# New Patient Packet

**Toni Haugen L.Ac MSTOM**
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**haugentoni@gmail.com**
**(716) 218-9338**

Thank you for choosing Queen City Acupuncture. I look forward to working with you soon. I want to reassure you that acupuncture and herbal medicine are safe and comfortable. They are modalities that help your body and mind heal naturally and with little to no concern for side effects. If you have not booked a treatment yet you may schedule an appointment by calling (716) 218-9338.

**HELPFUL GUIDELINES:**

• Please eat at least a light snack 1 to 2 hours before your appointment.

• Try not to drink coffee, caffeinated tea, smoke cigarettes or be under chemical influence up to 1 to 2 hours before treatment unless necessary for your health.

• Please wear loose-fitting clothes if possible. You can change at the office if needed.

Your initial visit will last approximately 60-90 minutes. This time will be spent interviewing you regarding your medical history and primary complaint, conducting a physical examination based on Traditional Chinese Medicine (TCM), and a treatment. The cost of an initial treatment is $150.00. Return visits are typically 45-60 minutes and cost $85.00. If you are unable to keep your scheduled appointment, please contact Toni at (716) 218-9338 at least 24 hours prior to your appointment time. Cancellations with 24 hours notice will not be charged for rescheduling. All appointments canceled with less than 24 hours notice will be charged the full price of the appointment.

**PAYMENT OPTIONS:**

I accept payment by cash, check, or credit/debit card (MC/Visa). Upon request, a Superbill can be provided once a month for your submission to your insurance provider. There is a $40.00 fee for a bounced check and only one occurrence is permitted. If a second check bounces, I will require cash only payment from then on. I am pleased to have you as a client and hope you will soon share my passion for the benefits of acupuncture, herbs and nutrition. My goal is to support your body's natural healing process and assist you in improving your overall health and longevity.

Name _____

Today's Date _____

Address _____

City _____

State _____ Zip _____

E-mail address _____

Home phone _____ Work phone_____Cell _____

Birth Day _____ Age ____ Ht ____ Wt ____

Sex ☐ M ☐ F ☐ Trans ☐ MTF ☐ FTM

Marital Status _____ No. of Children _____

Occupation _____

Emergency Contact: Name _____Phone _____

Primary Care Practitioner _____ ---_____

How did you hear about us?

_____

Is this your first time getting acupuncture? ☐ Y ☐ N

What are the main health problems for which you are seeking treatment?

_____

_____

When did the problem begin? (Be Specific)

_____

_____

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

_____

Does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)? Describe.

_____

_____

_____

What other forms of treatment have you sought?

_____

Do you have any other health complaints or issues you'd like to address? ☐ Y ☐ N

If yes, please list and prioritize if possible.

_____

_____

_____

**MEDICAL HISTORY:**

Do you or have you had any of the following conditions? If yes, please indicate date of diagnosis.

Cancer (Type) _____HIV_____

Diabetes (Type)_____Mental/EmotionalIllness_____

Heart Disease _____Seizures _____

Hepatitis(Type)_____Stroke_____

High Blood Pressure _____ThyroidDisease_____

High Cholesterol _____Tuberculosis _____

Sexually Transmitted Disease: ☐ Gonorrhea ☐ Syphilis ☐ HPV ☐ Chlamydia ☐ Herpes

Date _____

Infectious Disease (Type)_____Other_____

Please list any surgeries or major injuries with dates.

_____

_____

_____

Please list any significant emotional traumas with dates.

_____

_____

_____

List any medications or supplements you have taken in the last 2 months.

_____

_____

_____

Do you have a pacemaker or any metal device in your body? ☐ Y ☐ N

**FAMILY HISTORY:**

Indicate close family members with any of the following.

Cancer (Type) _____High Cholesterol _____

Diabetes (Type 1 or 2) _____ Mental Illness _____

Heart Disease _____Stroke_____

High Blood Pressure _____ Alcoholism_____

**LIFESTYLE HABITS**

How many hours per night do you sleep on average? _____Do you wake rested? ☐ Y ☐ N
Nicotine Use

_____
Alcohol Use (#drinks per week and type)

_____
Caffeine Use (#drinks per week and type)

_____
Water Intake (how much per day)

_____

Briefly describe your dietary habits (#meals per day and type of food).

