



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 the right to review the Notice of Privacy Practices to signing this consent. The Clinic reserves the right to revise its 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

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 each item):

No	Yes		No	Yes	
		Painful menses			Strong menstrual odor
		Irregular menses			Vaginal discharge
		Premenstrual changes			Strong vaginal odor
		Menstrual clots			Hot flashes
		Heavy menstrual flow			Onset of menopause
		Light menstrual flow			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)

<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	Eye pain
<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>	Red eyes	<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	Double vision	<input type="checkbox"/>	Eye floaters	<input type="checkbox"/>	Loss of balance
Headaches: where? _____					

<input type="checkbox"/>	Poor hearing	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	Ear ringing
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<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	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: _____ _____
