KATHLEEN M. DUGGAN, LIC.AC.
ACUPUNCTURE
NORWELL, MA | 781.878.0222

Health History

Please take some time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask.

Name _____ Date _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Mobile Phone _____ E-mail _____
Date of Birth _____ Age ____ Marital Status _____
Referred by _____ Occupation _____
Physician _____ Address _____
City _____ State _____ Zip _____ Phone _____
In Emergency Notify _____ Phone _____

Main complaint (symptoms, diagnosis, duration, etc.)

_____

Significant trauma (physical or emotional)

_____

Birth history (prolonged labor, forceps delivery, complications, etc.)

_____

Surgeries (please include date of procedure)

_____

Allergies (chemical, environmental, food, drugs, etc.)

_____

Medications (names & dosages) — please attach an additional page if necessary.

_____

Vitamins/supplements/herbs _____

EXERCISE:

Days per week _____ **Length of workout** _____ **Type of activity** _____

DIET:

Meals per day _____ **Snacks** _____ **Caffeinated drinks** _____ **Alcohol per week** _____

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Personal History

Please check any conditions or symptoms you have now.

- ☐ Arthritis
- ☐ High/Low Blood Pressure
- ☐ Cancer
- ☐ Ulcer
- ☐ Chronic Fatigue
- ☐ Alcoholism
- ☐ Gastritis/Pancreatitis
- ☐ Liver/Gall Bladder Disease
- ☐ Hypo/Hyperglycemia
- ☐ Diabetes
- ☐ Seizures
- ☐ Anemia
- ☐ Lyme Disease
- ☐ Asthma
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Food Allergies/Intolerance
- ☐ Hepatitis
- ☐ Thyroid Imbalance
- ☐ Chronic Pain Condition
- ☐ Infertility
- ☐ Heart Disease
- ☐ Elevated Blood Cholesterol
- ☐ Diverticulitis/IBS
- ☐ Raynaud's Disease
- ☐ Respiratory Allergies
- ☐ Impotence
- ☐ Emphysema

Family Medical History

Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to condition.

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Other
- ☐ Seizures
- ☐ Allergies
- ☐ Heart Disease
- ☐ Cancer
- ☐ Stroke
- ☐ Asthma

Please check if you have had any of the items listed below in the **last 3 months.**

General

- ☐ Poor appetite
- ☐ Chills
- ☐ Cravings
- ☐ Bleed/bruise easily
- ☐ Muscle weakness/fatigue
- ☐ Poor sleeping
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Weight loss/gain
- ☐ Sudden energy drop
- ☐ Fatigue
- ☐ Sweat easily
- ☐ Poor balance
- ☐ Peculiar tastes/smells
- ☐ Strong thirst (hot/cold drinks)
- ☐ Fevers
- ☐ Tremors
- ☐ Change in appetite
- ☐ Dental/gum problems

Skin and Hair

- ☐ Rashes
- ☐ Eczema/Psoriasis
- ☐ Skin discoloration
- ☐ Dermatitis
- ☐ Ulcerations
- ☐ Dandruff
- ☐ Acne
- ☐ Warts
- ☐ Hives/allergic dermatitis
- ☐ Loss of hair
- ☐ Change in skin/hair texture
- ☐ Fungal infection
- ☐ Itching
- ☐ Recent moles
- ☐ Face flushing

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Eye strain
- ☐ Color blindness
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Sores on lips/tongue
- ☐ Difficulty swallowing
- ☐ Eye pain
- ☐ Cataracts
- ☐ Poor hearing
- ☐ Recurrent sore throat/cold
- ☐ Dental problems
- ☐ Migraines
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Spots in front of eyes
- ☐ Grinding teeth
- ☐ Jaw clicks/locks
- ☐ Glasses
- ☐ Night blindness
- ☐ Earaches
- ☐ Sinus problems
- ☐ Facial pain
- ☐ Headaches

Cardiovascular

- ☐ Chest pain or pressure
- ☐ Cold hands/feet
- ☐ Shortness of breath
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Swelling of hands/feet
- ☐ Varicose/spider veins
- ☐ Spontaneous sweating
- ☐ Palpitations at rest
- ☐ Blood clots
- ☐ Pressure in chest
- ☐ Dizziness
- ☐ Fainting
- ☐ Phlebitis
- ☐ High blood pressure

Respiratory

- ☐ Cough/wheezing
- ☐ Coughing blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pain with deep inhalation
- ☐ Tight sensation in chest
- ☐ Difficult to inhale/exhale
- ☐ Difficulty breathing when lying down
- ☐ Production of phlegm
- What color? _____

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stool
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Bloating/edema
- ☐ Chronic laxative use
- ☐ Loose stools (> 2 per day)
- ☐ Abdominal pain/cramps
- ☐ Changes in appetite
- ☐ Acid reflux/GERD
- ☐ Hernia
- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Significant thirst
- ☐ IBS/Crohn's Disease

Genito-Urinary

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgent urination
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Scanty flow
- ☐ Copious flow
- ☐ Impotence
- ☐ Sores on genitals
- ☐ Urinary tract infection
- ☐ Burning urination
- ☐ Premature ejaculation
- ☐ Decreased libido
- ☐ Prostatitis
- ☐ Dribbling after urination
- ☐ Nocturnal emission
- ☐ Pain in testicles
- ☐ Herpes
- ☐ Infections
- ☐ Night urination
- What time? _____
- How often? _____

Gynecological/Reproductive

- ☐ Difficult/painful intercourse
- ☐ Ovarian cysts
- ☐ Age at first menses _____
- ☐ Vaginal dryness
- ☐ Endometriosis
- ☐ Date of last menses _____
- ☐ Vaginal sores
- ☐ Uterine fibroids
- ☐ Date of last PAP/pelvic _____
- ☐ Vaginal discharge
- ☐ Fibrocystic breast tissue
- ☐ Number of pregnancies _____
- ☐ Infertility
- ☐ Polycystic Ovarian Disease
- ☐ Number of ectopic pregnancies _____
- ☐ Irregular menstruation
- ☐ PMS
- ☐ Number of live births _____
- ☐ Painful menstruation
- ☐
- ☐ Number of miscarriages or abortions _____

Do you practice birth control? ___ What type? _____ How long? _____

Musculoskeletal

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Hand/wrist pain
- ☐ Carpal Tunnel
- ☐ Knee pain
- ☐ Sprains/strains
- ☐ Sciatica
- ☐ Foot/ankle pain
- ☐ Hip pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Tendonitis
- ☐ Back pain Low _____ Middle _____ Upper _____
- ☐ Bursitis
- ☐ Rotator cuff

Neuropsychological

- ☐ Seizures
- ☐ Loss of balance
- ☐ Vertigo/dizziness
- ☐ Areas of numbness
- ☐ Lack of coordination
- ☐ Poor memory
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety/panic attacks
- ☐ Bad temper/irritable
- ☐ Easily susceptible to stress
- ☐ Seasonal Affective Disorder
- ☐ Nervousness
- ☐ ADD/ADHD
- ☐ Manic depression
- ☐

Have you ever been treated for emotional problems? ☐ Yes ☐ No
Have you ever considered or attempted suicide? ☐ Yes ☐ No
Have you ever been treated for substance abuse? ☐ Yes ☐ No

Comments Please inform me of any other problems you would like to discuss.

_____

_____

_____

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Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture. I understand that acupuncturists practicing in the state of Massachusetts are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by Kathleen Duggan, Lic.Ac.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Email Address:** _____

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Informed Consent

I, the undersigned, hereby give consent for the administration of treatment by the method of acupuncture/magnet therapy.

I understand that acupuncture is performed by the insertion of needles, with or without the addition of an electric current, through the skin or the application of heat to the skin, or both, at certain points on the body in an attempt to improve body function and/or relieve pain.

I have been made aware that certain side effects may result. These may include, but are not limited to, some local bruising, bleeding, fainting, temporary pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment.

I am aware that the use of acupuncture/magnets is not yet a common practice in this community and I understand that no guarantees concerning their use and effects are given to me.

I understand that none of the foregoing provisions shall prevent administration to me of more conventional medical therapy by a licensed physician when in his or her own discretion such therapy is deemed appropriate.

I hereby certify that I have read the above and that I understand the provisions described herein.

Patient Signature_____ **Date:**_____

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Notice of Privacy Rights and Practices (Medical)

This notice describes how medical information about you may be used and disclosed and how you get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care provider. An example of this would include a physical examination.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to Kathleen Duggan Acupuncture.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. If we do not agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosure of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our *legal duties and privacy practices with respect to protected health information.*

This notice is effective as of January 1, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of civil Rights, about violations of the provisions of this notice of the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about “HIPAA” or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
(202)

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HIPAA Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and provider certifications.**

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent.

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____