Greenfield Community Acupuncture, LLC
278 Main St, Suite 404
Greenfield, MA 01301

413-992-8877
www.tryGCA.com

Registration Form

Please print your information to the best of your ability.	**D.O.B.** / /
	Gender:
	Pronouns:
Name:	
Street:	**Apt #:**
City:	**State:** **Zip;**
Tel (Home) **(Work)** **(Cell)**	
Email:	
Occupation:	
Emergency contact:	**Relationship:**
Address:	
Tel (Home) **(Work)** **(Cell)**	
Primary Care Physician:	**Tel:**
How did you learn about GCA? ***Please let us know if someone referred you – we'd like to thank them!***	

Signature: **Date:** /

GREENFIELD COMMUNITY ACUPUNCTURE, LLC

HEALTH HISTORY

NAME:_____

What are your *3 main reasons* for seeking treatment?	**Check symptoms you have or have had in the last year:** ❑ Depression ❑ Difficulty in focusing ❑ Dizziness ❑ Easily startled ❑ Excessive worry ❑ Excessive anger ❑ Excessive fear ❑ Fatigue/tiredness ❑ Headaches ❑ Loss of sleep/poor sleep ❑ Unusual loss of weight ❑ Unusual gain of weight ❑ Nervousness/irritability ❑ Overwhelmed by life
1. **Date problem began:** **Rate on a scale of 1 (mild) to 10 (unbearable)**	
2. **Date problem began:** **Rate on a scale of 1 (mild) to 10 (unbearable)**	**List all known allergies:**
3. **Date problem began:** **Rate on a scale of 1 (mild) to 10 (unbearable)**	**Yesterday, what did you eat for:** **Breakfast** **Lunch**
When was your last complete medical exam?	**Dinner** **Snacks**

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

- ❑ Tremors
- ❑ Cramps
- ❑ Swollen joints

Pain/weakness/numbness in:

- ❑ Arms
- ❑ Hips
- ❑ Ankles
- ❑ Knees
- ❑ Back
- ❑ Feet
- ❑ Hands
- ❑ Neck
- ❑ Shoulders
- ❑ Elbows
- ❑ Herniated disks
- ❑ Other: _____

EYES/EARS/NOSE/THROAT/HEAD

- ❑ Sinus problems
- ❑ Earache/infections
- ❑ Loss of hearing
- ❑ Ringing in the ears
- ❑ Dry throat/hoarseness
- ❑ Enlarged glands
- ❑ Eye pain
- ❑ Blurred or failing vision
- ❑ Floaters
- ❑ Gum trouble
- ❑ Nose bleeds
- ❑ Headaches
- ❑ Jaw tightness/TMJ
- ❑ Grinding teeth
- ❑ Migraines
- ❑ Other: _____

RESPIRATORY

- ❑ Asthma/wheezing
- ❑ Bronchitis
- ❑ Tuberculosis
- ❑ Difficulty breathing
- ❑ Frequent colds
- ❑ Persistent cough
- ❑ Allergies
- ❑ Currently a smoker

SKIN

- ❑ Bruise easily
- ❑ Dry skin
- ❑ Itching/rash
- ❑ Sensitive skin
- ❑ Sore that won't heal
- ❑ Boils
- ❑ Excessive sweating
- ❑ Eczema
- ❑ Cysts
- ❑ Infectious skin disease
- ❑ Acne
- ❑ Psoriasis

GENITO/URINARY

- ❑ Blood/pus in the urine, dark urine
- ❑ Frequent urination
- ❑ Painful urination
- ❑ Inhibited urination
- ❑ Inability to control urine
- ❑ Kidney infection/stones
- ❑ Lowered libido
- ❑ Frequent UTIs
- ❑ Vaginal dryness
- ❑ Painful intercourse
- ❑ STIs:_____

CARDIOVASCULAR

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest pain
- ❑ Hardening of the arteries
- ❑ Poor circulation
- ❑ History of heart attack
- ❑ Irregular heartbeat
- ❑ Palpitations
- ❑ Swelling of ankles
- ❑ History of stroke
- ❑ High cholesterol
- ❑ Blood thinning medications
- ❑ Anemia
- ❑ Cold hands and/or feet
- ❑ History of blood clots
- ❑ History of excessive bleeding
- ❑ Other:_____

GASTROINTESTINAL

- ❑ Belching
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficulty swallowing
- ❑ Bloating
- ❑ Gas
- ❑ Gas pain
- ❑ Excessive hunger
- ❑ Gallstones
- ❑ Hemorrhoids
- ❑ Indigestion/heartburn
- ❑ Nausea
- ❑ Pain over the stomach
- ❑ Poor appetite
- ❑ Vomiting
- ❑ Food sensitivities/intolerances
- ❑ Type I diabetes
- ❑ Type II diabetes
- ❑ Ulcers
- ❑ Disordered eating
- ❑ Cravings
- ❑ Frequent thirst

SLEEP

- ❑ Trouble falling asleep
- ❑ Snoring
- ❑ Wake during the night
  How often? _____
- ❑ Sleep apnea
- ❑ Restless sleep
- ❑ Groggy in the morning

Number of hours of sleep: _____

MENTAL AND EMOTIONAL

- ❑ Drug abuse
- ❑ Alcohol abuse
- ❑ Anxiety
- ❑ Depression
- ❑ Anger
- ❑ Irritability/short temper
- ❑ Panic attacks
- ❑ Withdrawn/unmotivated
- ❑ Poor memory
- ❑ Suicide attempts
- ❑ Easily worried
- ❑ High stress
- ❑ Other

MENSTRUAL/UTERINE

Age of first period: _____
Length of bleeding: _____
Length between cycles:_____
Date of last period: _____
Age at menopause: _____
pregnancies: _____
live births: _____
What kind of birth control do you practice, if any: _____
Is it possible that you are pregnant: _____
Do you plan to become pregnant in the next 3 months: _____

- ❑ Endometriosis
- ❑ Vaginal discharge
- ❑ Painful menstruation
- ❑ PMS
- ❑ Hysterectomy
- ❑ Breast lumps
- ❑ Heavy menstruation
- ❑ Difficult pregnancy/childbirth
- ❑ Recurrent yeast infections
- ❑ Polycystic ovarian syndrome
- ❑ Light menstruation
- ❑ Irregular cycles
- ❑ Bleeding between periods
- ❑ Cyclic emotional swings
- ❑ Cyclic bowel changes
- ❑ Cyclic migraines

PROSTATE/PENILE

- ❑ Erectile dysfunction
- ❑ Prostate disease/enlarged prostate
- ❑ Penile discharge
- ❑ Premature ejaculation
- ❑ Testicular masses/pain
- ❑ Hernia
- ❑ Vasectomy

OTHER CONDITIONS

- ❑ Multiple Sclerosis
- ❑ Cancer
- ❑ Epilepsy/seizure disorder
- ❑ Autoimmune disorder
- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ Implanted device/metal plate
- ❑ Other:

Name of Medication	Date Began Taking	Dose and Frequency	Reason for Taking	Side Effects for you, if any

List serious illnesses, accidents or surgeries, with dates:

Is there anything else you would like us to know?

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature: _____ Date: _____

GREENFIELD COMMUNITY ACUPUNCTURE, LLC

Please sign the form below. Treatment will not be performed without your signed consent.

CONSENT FORM FOR ACUPUNCTURE TREATMENTS

I, the undersigned, hereby authorize the Licensed Acupuncturists at Greenfield Community Acupuncture, LLC to perform the following specific procedures on me (or on the patient listed below, for whom I am legally responsible):

> **Acupuncture**: insertion of special sterilized needles through the skin into the underlying tissues at specific points on the surface of the body.
>
> **Cupping:** the use of vacuum cups on acupuncture points.
>
> **Gua sha:** scraping of the muscles.

I understand that acupuncture is a generally safe method of treatment, but may have some side effects as described below.

> **Potential benefits**: drugless relief of presenting symptoms and improved balance of bodily energies which may lead to prevention or elimination of the presenting problem.
>
> **Potential risks**: discomfort, pain, infection and blistering at the site of procedure, temporary discoloration of aggravation of symptoms existing prior to the acupuncture treatment. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Bruising is a potential side effect of gua sha and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.
>
> **Pregnancy:** Acupuncture can be very beneficial in the treatment of symptoms during pregnancy. I will notify my acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points that could induce premature labor or miscarriage.

Acupuncture treatment is not a replacement for diagnostic medical procedures. An acupuncturist does not diagnose according to standard medical practice, nor should a 'Chinese diagnosis' be considered a replacement for standard medical evaluation or testing. If you have any concerns about what may be causing your symptoms, you must see a medical doctor.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the Licensed Acupuncturists at Greenfield Community Acupuncture, LLC regarding cure or improvement of my condition.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions

about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I hereby release the Licensed Acupuncturists at Greenfield Community Acupuncture, LLC from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care.