_____
_____
_____
Please list the emotion/s you feel most often (i.e. anxiety, joy, shame, fear, sad, dull, happy etc).

_____
Is there anything else you would like to share that you feel might be helpful in some way?

_____
_____
_____

**PLEASE CHECK ALL THAT APPLY:**

**Energy and immunity:**
☐ Fatigue ☐ Allergies (Specify) _____ _____
☐ Anemia ☐ Chronic Fatigue Syndrome
☐ Thyroid Problems ☐Tendency to Catch Colds

**Head, Eye, Ear, Nose, and Throat:**
☐ Eye Dryness ☐ Blurry Vision ☐ Poor Night Vision ☐ Ear Ringing ☐ Hearing Difficulties
☐ Headaches / Migraines ☐ Teeth Grinding / TMJ ☐ Sore Throat ☐ Chronic Sinus Congestion
☐ Dry Mouth ☐ Bad Breath ☐ Mouth Sores / Bleeding Gums ☐Increase in Thirst

**Respiratory / Cardiovascular:**
☐ Shortness of Breath ☐ Asthma ☐ Chest Pain ☐ Palpitation / Fluttering ☐ Poor Circulation (Cold hands/feet) ☐ Chronic Cough ☐ Night Sweats ☐ Unusual Sweating ☐ Hot/Cold Intolerance

**Gastrointestinal:**
☐ Ulcers ☐ Changes in Appetite ☐ Nausea / Vomiting ☐ Bloating / Pain ☐ Gas ☐ Heartburn / Acid Reflux ☐ Belching ☐ Hemorrhoids ☐ Diarrhea ☐ Constipation ☐ Sudden Weight Change

**Kidney / Urinary:**
☐Painful Urination ☐ Frequent Urinary Tract Infections ☐Frequent / Urgent Urination
☐ Edema/Swelling

**Musculoskeletal:**
☐Neck / Shoulder Pain ☐ Muscle Spasms / Cramps / Weakness ☐ Arm Pain ☐ Finger Pain / Tingling / Numbness ☐ Upper Back Pain ☐ Mid Back Pain ☐ Low Back Pain ☐ Leg / Knee Pain ☐ Foot / Ankle Pain ☐ Hip / Pelvic Pain ☐ Arthritis

**Neurological:**
☐Vertigo / Dizziness ☐ Numbness / Tingling ☐ Difficulty Concentrating / Poor Memory

**Skin:**
☐ Rashes / Eczema / Hives / Psoriasis ☐Dry Hair or Hair Loss ☐ Changes in Skin Color ☐Easy Bruising ☐ Acne ☐ Dry / Itchy Skin

**Uritiogenital Health:**
☐Irregular Cycle ☐ Heavy Flow ☐ Light Flow ☐ Clots in Menstrual Blood ☐ Menstrual Related Moodiness ☐ Menstrual Related Breast Tenderness ☐ Menstrual Related Bloating ☐ Bleeding Between Cycles ☐ Painful Periods ☐ Hot Flashes ☐ Vaginal Dryness ☐ Breast Lumps / Cysts
☐ Uterine Fibroids☐ Endometriosis ☐Ovarian Cysts ☐ Unusual Vaginal Discharge Odor ☐ Frequent Yeast Infections ☐ Decreased Libido

**Uritiogenital Health:**
☐ Prostate Enlargement ☐ Impotence ☐ Premature Ejaculation ☐ Decreased Libido ☐ Groin Pain

Our office is dedicated to providing services with respect for human dignity. Protecting your privacy and healthcare information is fundamental to our relationship with you. This notice will remain in effect until it is replaced or amended by changes in the law.
We gather personal information and health information in several ways:
• Information we receive from you
• Information we receive from other healthcare providers
• Information we receive from third party payers

Protected Health Information is any information that includes demographic information; information gathered by this office as it relates to your past, present, and future physical or mental health or condition; or past, present, or future payments for healthcare services.
You should be aware that during the course of our relationship with you, we will likely use and disclose health information about you for the treatment, and healthcare operations performed.

Without your consent or authorization, this office may disclose information about you only to the following groups for the specified purposes:
• to a public health agency, for a purpose such as controlling disease.
• in case of suspected child abuse, to the appropriate governmental authority.
• in other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.
• to health oversight authorities, for regulatory, licensing, and other legal purposes.
• in litigation, subject to certain requirements controlling the terms of the disclosure.
• to law enforcement agencies, subject to applicable legal requirements and limitations.
• for medical research purposes, subject to your authorization or approval by an institutional review board.
• if you are in the United States military, national security, or intelligence for Foreign Service, to your authorized superiors or other authorized federal officials.

We may not use or disclose information about you for any other purpose without your authorization, provided separately from your written consent. You may submit written authorization to disclose Protected Health Information to a person or group specified by you.

This notice summarizes how health data about you may be used and shared and how you can get access to this data.

Disclosure:
This office may use or disclose your Protected Health Information when required by law.
Patient Rights Upon written request, you have the right to access, review, or receive copies of your healthcare records. Upon written request, unless prohibited by law, you have the right to receive a list of items this office disclosed about your health care information.

More Information If you have any questions or complaints, or would like to receive more information, contact Toni Haugen (716) 218-9338, or at the address below.

NOTICE OF PRIVACY POLICIES
I, the undersigned, have received a copy of, read, reviewed, understand, and agree to the "Notice of Privacy Policies" for healthcare services from Toni Haugen L. Ac
Client Signature_____Date_____

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