- ☐ Disturbed sleep
- ☐ Localized weakness
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Changes in appetite
- ☐ Sweating easily
- ☐ Tremors
- ☐ Bleeding or bruising easily
- ☐ Night sweats
- ☐ Fever
- ☐ Chills
- ☐ Sudden energy drop (time of day?) _____
- ☐ Poor balance

Other unusual or abnormal conditions you have noticed in your general sense of health: _____

_____

SKIN AND HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair loss
- ☐ Recent moles
- ☐ Changes in texture of hair or skin

Any other hair or skin issues: _____

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Eye strain
- ☐ Sinus problems
- ☐ Recurrent sore throats
- ☐ Nose Bleeds
- ☐ Grinding teeth
- ☐ Sores on lips or tongue
- ☐ Facial pain
- ☐ Teeth problems
- ☐ Headaches (where? when?)
- ☐ Jaw clicks

Any other head or neck issues: _____

_____

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Difficulty in breathing
- ☐ Phlebitis

Any other heart or blood vessel issues: _____

_____

RESPIRATORY

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pain with deep inhalation
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Excessive phlegm (color?)

Any other lung issues: _____

_____

DIGESTIVE

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramp
- ☐ Chronic laxative use
- ☐ Bad breath

Any other issues with stomach or intestines: _____

_____

GENITOURINARY

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Decrease in flow
- ☐ Impotence
- ☐ Sores on genitals

Do you wake up at night to urinate:_____ If yes, how often? _____

Any particular color to your urine: _____

Any other genital or urinary issues: _____

GYNECOLOGIC

- ☐ Premenstrual changes
- ☐ Menstrual clots
- ☐ Painful menses
- ☐ Unusual menses
- ☐ Heavy menstrual flow
- ☐ Light menstrual flow
- ☐ Irregular menses
- ☐ Other problems
- ☐ Premature births
- ☐ Miscarriages
- ☐ Abortions

Age at first menses: _____ Age at menopause: _____ Number of Pregnancies: _____

Time between cycles: _____ Duration of bleeding: _____ First day of last menses: _____

Do you practice birth control: _____ If so, what type: _____ For how long: _____

Any other gynecologic issues: _____

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Muscle pains
- ☐ Knee pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Foot/ankle pain
- ☐ Hand/wrist pain
- ☐ Shoulder pains
- ☐ Hip pain

Any other joint or bone issues: _____

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Dizziness
- ☐ Loss of balance
- ☐ Areas of numbness
- ☐ Poor memory
- ☐ Lack of coordination
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Bad temper
- ☐ Easily susceptible to stress

Have you ever been treated for emotional issues: _____

Have you ever considered or attempted suicide: _____

Any other neurological or psychological issues: _____

PLEASE LIST ANY OTHER ISSUES YOU WOULD LIKE TO DISCUSS

_____

_____

Riverwalk Physical Therapy, LLC

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to the Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to the Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Financial Responsibility

I have requested professional services from RIVERWALK PHYSICAL THERAPY, LLC, ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advanced.

I hereby instruct and direct _____Insurance Company to pay by check made out and mailed to: **RIVERWALK PHYSICAL THERAPY, 665 MARTINSVILLE ROAD, BASKING RIDGE, NJ 07920**. or If my current policy prohibits direct payment to Riverwalk Physical Therapy, LLC., I hereby also instruct and direct you to make out the check to me and mail it as follows: **RIVERWALK PHYSICAL THERAPY, 665 MARTINSVILLE ROAD, BASKING RIDGE, NJ 07920** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. If payment is mailed directly to me I will bring in the check and explanation of benefits within 1 week of receipt.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient or Parent/Guardian Signature_____ Date_____

Riverwalk Physical Therapy, L.L.C.

INFORMED CONSENT AND PRIVACY POLICY

I hereby request and consent to the performance of Acupuncture treatments including acupuncture and other procedures on me by Carolyn Raiman, LAc and/or other licensed acupuncturists/practitioners of Acupuncture who now or in the future treat me while employed by, working or associated with Riverwalk Physical Therapy, L.L.C.

I understand the Acupuncture treatments may include, but are not limited to, acupuncture, micropuncture, moxabustion, cupping, Tuina, and other East Asian forms of massage, Gua Sha, Qigong, and lifestyle/dietary counseling. I understand that herbs may need to be prepared and consumed according to instructions provided to me either orally or in written form. The herbal teas may have an unpleasant smell and taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of herbs.

I understand that acupuncture is generally a very safe method of treatment with few, but some possible side effects, including bruising, numbness at the needle site, dizziness or fainting. Bruising is a common side effect of cupping and Gua Sha. Moxabustion and the use of heat therapies may in rare instances cause burning or scarring. Chinese herbs that are recommended are traditionally considered safe, although some may be toxic in large doses. I understand that some herbs are inappropriate during pregnancy and along with other herbs or prescription medication. I will notify a staff member if I become or suspect that I am pregnant. I will also notify a staff member of drugs (medicinal or recreational) and supplements that I take and if there is any change in them. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications, and I understand results cannot be guaranteed.

I understand that Carolyn Raiman, LAc and staff may review my patient records, but all records will be kept confidential and will not be released without my written consent. I also understand Carolyn Raiman, LAc and staff may from time to time send me information via mail or e-mail including but not limited to receipts, newsletters, and office announcements but that my name and contact information will never be released to any other business or organization. I have been notified that the full Carolyn Raiman, LAc Privacy Policy is available and I understand that I may receive a print copy if I request.

By voluntarily signing below, I show that I have read or have read to me, the above consent to treatment, have been told about the benefits and risks of the above procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for any present condition and for any future condition(s) for which I seek treatment.

_____

Patient Signature (or patient representative) Date (relation to patient if not self)

_____

Office Signature Date