Hilary Leitner Acupuncture and Massage

HILARY LEITNER, MS, LAC, LMT
74 PROSPECT PLACE
BROOKLYN, NY 11217
718-344-0745
hilaryleitner@yahoo.com
NYS Licensed and Board Certified

Initial Intake Form

Today's date ____/_____/_____

Thank you for taking the time to complete the following information which will help me assess your health needs. All information is confidential. I will be happy to answer any questions.

General Information

Name_____Birthdate_____/_____/_____ Age____

Gender_____

Address_____City_____

State_____Zip_____

Phone numbers (please mark * next to best number):

Home_____ Cell_____

Work_____

E-mail address_____

Marital Status_____# of children _____

their age(s)_____

Occupation _____Hrs per week_____

Employer & location _____

Emergency Contact

Name_____Ph_____Relationship_____

Under 18 ---Responsible Party Information

Name_____ Relationship to Patient_____

Healthcare Providers ---please list those you work with.

Physicians: GP/Primary Care: _____

Specialist (describe): _____

Chiropractor: _____

Massage Therapist:_____

Physical Therapist:_____

Psychotherapist:_____

Personal Trainer:_____

Midwife:_____

Other:_____

May I contact these providers to ensure coordination of your care? □ Y □ N

Previous experience with acupuncture? □ Y □ N

With whom and results_____

Health History

Please list your major health concerns in order of importance to you:

_____
_____
_____
_____

Check those that apply to your past medical history:

□ Adverse reaction to medical treatment □ Allergies □ Asthma □ Birth Trauma □ Blood disease □ Diabetes □ Eating disorder □ Heart disease □ Immune disorder □ Joint replacement □ Kidney disorder □ Low blood pressure □ Lyme's disease □ Polio □ Rheumatic arthritis □ Special diet □ Stroke □ Substance abuse □ Thyroid disease □ Tuberculosis □ Ulcer □ Venereal Disease/STD	□ Alcoholism □ Arthritis or rheumatism □ Attempted suicide □ Bleeding disorder □ Cancer or tumor □ Emphysema □ Fibromyalgia □ Hepatitis/Liver disease □ Herpes □ High blood pressure □ HIV/AIDS □ Lymph nodes removed □ Mental illness □ Multiple Sclerosis □ Pacemaker □ Rheumatic fever □ Sciatica □ Scarlet fever □ Seizures/Epilepsy □ Sinus infections □ Skin disease □ Other_____

List any serious diseases, injuries, surgeries, or hospitalizations you have had and the year they occurred:

_____
_____
_____

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had (e.g. divorce, injury, family death, bankruptcy, etc).

Date____/_____Event_____

Date____/_____ Event_____

Date____/_____Event_____

Date____/_____ Event_____

Family History (List any family physical or mental illnesses and age of death):

Mother_____

Father_____

Grandparents_____

Siblings_____

Children_____

Medications, Herbs, Supplements (List those you are currently taking):

Name_____Reason _____

How long and Dose_____

Name_____Reason _____

How long and Dose_____

Name_____Reason _____

How long and Dose_____

Name_____Reason _____

How long and Dose_____

Lifestyle Habits

Describe your typical daily diet:
Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Special diet_____

3 worst foods you eat_____

Do you:	Yes	No	
Average 6-8 hours sleep?			What is the major source of joy in your life? _____ _____ _____ What is the major source of stress in your life? _____ _____ _____
Have a supportive relationship?			
Have a history of abuse?			
Enjoy your work?			
Take vacations?			
Spend time outside?			
Exercise?			Describe exercise: _____
Watch TV?			How many hours weekly?
Read Books?			How many hours weekly
Computer games/browsing?			How many hours weekly
Spiritual/religious practice?			Describe:
Smoke cigarettes?			How much?
Smoke cigarettes in the past?			How many years? How many packs?
Eat out often?			How many meals a week?
Drink coffee?			How many cups a day?
Drink tea?			How many cups a day?
Drink soft drinks?			How many a day?
Use sugar?			How much?
Drink alcohol?			How many drinks a week?
Use recreational drugs?			What and how often?
Have an addiction?			To what and how long?
Been outside the U.S. in past 12 months?			Where?

What are your goals for your health?

_____
_____
_____
_____

Please circle your level of commitment to correcting your health issues? (10 = highest level) 1 2 3 4 5 6 7 8 9 10

Tests and Immunizations

Please list the date of your most recent visit:

Chest X-ray _____ Mammogram _____ GI Series _____

Sigmoidoscopy _____ TB Skin Test _____ Flu Shot _____

EKG _____ Stool Blood Test _____
Pap Smear _____ Complete Physical _____

Pneumonia Shot _____ Other _____

Please mark the appropriate squares in the following list of symptoms.

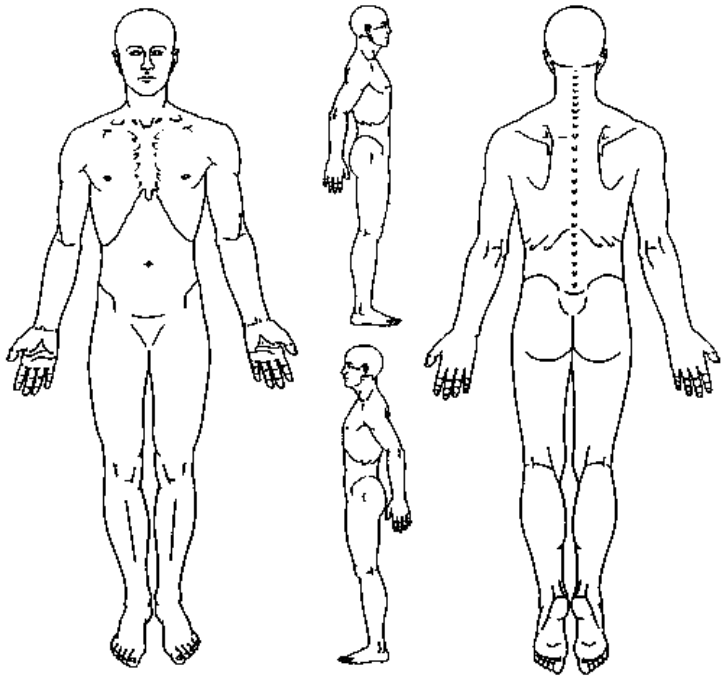
If you have had a symptom in the PAST and do not have it now, check the box like this: ☑

If you are having the symptom CURRENTLY, fill in the box like this: ■

Liver/Gallbladder	Heart/Small Intestine
□ Depression / Stress □ Headaches / Migraines □ Red / Dry / Itchy Eyes □ Visual Problems / Blurred Vision □ Dizziness □ Gall Stones □ Feeling of Lump in Throat □ Clenching Teeth at Night □ Muscle Cramping / Twitching □ Neck/Shoulder Pain / Tightness □ Seizures/Tremors □ Poor Circulation □ Soft/Brittle Nails □ Bitter Taste in Mouth □ PMS/Menstrual Problems □ Tendonitis □ Pain Below Ribcage □ Do you crave: Sour □ Tend to be Irritable / Angry	□ Heart Palpitations □ Rapid or Irregular Heartbeat □ Chest Pain □ High Blood Pressure □ Low Blood Pressure □ Insomnia / Sleep Problems □ Vivid Dreams / Nightmares □ Easily Startled □ Dark Urine □ Red Complexion □ Do you crave: Bitter □ Anxiety / Nervous or Restless
Spleen/Stomach	Lung/Large Intestine
□ Body Heaviness □ Hard to get up in Morning	□ Bloody Cough □ Dry Cough

