Natural Approach Healthcare

Stony Brook Medical Park
2500 Nesconset Highway
Suite 4-A
Stony Brook, NY 11790
(631) 675-9000
Fax (631) 675-9002
www.naturalapproach.us

Entrance Case History

(Please write or print clearly)

Today's Date ____/____/____ ☐ Male ☐ Female

Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Birth Date ____/____/____ Age _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

E-Mail Address _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Emergency Contact _____ Relationship _____

Emergency Contact Phone Number (____) _____ Alternate Phone (____) _____

Occupation _____ Last Grade Completed _____

IF UNDER THE AGE OF 18, PARENT'S NAME/GUARDIAN'S NAME REQUESTED:

Mother's Name _____ Father's Name _____

Guardian's Name _____ Relationship _____

Who referred you to us? _____

Who is your primary health care provider? _____ Phone Number (____) _____

Main complaint you would like us to help you with: _____

_____.

How long ago did this problem begin? _____

Have you been given a diagnosis for this problem? If so, what? _____

_____.

What kind of treatments have you tried? _____

_____.

Have these treatments helped alleviate the condition/problem? _____

What type of medications have you taken? _____

Were the medications effective? _____ Are you still taking the medications? _____

Are you currently receiving treatments for your problem? If so, describe: _____

_____.

Name of Insured _____

Address of Insured _____

City _____ State _____ Zip _____

Insured Phone Number: (____) _____

Insurance Plan _____ ID # _____

Group Number _____ Insurance Phone Number (____) _____

Relationship to Insured _____

Insured's Date of Birth _____ Insured's Employer _____

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MEDICAL INFORMATION RELEASE

I,_____, give Natural Approach Healthcare and Kris Johnston MSOM, LAc permission to release my medical information to the following people:

_____ _____
Name Contact Phone Number

_____ _____
Name Contact Phone Number

_____ _____
Name Contact Phone Number

This permission can be revoked in writing only.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated).

_____.
Date Consent Completed

_____.
Print Name of Patient (or patient representative, if applicable)

_____.
Signature of Patient or Representative

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PATIENT BILLING ACKNOWLEDGEMENT

I, _____, being a patient of Kris Johnston MSOM, LAc, CH, located at Stony Brook Medical Park, 2500 Nesconset Highway, Unit 4-A, Stony Brook, NY 11790, do hereby acknowledge that I have been informed in advance of receiving treatment that my health insurance benefits will/or may not cover acupuncture treatment. Upon signing this form, I acknowledge that I have chosen to undergo treatment and acknowledge that I am, therefore, solely financially responsible for the payment of services rendered to me.

_____
Patient Name (Print)

_____ _____
Patient Signature Date

_____ _____
Witness Date

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With this consent, Kris Johnston MSOM, LAc and Natural Approach Healthcare (Clinic), may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the Clinic's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have to right to review the Notice of Privacy Practices to signing this consent. The Clinic reserves the right to revise it's Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office Manager, Stony Brook Medical Park, 2500 Nesconset Highway, Unit 4-A, Stony Brook, NY 11790.

With my consent, the Clinic may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the Clinic in carrying out TPO, such as appointment reminder, and any call pertaining to my clinical care.

With my consent, the Clinic may mail to my home, or other designated location, any items that assist the Clinic in carrying out TPO, such as appointment reminder cards.

I have the right to request the Clinic restrict how it uses or disclosed my PHI to carry out TPO. However, the Clinic is not required to agree to my requested restrictions, but if it does, it is bound by this Agreement.

By signing this form, I am consenting to the Clinic use and disclosure of my PHI to carry out TPO.

When my information is used or disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the applicable privacy laws. I have the right to revoke this Authorization in writing except to the extent that the Clinic has acted in reliance upon this authorization. My written revocation must be submitted to the Clinic's Office Manager, Stony Brook Medical Park, 2500 Nesconset Highway, Unit 4-A, Stony Brook, NY 11790.

_____ _____

Date *Signature of Patient or Legal Guardian*

_____

Relationship to Patient

_____

Patient's Name

_____

Print Name of Patient or Legal Guardian

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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.

You may contact the Office Manager at Natural Approach Healthcare, Stony Brook Medical Park, 2500 Nesconset Highway, Suite 4-A, Stony Brook, N. Y. 11790, or at (631) 675-9000 or via fax at (631) 675-9002.

By signing below, I hereby acknowledge receipt of the Clinic's Notice of Privacy Practices.

_____ _____

Date **Patient's Name**

_____

Patient's Signature

FOR USE BY CLINIC STAFF ONLY

☐ **Patient refused to sign**

☐ **Patient unable to sign**

_____

Employee's Initials

_____

Date

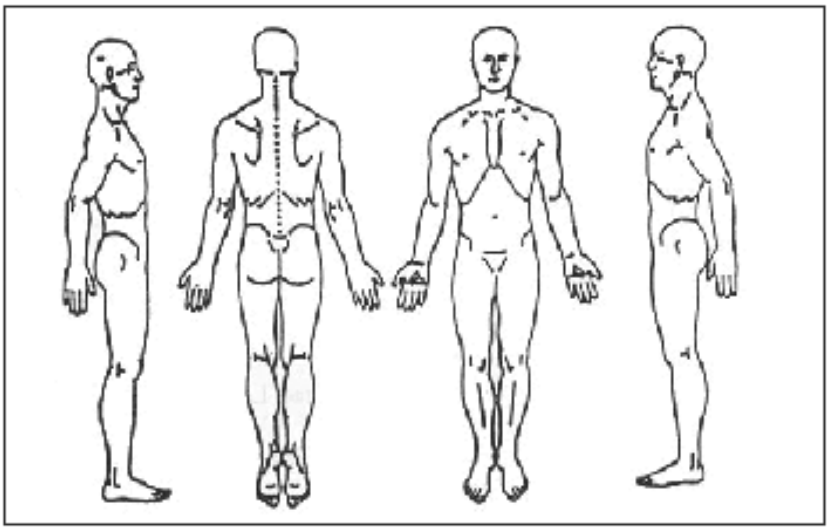
PATIENT QUESTIONAIRE

1. Have you been treated with Acupuncture in the past?
___ No
___Yes (when?) _____

2. What makes your condition better? _____

3. What makes your condition worse? _____

4. If there is pain, locate the place of the pain on the diagram below.



5. Medications/Herbs OTC that you are currently taking — For what condition?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

6. List Surgeries/Operations you have had with dates:

_____

_____

_____

Family History	**Father**	**Mother**	**Sibling**	**Children**	**Self**
Arthritis					
Asthma					
Cancer (type)					
Heart Trouble					
High Blood Pressure					
Stroke					
Diabetes					
Kidney Disorders					
Thyroid Disorders					

7. Prior Health History

A. Childhood illnesses: _____

B. Past Traumas: _____

C. Allergies: _____

8. Do you currently smoke? ___ No ___ Yes- _____/per day

9. Do you drink alcohol? ___ No ___ Yes- _____/per week

10. Do you drink caffeine? ___ No ___ Yes- _____/per day

11. What is your Energy Level? _____

High time of the day: _____

Low time of the day: _____

12. How is your appetite?

___ Absent ___ Weak ___Strong

13. What tastes or foods do you crave? (Please check all that apply)

___ Sweet ___ Hot/Spicy ___Salty

___ Bland ___ Sour ___ Bitter

___ None ___ Other: _____

14. On average, how many hours do you sleep each night? _____

15. Do you have the following? (please check all that apply)

	Often	Seldom	Severe	Mild	None
Nausea					
Vomiting					
Belching					
Indigestion					
Stomach Pain					
Lower Abdominal Pain					
Bloody Stools					
Black Stools					
Mucus in Stools					
Hemorrhoids					
Lower Bowel Gas					
Stools Have Foul Odor					
Colon Problems					
Diarrhea					
Constipation					
Other					

Bowel Movements Occur _____ time/s in _____ day/s

16. Have you had recent:

___ Weight loss, _____ lbs. ___ Weight gain, _____ lbs.

17. For FEMALE patients, do you experience any of the following? (Please answer <u>each item</u>):

No	Yes	
		Painful menses
		Irregular menses
		Premenstrual changes
		Menstrual clots
		Heavy menstrual flow
		Light menstrual flow

No	Yes	
		Strong menstrual odor
		Vaginal discharge
		Strong vaginal odor
		Hot flashes
		Onset of menopause
		Infertility

Number of pregnancies _____
Number of live births _____
Number of miscarriages/abortions _____
Typical menstrual color _____

Age of first menses _____
Date of last period _____
Duration of flow _____
Length from period to period _____

18. Do you experience the following? (Please check all that apply)

	Dizziness		Memory loss		Eye pain
	Dry eyes		Red eyes		Blurred vision
	Double vision		Eye floaters		Loss of balance

Headaches: where? _____

	Poor hearing		Earaches		Ear ringing

	Nose bleeds		Sinus trouble		Congestion
	Frequent colds: how many _____/per year				

	Hard to breathe		Wheezing		Chest pressure
	Palpitations		Persistent cough		Chest pain
	Coughing blood		Dry cough		
	Coughing phlegm: what color & consistency_____				

	Frequent urination		Hard to hold urine		Hard to urinate
	Pain/Burning urination		Blood in urine		
	Urination during the night: how many _____/per night				

If you wish to provide additional information, please use the space below:

Patient's Signature: _____