

CONFIDENTIAL PERSONAL INFORMATION

Adult Intake Form

Full Legal Name	_____		
	Last Name	First Name	Middle Initial
Address	_____		
	Street/PO Box	City	State Zip Code
Telephone	_____		
	Home	Work	Cell Phone
E-mail address	_____		
Emergency Contact	_____		
	Name	Telephone	Relationship
Date of Birth _____	Age _____	Female _____	Male _____
Single _____	Married _____	Other _____	Partner's Name _____
Occupation _____	Full time	Part time	Student Retired
Is there a number you prefer me NOT to leave a message? _____			
Who is your primary care physician?			

Doctor's Name	Name of Practice	Telephone if Known	
For what concern did you last receive health or medical care? _____			

MAIN CONCERNS

What are the concerns for which you are seeking care?

1. _____ Date of onset _____
2. _____ Date of onset _____
3. _____ Date of onset _____
4. _____ Date of onset _____

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

FAMILY HISTORY

	Father	Mother	Brother	Sister	Children	Maternal GParent	Paternal GParent
Age if Living							
Current Health							
Age at Death							
Cause of Death							

Indicate if you or your family has had any of the following diseases.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Alzheimer's Dz | <input type="checkbox"/> High Blood Pressure | |

PAST MEDICAL HISTORY

Indicate if you have had any of the following Childhood Illnesses.

Scarlet fever Diphtheria Rheumatic Fever Mumps German measles Mono

Have you had any immunizations? Yes No

Have you had any negative reactions from immunizations? _____

HOSPITALIZATIONS, SURGERY, X-RAY AND SPECIAL STUDIES

What hospitalizations, surgeries, x-rays, or special studies have you had?

- | | |
|---------------------|---------------------|
| 1. _____ Year _____ | 4. _____ Year _____ |
| 2. _____ Year _____ | 5. _____ Year _____ |
| 3. _____ Year _____ | 6. _____ Year _____ |

INFECTIOUS DISEASES

Do you have any known contagious diseases at this time? Yes No

If yes please list: _____

ALLERGIES

Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list.

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

REVIEW OF SYMPTOMS

SKIN

- Rashes
- Eczema, Hives
- Acne, Boils
- Itching
- Fungal Infections
- Color change
- Hair Loss
- Dry skin/ scalp
- Lumps
- Night Sweats
- Slow healing ulcerations
- Flushing or hot flashes
- Excessive sweating

NOSE AND SINUSES

- Frequent colds
- Nose Bleeds
- Stuffiness
- Hay fever
- Sinus problems
- Loss of smell
- Loss of balance

EYES AND EARS

- Itchy eyes
- Watery eyes
- Dry eyes
- Swollen/ painful eyes
- Red Eyes
- Impaired vision/ Blurriness
- Floaters in vision
- Cataracts
- Color blindness
- Double Vision
- Glaucoma
- Hearing difficulty
- Ringing
- Earaches/ Infection
- Cold hands/ feet

MOUTH AND THROAT

- Sore throat
- Copious saliva
- Teeth grinding
- Sore tongue/ lips
- Gum problems
- Hoarseness
- Gagging/choking
- Difficulty swallowing

HEAD/ NECK

- Headache/ migraine
- Faintness
- Dizziness
- Jaw Pain
- Goiter
- Pain or stiffness
- TMJ

RESPIRATORY

- Chest congestion
- Wheezing
- Asthma
- Bronchitis/ Pneumonia
- Emphysema
- Difficulty/ Pain breathing
- Shortness of breath
- Tuberculosis
- Cough ___ Wet or ___ Dry
- Coughing blood

CARDIOVASCULAR

- Heart disease
- Angina/ Chest pain
- High/ Low Blood Pressure
- Murmurs
- Blood clots
- Irregular heart beat
- Palpitations/ Fluttering
- Swelling in ankles
- Color blindness

CIRCULATION

- Easy bleeding or bruising
- Anemia
- Deep leg pain
- Varicose veins
- Hemorrhoids
- Itchy/ Burning Anus

ENDOCRINE

- Hypothyroid
- Heat or cold intolerance
- Hypoglycemia
- Diabetes
- Excessive thirst
- Excessive hunger
- Fatigue
- Seasonal depression

IMMUNE

- Chronic Fatigue Syndrome
- Chronic infections
- Chronically swollen glands
- Slow wound healing

MUSCLES/ JOINTS/ BONES

- Joint pain
- Muscle pain
- Muscle spasms/ cramps
- Restless leg Syndrome
- Sciatica
- Osteoporosis

NEUROLOGIC

- Seizures
- Paralysis
- Muscle weakness
- Numbness or tingling
- Easily stressed
- Vertigo or dizziness
- Loss of balance
- Tics

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

REVIEW OF SYMPTOMS

Check any of the following you have or have had in the past.

DIGESTION

- Trouble swallowing
- Heartburn/ Acid Reflux
- Change in thirst/ appetite
- Ulcer
- Nausea/ Vomiting
- Gas/ Bloating
- Belching or passing gas
- Diarrhea
- Constipation
- Pain or cramps
- Mucous in stools
- Black/ Bloody stool
- Hemorrhoids
- Itchy/ Burning Anus
- Rectal Pain
- Liver/ Gall Bladder trouble
- Jaundice (yellow skin)
- Bowel Mvnt. How often? _____
- Is this a change? _____
- Stools Hard Firm
 Soft Loose

URINARY

- Pain on urination
- Increased frequency
- Frequency at night
- Frequent infections
- Inability to hold urine
- Kidney stones
- Blood in urine

MALE ONLY

- Hernias
- Testicular masses
- Testicular pain
- Prostate disease
- Sexually transmitted disease
- Discharge or sores

MALE ONLY

- Sexual dysfunction
- Are you sexually active? Yes No
- Sexual orientation? _____
- Birth control? Type? _____

FEMALE ONLY

- Irregular cycles
- Bleeding between cycles
- Pain during intercourse
- Clotting
- Heavy or excessive flow
- PMS
- Endometriosis
- Difficulty conceiving
- Painful menses
- Vaginal discharge? Color? _____
- Vaginal Odor
- Ovarian cysts
- Menopausal symptoms
- Abnormal PAP
- Sexually transmitted disease
- Breast pain/tenderness
- Nipple discharge
- Breast Lumps

- Age at which menses began _____
- Age of last menses (if menopausal) _____
- Length of Cycle _____
- Duration of Flow _____
- Date of last period _____
- Are you sexually active? Yes No
- Sexual orientation? _____
- Birth control? Type? _____
- Number of pregnancies _____
- Number of live births _____
- Number of miscarriages _____
- Number of abortions _____
- Difficult or premature births

FEMALE ONLY

- Do you do breast self-exams? Yes No
- Date of last Pap smear _____
- Date of last mammogram _____
- Could be pregnant now? Yes No
- Any other feminine difficulties? _____

MENTAL/ EMOTIONAL

- Mood Swings
- Anxiety or nervousness
- Considered/Attempted suicide
- Depression
- Poor concentration
- Poor Memory
- Other _____

GENERAL

- Poor Sleep/ Insomnia
- Dream disturbed Sleep
- Fatigue/ Low Energy
- General feel Hot
- General feel Cold
- Chills
- Fevers
- Poor Appetite
- Constant Hunger
- Low Libido
- High Stress
- Cravings _____
- Peculiar taste in mouth _____
- Coffee How much _____
- Alcohol How much _____
- Cigarettes How many _____

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

LIFESTYLE

- | | |
|---|--|
| <input type="checkbox"/> Weight | <input type="checkbox"/> Drink coffee |
| <input type="checkbox"/> Height | <input type="checkbox"/> Drink black or green tea |
| <input type="checkbox"/> Average 8 hrs of sleep | <input type="checkbox"/> Drink cola or soda |
| <input type="checkbox"/> Have a supportive relationship | <input type="checkbox"/> Enjoy your work |
| <input type="checkbox"/> History of abuse | <input type="checkbox"/> Spend time outside |
| <input type="checkbox"/> Major trauma | <input type="checkbox"/> Watch TV? How much? _____ |
| <input type="checkbox"/> Use recreational drugs | <input type="checkbox"/> Read? How often? _____ |
| <input type="checkbox"/> Treated for drug dependence | <input type="checkbox"/> Use tobacco currently |
| <input type="checkbox"/> Use Alcoholic beverages? How much? _____ | <input type="checkbox"/> Used tobacco in the past |
| <input type="checkbox"/> Treated for alcoholism | <input type="checkbox"/> How many Years? |
| <input type="checkbox"/> Do you exercise | <input type="checkbox"/> How many packs? |

How often do you exercise? _____

What kind of exercise? _____

List your main interests and hobbies

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |

MEDICATIONS AND SUPPLEMENTS

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking?

- | | |
|---------------------|----------------------|
| 1. _____ Dose _____ | 6. _____ Dose _____ |
| 2. _____ Dose _____ | 7. _____ Dose _____ |
| 3. _____ Dose _____ | 8. _____ Dose _____ |
| 4. _____ Dose _____ | 9. _____ Dose _____ |
| 5. _____ Dose _____ | 10. _____ Dose _____ |

Check each that you currently use:

- | | | | |
|--------------------------------------|--|---|------------------------------------|
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Thyroid Medication | <input type="checkbox"/> Pain Reliever | <input type="checkbox"/> Cortisone |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Heart/ Blood Medication | <input type="checkbox"/> Allergy Medicine | <input type="checkbox"/> Antacids |

.....
By signing below, I verify that the above information is correct and true to the best of my knowledge.

Patient Name (Please print) _____

Patient Signature _____

Legal Guardian Signature _____

Today's Date _____

OPTIONAL CONTEXT OF CARE OVERVIEW

I would like to take a moment to welcome you to New Leaf Holistic Health. Whether you are here for a one-time visit, or are looking for a longer-term comprehensive health solution, I look forward to my role in your care. Below are a few questions that will assist me in understanding how I can best support your health.

- 1) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

If you answered less than "10", what stands between your current commitment and 100%?

- 2) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)
- 3) What do you love most about your life at this time?
- 4) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list)
- 5) What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols which I will be sharing with you?
- 6) What are your top three expectations of me?

NOTICE OF PRIVATE PRACTICES

PATIENT RIGHTS

Right to request restrictions on uses and disclosures. To request a restriction, please write a request to New Leaf Holistic Health. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.

Right to receive confidential communications. This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via Email than by regular mail. To verify or modify where or how you would like communication sent, contact New Leaf Holistic Health. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record.

Right to inspect and copy. Includes the rights to see and get copies of your information that we maintain. Submit your request in writing to New Leaf Holistic Health and we will respond to you within 30 days of receipt of your written request.

Right to amend. If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to New Leaf Holistic Health. We will respond within 30 days of receipt of your written request. We may deny your request in writing if your information is 1) correct and complete, 2) not created by us, 3) not allowed to be disclosed, or 4) not part of our records. Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information.

Right to receive an accounting of disclosures. This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 30 days of receiving written request. Please include the time period for which you want the accounting (can be no longer than 6 years and may not include dates before April 14, 2003). The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee in advance.

Right to get a paper copy of this Notice. At any time even if you previously agreed to receive an electronic copy.

Right to file a complaint. If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us. Contact Ne Leaf Holistic Health to file a complaint. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with us or the DHHS.

I acknowledge having carefully read this copy of the Notice of Privacy Practices.

Patient Name (Please print) _____

Patient Signature _____

Legal Guardian Signature _____

Today's Date _____

Note: if this acknowledgement is being signed by a legal representative, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.

NEW LEAF HOLISTIC HEALTH FINANCIAL POLICIES

Unless prior arrangement is made, full payment is appreciated at the time of service.

- Your payment options are: cash, check, or credit/debit cards.
- We accept Visa, MasterCard, and Discover.
- Twenty-four hour cancellation notice is appreciated.

Insurance Billing

- If you would like us to bill your insurance, we will contact your insurer(s) and bill them based upon the **non-guaranteed** information they provide to us.
- You are responsible for all co-payments, deductibles and other adjustments made by your insurer(s).
- Insurance companies may reimburse differently than the information they initially provide to us.
- **You are responsible for and will be billed for any resulting unpaid balance.**

Past Due Accounts

- **Accounts greater than 30 days past due will be charge a \$5.00/month administrative fee.**
- **Accounts greater than 90 days overdue will be sent to a collections agency.**

Below is our Fee Schedule

- **New Patient**

Initial Naturopathic Consultation 90 Min	175.00
Focused Naturopathic Consultation 55 Min	105.00
Acute Naturopathic Consultation 35 Min	75.00
- **Established Patient**

Follow Up Visit 55 Min	75.00
Focused Follow Up Visit 35 Min	55.00
Brief Follow Up Visit 25 Min	45.00
- **Acupuncture**

Acupuncture Or Cupping 55 Min	75.00
Three Acupuncture Or Cupping Visits	195.00
- **Therapeutic Massage**

Sixty Minutes Massage	75.00
Ninety Minutes Massage	100.00
- **Hydrotherapy**

Single Hydrotherapy	85.00
Three Hydrotherapy	225.00

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I have read, understood and agree to the policies described above.

Patient Name (Please print) _____

Patient Signature _____

Legal Guardian Signature _____

Today's Date _____

INFORMED CONSENT

ILEANA TECCHIO N.D., L.Ac., Dipl.Ac., M.S.O.M.

Ileana Tecchio N.D., L.Ac. is licensed to practice acupuncture by the state of New York. Ileana Tecchio N.D., L.Ac. is licensed to practice Naturopathic Medicine by the state of Vermont. She is Board Certified in Oriental Medicine by the National Certification Commission for Colleges of Acupuncture and Oriental Medicine (NCCAOM). Ileana Tecchio N.D., L.Ac. has a Master degree in the Science of Oriental Medicine and a Doctorate degree in Naturopathic Medicine from the National College of Natural Medicine. She is a member of the American Association of Naturopathic Physicians. Ileana Tecchio N.D., L.Ac. use disposable-sterilized needles. She has passed the "Clean Needle Technique" examination of the Council of College of Acupuncture and Oriental Medicine (CCAOM). Ileana Tecchio N.D., L.Ac. does not provide after hour services, and in case of an emergency I understand I should contact the appropriate licensed health care provider.

Naturopathic Medicine in the state of New York

A Naturopathic Doctor is trained as a primary care provider and is a board-certified physician in states where licensure is applicable. **However, currently licensure for Naturopathic Doctors is not available in the state of New York.** Therefore, Ileana Tecchio N.D., L.Ac. does not practice medicine, and does not diagnose or treat diseases or medical conditions in the state of New York. In the state of New York Ileana Tecchio N.D., L.Ac. focuses her practice on the enhancement of health. The services Ileana Tecchio N.D., L.Ac. provides are not meant to substitute or replace those of a licensed physician. Patients seeking her consultation are advised to also be under the care of a licensed New York state physician.

Naturopathic Medicine in the State of Vermont

As a Naturopathic Doctor in the state of Vermont, Ileana Tecchio N.D., L.Ac. is licensed to practice as a primary health care provider and as a board-certified physician.

.....

I hereby request and consent to acupuncture, herbal treatments and other procedures associated with Oriental Medicine on me (or on the patient named below, for which I am legally responsible) by Ileana Tecchio N.D., L.Ac. I understand that methods of treatments may include, but are not limited to:

- **Acupuncture** – whereby special sterilized fine needles are inserted through the skin into the underlying tissues and muscles at specific points on the body.
- **Moxibustion** – whereby indirect herbal heat is applied to specific acupuncture points.
- **Cupping** – whereby suction cups are applied to specific points on the body and on occasion are moved from point to point.
- **Electrical Stimulation** – whereby the needles are electrically stimulated at 9 volt or less to cause relaxation of the muscles and analgesia of the area of pain involved.
- **Herbal Medicine** – whereby herbs and nutritional supplements, which are from plant, animal and mineral sources are recommended.
- **Oriental Nutritional Counseling** – whereby a healthful diet is individually tailored and recommended.

Acupuncture has the effect of normalizing physiological functions, modifying the perception of pain, and of treating certain diseases and imbalances of the body. Most people experience a sense of well being and relaxation during and after the treatment. I have been informed that acupuncture is a safe method of treatment, but that occasionally bruising, numbness or tingling at the site of needle insertion may occur after treatment. Bruising is also a possible side effect of cupping. Burns on the skin are a potential risk of indirect moxibustion. Rare side effects include dizziness or fainting, especially if the patient is overdue for a meal. There have been extremely rare instances of spontaneous miscarriage and pneumothorax – collapsed lung.

_____ Initials

INFORMED CONSENT Cont.

ILEANA TECCHIO N.D., L.Ac., Dipl.Ac., M.S.O.M.

I understand that while this document describes the major risks of treatment, other side effects may occur. I do not expect Ileana Tecchio N.D., L.Ac. to be able to anticipate all risks and complications. I wish to rely on Ileana Tecchio N.D., L.Ac. to exercise judgment during the course of the procedure which Ileana Tecchio N.D., L.Ac. feels at the time, based on the facts then known, and is in my best interests.

_____ Initials

Herbal and nutritional supplements are traditionally considered safe in the practice of Oriental Medicine. I understand the same herbs and nutritional supplements may be inappropriate during pregnancy and **will inform Ileana Tecchio N.D., L.Ac. immediately of pregnancy status**. If I experience any gastro-intestinal reactions or any adverse effects, I will inform Ileana Tecchio N.D., L.Ac. immediately.

_____ Initials

I state that in addition to not being pregnant; I do not have the following conditions: bleeding disorders, pacemaker, local infections, diabetes, cancer, and I am not taking anti-coagulant drugs.

_____ Initials

While Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture or herbal medicine treatment. To comply with Article 160, Section 8211.1 (b) of NYS Education Law, Ileana Tecchio N.D., L.Ac. requests that you read and sign the following statement.

I/We, the undersigned, do affirm that _____ (patient) has been advised by Ileana Tecchio, N.D., L.Ac., to consult a physician regarding the condition(s) for which such patient seeks acupuncture and/or herbal medicine treatment(s).

I understand that all my records will be kept confidential and **will not** be released without my written consent.

I understand it may be necessary for Ileana Tecchio N.D., L.Ac. to contact another one of my health care providers in order to discuss any emergency situation. My signature gives Ileana Tecchio N.D., L.Ac. permission to release my medical records for the reason listed above.

I have been informed that I have the right to refuse any form of treatment. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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 have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures.

Ileana Tecchio N.D., L.Ac., M.S.O.M., Dipl.Ac.

Patient Name _____

Patient Signature _____

Legal Guardian _____

Today's Date _____