□ Muscles Often Feel Tired ___ Energy Level: 1-10 (low to high) □ Edema(□Hands □Feet) □ Easily Bruising / Bleeding □ Bad Breath □ Sweetish Taste in Mouth or Lack of Thirst (circle which) □ Nausea / Vomiting □ Gas / Belching □ Hemorrhoids □ Organ Prolapse (i.e. uterus) □ Chronic Loose Stools □ Abdominal Pain □ Indigestion / Heartburn □ Lack of Taste □ Excess or Low Appetite (circle which) □ Brain Foggy □ Mouth Ulcers □ Tendency to Gain Weight □ Do you crave: Sweet □ Over-thinking / Worry	□ Chronic Cough □ Cough with Sputum □ Nasal Discharge □White □Yellow □Green □ Post Nasal Drip □ Sinus Infection / Congestion □ Itchy, Red, or Painful Throat □ Dry Mouth / Nose / Throat □ Skin Rashes / Hives □ Snoring □ Shortness of Breath □ Allergies / Asthma □ Low Immunity □ Catch Colds Easily □ Bronchitis □ Black or Bloody Stools □ Constipation □ IBS □ Diarrhea □ Colitis / Spastic Colon □ Do you crave: Pungent / Spicy □ Grief / Sadness
Kidney/Urinary Bladder □ Urinary Problems (i.e. night-time) _____ □ Bladder Infection □ Incontinence □ Weakness / Pain in Low Back □ Osteoporosis □ Feel Cold or Hot Easily (circle which) □ Cold Hands / Feet □ Low or Excess Sex Drive (circle which) □ Dark Circles under Eyes □ Thyroid Problems _____ □ Poor Memory □ Hair Loss / Grey Hair □ Hearing Problems / Tinnitus □ Cavities □ Hot Flashes / Night Sweats □ Impotence or Premature Ejaculation (circle which) □ Do you crave: Salt □ Fear	

PAIN: please indicate on the figures below the areas of the body you experience pain:



How would you characterize your pain (circle all that apply):
dull/achy sharp/stabbing burning tingling numbness electrical superficial deep shooting
The pain is (circle all that apply):
better/worse with heat better/worse with cold better/worse with pressure
better/worse with movement better/worse with rest worse in am/pm

Treatment Terms and Conditions
The following are specific policies that will govern our work together:

Cancellation Policy

In the event that you must cancel an appointment, please give me the courtesy of as much notice as you can, but at least 24 notice. I will try to reschedule your appointment for the same week so that you don't miss your treatment. You will be charged the full fee for your session if you do not show up for your appointment or cancel your appointment with less than 24 hours notice (1 full day).

Late Policy

If you are going to be late, please call and let me know and I will wait until the time we agree upon. If you do not give notice, I will wait 15 minutes beyond the start time of your appointment. If you have not arrived by then your appointment will be cancelled and you will be responsible for the full payment of the session.

Confidentiality and Privacy Practices

As a health care provider, we are required by law to maintain and protect the confidentiality of your health information. You must give us written consent to waive this confidentiality. Exceptions to this rule are strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, law enforcement activities, obtaining payment from third-party payers, and in consultation with other healthcare professionals. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. Your rights to privacy regarding your protected health information:

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.

Fees

It is my policy that you pay the entire session fee or co-pay at the time of each session. If you would like to arrange another payment option, please discuss it with us. We will provide a minimum of one month's notice of any changes to our fees.

We are partners in your healthcare.

Your participation in your healing process is crucial. My goal is to get you well as soon as possible, which requires that you apply our health recommendations and comply with my treatment plan.

Agreement

I have read and understood the clinic's policies. *I agree to the all of the above treatment terms and conditions.*

Signature: _____ Date:_____

Informed Consent & Disclosure

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, herbal medicine, moxibustion, cupping, electrical stimulation, medical qigong,

massage, gua sha, heat therapy, ear seeds, dietary advice, qigong exercise prescriptions, and lifestyle counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Very unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential but unlikely risks of moxibustion are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I also understand that certain social habits and medications may decrease the beneficial effects of Chinese medical treatment. These include the use and abuse of alcohol, pain killers, steroids, narcotics, tobacco, anti-depressants, and illegal drugs.

Acupuncture is a natural medicine that works with the body's ability to heal itself, but is not a substitute for conventional medical diagnosis and treatment. The results of acupuncture are not always felt immediately, especially with chronic conditions. Frequent, regular treatment is what gives acupuncture and herbs the best results.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her updated on any changes.

_____Patient Signature _____Date