_____

Patient or Patient Representative Signature **Date**

_____

Relationship to patient

_____

Office Signature **Date**

GREENFIELD COMMUNITY ACUPUNCTURE, LLC

PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION

Your health information in this office will not be shared with anyone who does not require it. We will use and communicate your health information only for the purpose of providing treatment, obtaining payment, and conducting health care operations. Your personal information will not be used for any other purposes, unless we have asked for and been given your written permission.

Your health information will be used to:

- **Provide treatment.** We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between therapist and office staff. We may share your health information, when appropriate, with referring physicians, clinical and pathology laboratories, or other health care personnel providing treatment to you, with your written permission.

You have the right to:

- **Inspect and copy your health care information.** You may read, review and copy your health information, including your chart and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a small fee to duplicate and assemble your copy.
- **Amend your health information.** You may ask us to update or modify your records if you believe that they are incorrect or incomplete. We will accommodate your request as long as our office maintains this information. Please make your request in writing, and inform us of the reason for the change, in detail. Your request may be denied if the health information requested was not created by our office, is not part of our records or if the records pertaining to your health information are determined to be accurate and complete.
- **Receive documentation of your health information.** You may ask for a description of how and where your health information was used by our office for any reason other than treatment or payment or healthcare operations. We will be able to provide this information as long as it is not older than seven years.
- **Request a paper copy of this notice**. You may obtain a copy of this privacy policy notice for your records at any time.

Patient acknowledgement:

Signature: _____ Date: _____

Office initials and date: _____

GREENFIELD COMMUNITY ACUPUNCTURE, LLC

SPECIAL PRIVACY NOTICE FOR GROUP TREATMENT (COMMUNITY ACUPUNCTURE)

Because patients are so close to each other during treatment, it is very important that we all make an effort to respect one another's privacy. We can do this by keeping our voices to a whisper, and by not speaking about what we have seen or heard about another's treatment to anyone else.

Privacy Consent for Group Treatment
I consent to receive acupuncture treatment from the Licensed Acupuncturists at Greenfield Community Acupuncture, LLC in a group setting. I understand that it is more difficult to maintain complete privacy in this setting, and that it is possible that other people will overhear conversations between me and my acupuncturist. I understand that I can choose not to mention, or have my acupuncturist not mention, any sensitive health information in the group treatment room. This sensitive information can be addressed in writing or in private. I understand that my written health record will remain confidential regardless of the setting in which I am treated.

Initials: _____

FINANCIAL POLICY

Payment is due at the time of treatment. We accept checks, cash, debit & credit cards, FSA/HSA cards, and Common Good cards. Checks can be made out to: G.C.A.

We make every attempt to make acupuncture available to as many people as possible at the most affordable rates. In respect for this, we ask for 24 hours notice in advance of an appointment if it is necessary to cancel or reschedule an appointment.

Late cancellations (canceled less than 24 hours before appointment time) and missed appointments with no notice are subject to a cancellation fee.

We do not accept/process insurance. However, if your health insurance, auto insurance or worker's compensation covers acupuncture treatments, we are happy to provide you with a detailed receipt to submit for reimbursement. Acupuncture is also considered a qualified medical expense under Flexible Spending Account and Health Savings Account plans.

Thank you for your understanding.

I agree to the above policy.

Signature: _____ **Date:** _____

Office initials and date: _____

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all eight places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could include receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, similar to other healthcare professionals, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- Have you ever tested positive for the COVID-19 virus? ☐ Yes ☐ No
  If Yes, date diagnosed? _____
  Did you require hospitalization? ☐ Yes ☐ No _____
- Have you received the COVID Vaccine? ☐ Yes ☐ No
  If Yes, which Vaccine? _____ **Please provide a copy of your Vaccination Card*
  Date of 1st dose? _____ If Pfizer Vaccine: Date of 2nd dose? _____ _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

BOTH PARTIES AGREE THAT THIS AGREEMENT MAY BE ELECTRONICALLY SIGNED, AND THAT THE ELECTRONIC SIGNATURES APPEARING ON THIS AGREEMENT ARE THE SAME AS HANDWRITTEN SIGNATURES FOR THE PURPOSES OF VALIDITY, ENFORCEABILITY, AND ADMISSIBILITY.

Patient or Guardian Signature:	_____	Witness Signature:	_____
Name:	_____	Name:	_____
Date:	_____	Date:	_____