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

413-992-8877
www.tryGCA.com

HEALTH HISTORY 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?			

Signature: **Date:**

GREENFIELD COMMUNITY ACUPUNCTURE, LLC

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**
When was your last complete medical exam?	**Lunch** **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 use
- ❑ Alcohol use
- ❑ 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
- ❑ PCOS
- ❑ 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

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 acknowledgment:

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: _____

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include 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.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. 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.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

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ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE