Mark Thompson Acupuncture

145 West 57th Street * 10th Floor * New York NY 10019 * (212) 974-7240 * fax (212) 974-7228

NAME ____ DATE ________________

ADDRESS ____

CITY__________________________ STATE_________________ ZIP_____________

HOME PHONE _____________________________ CELL PHONE___________________________

EMAIL ____

DATE OF BIRTH ______________________________ HEIGHT _________ WEIGHT____________

OCCUPATION ____

REFERRED BY____

PRIMARY CARE PHYSICIAN____

MAY WE COMMUNICATE WITH YOUR PHYSICIAN REGARDING YOUR TREATMENT? YES NO

***

WHAT ARE THE MAIN CONDITIONS YOU WOULD LIKE TO BE HELPED WITH?

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WHEN DID IT/THEY BEGIN? PLEASE BE SPECIFIC.

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TO WHAT EXTENT DOES THIS INTERFERE WITH YOUR DAILY LIFE (SLEEP, WORK, PLAY, ETC)?

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HAVE YOU BEEN GIVEN A MEDICAL DIAGNOSIS? IF SO, PLEASE EXPLAIN.

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WHAT KINDS OF TREATMENT HAVE YOU TRIED?

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ARE YOU PRESENTLY BEING TREATED WITH OTHER HEALTH CARE MODALITIES? IF SO, WHICH?

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FAMILY HISTORY

PLEASE NOTE ALL MAJOR ILLNESSES IN YOUR FAMILY, SUCH AS DIABETES, HEART DISEASE, BLOOD PRESSURE, NEUROLOGICAL DISORDERS, PSYCHOLOGICAL DISORDERS, BLOOD DISORDERS, ORTHOPEDIC DISORDERS, ETC.

GRANDPARENTS: ____

____

PARENTS:____

____

SIBLINGS: ____

____

YOUR HEALTH HISTORY

PLEASE DESCRIBE ANY SURGERIES, INJURIES, ACCIDENTS, OR ILLNESS DATE/AGE

BIRTH (ANY COMPLICATIONS?)

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____

CHILDHOOD ____

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____

ADOLESCENCE ____

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____

ADULTHOOD ____

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DO YOU HAVE ANY SCARS? PLEASE NOTE THE LOCATION OF ALL OPERATION OR INJURY SCARS

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PLEASE **CIRCLE** ANY PROBLEMS YOU HAVE HAD, ADD A *** TO INDICATE CURRENT** PROBLEMS:

SKIN:
~ECZEMA
~ACNE
~SKIN RASH
~DERMATITIS
~FURUNCLES
~FUNGAL INFECTION
~WARTS
~PSORIASIS
~DANDRUFF
~DRY SCALP
~HERPES SIMPLEX/ZOSTERS
~BRITTLE NAILS
~CHANGES IN NAILS
~BRUISES EASILY
~HIVES
~ITCHING (PRURITES)
~UNUSUAL SWEATING
~NEVER SWEATING

HEART AND VASCULAR:
~FAST PULSE (OVER 100 BEATS/MIN)
~SLOW PULSE (LESS THAN 60 BEATS/MIN)
~IRREGULAR PULSE
~PALPITATIONS
~FEELING OF PRESSURE IN THE CHEST
~CHEST PAIN
~DIZZINESS
~MIGRAINE
~HEADACHE WITH NAUSEA
~COLD HANDS
~COLD FEET
~REYNAUD'S DISEASE
~ANGINA PECTORIS
~FLUSHED FACE
~HIGH BLOOD PRESSURE
~LOW BLOOD PRESSURE
~EDEMA (GENERALIZED SWELLING)
~HEART DISEASE
~COLD SWEATS
~FAINTING
~BLEEDING TENDENCY
~CHANGES IN SKIN TEMPERATURE AND COLOR
~SWELLING AT ANKLES OR LEGS
~SKIN ULCERATIONS

GASTROINTESTINAL:
~ABDOMINAL DISTENTION
~ABDOMINAL MASS
~ABDOMINAL PAIN
~VOMITING
~CONSTIPATION
~DIARRHEA
~RECTAL BLEEDING
~NO APPETITE
~INDIGESTION
~HEARTBURN/ACID REFLUX/GERD
~INTESTINAL GAS
~GALL STONES
~STOMACH DISORDER
~BELCHING
~ULCER
~GASTRITIS
~LACK OF STOMACH ACID
~HEMORRHOIDS
~ILEOCECAL VALVE SPASMS
~PERITONITIS
~PANCREATITIS
~IRRITABLE BOWEL
~POLYPS
~GI TUMORS
~HEPATITIS A, B, OR C
~LIVER DISEASE

NEUROLOGICAL:
~CHANGES IN CONSCIOUSNESS
~CONFUSION
~DIFFICULTY CONCENTRATING
~DYSPHASIA (DIFFICULTY SPEAKING)
~GAIT DISTURBANCE
~NUMBNESS OR TINGLING
~LOSS OF CONSCIOUSNESS
~PARALYSIS
~POST SHINGLES PAIN
~PROBLEMS COORDINATING MOVEMENTS
~SEVERE FORGETFULNESS
~TREMOR
~VISUAL DISTURBANCES
~WEAKNESS

UROGENITAL:
~KIDNEY DISEASE
~KIDNEY STONES
~URINARY TRACT INFECTION (UTI)
~GLOMERULONEPHRITIS
~DIFFICULTY WITH FLOW
~RED URINE
~INCONTINENCE

ORAL DISEASE:
~Bleeding Gums
~Periondontitis
~Dental Abscess
~Mumps
~Stomatitis (inflamation of the mouth)
~TMJ
~Toothache without Cavity

RESPIRATORY:
~Asthma
~Bronchitis
~Emphysema
~Cough
~Wheeze
~Pneumonia
~Tuberculosis
~Hay Fever
~Chest Pain or Tightness
~Bluish Discoloration of Skin
~Voice Changes
~Sputum Production
~Shortness of Breath

AUTOIMMUNE, INFECTION AND INFLAMMATORY CONDITIONS:
~AIDS
~HIV
~Hashimotos Disease(thyroid)
~Rheumatism
~Systemic Lupus Erythematosus
~Colitis
~Crohns Disease
~Alopecia(baldness)
~allergy
~Food Allergy ________________
~Vulvitis
~Atopic dermatitis
~Neuralgia/Neuritis
~Neurodermatitis
~Cellulitis
~Sinus Allergy
~Low Immunity
~Rheumatic Disease
~Rheumatic Fever
~Rheumatoid Arthritis
~Skin Disease
~Malaria
~Genital Herpes
~Mononucleosis
~Chicken Pox/Shingles
~Measles/Mumps

EAR, EYES, NOSE AND THROAT:
~Loss of Hearing
~Tinnitus (ringing in the ears)
~Itchy Ear
~Ear Pain
~Frequent Ear Infection
~Ear Discharge
~Problems With Balance (Vertigo)
~Far Sighted
~Near Sighted
~Eye Infection
~Loss of Vision
~Eye Redness
~Tearing or Eye Dryness
~Eye Pain
~Eye Discharge
~Sinus Pain/Pressure/Headache
~Yellow Mucus
~Constant Sinus Congestion
~Stuffy Nose
~Nose Bleeds
~Post-Nasal-Drip
~Olfaction (sense of smell) Impaired
~Itchy Throat
~Dry Throat
~Tonsilitis
~Streptococci Throat Infections
~Easily Catch Cold

CONNECTIVE TISSUE OR LIGAMENT DISEASE:
~Myofacial Pain Symptoms
~Fibromyalgia
~Tendonitis
~Ligament Pericarditis
~Constant Slight Fever
~Planter Fasciitis
~Scarlet Fever
~Swollen Glands
~Streptococci Throat Infection

MUSCULOSKELETAL:
~Weak Legs
~Restless Legs
~Osteoporosis
~Muscle Pain
~Stiffness
~Swelling
~Spasms or Cramps
~Limited Range of Motion
~Joint Clicking

HORMONAL IMBALANCE:
~Low Thyroid
~Overactive Thyroid
~Diabetes
~Hypoglycemia
~Blood Sugar

PSYCHOLOGICAL:
~Feelings of Grief
~Feelings of Sadness
~Feelings of fear/Anxiety/ Nervousness
~Difficulty Managing Anger
~Feeling Manic
~Feeling Worried or Overly Pensive
~Feelings of Panic
~Feeling Overwhelmed
~Extreme Mood Swings
~Extreme Lack of Emotion

GENERAL:
~Insomnia
~Nightmares
~Vivid Dreams
~Perspire Easily
~Sweaty Palms/soles
~Psychosomatic Weakness
~Exhaustion
~Difficulty Concentrating
~Low Energy
~Car/Sea/Air Sickness
~No Appetite in the A.M.
~Moody in the A.M.
~Teeth Grinding

Please **list** any other illnesses or problems, current or past, not listed above:

____

____

____

Please **list** any medications, herbs, vitamins or supplements you are currently taking.

____

____

Please **list** any medications, herbs, vitamins, etc. to which you are allergic.

____

____

How would you describe your appetite (weak, strong, excessive, etc)?

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____

____

PLEASE **CIRCLE** ANY PROBLEMS YOU HAVE HAD, ADD A *** TO INDICATE CURRENT** PROBLEMS:

~ANOREXIA	~BULIMIA	~OBESITY
~OVERWEIGHT	~BELCHING	~FLATULENCE
~HEARTBURN	~ABDOMINAL BLOATING	~ABDOMINAL PAIN
~PAIN AFTER EATIING	~PAIN BEFORE EATING	~TIRED AFTER EATING
~UNDERWEIGHT	~ULCER	~COLITIS NAUSEA
~RAPID WEIGHT CHANGE	~HYPOGLYCEMIA	~IRRITABLE BEFORE EATING
~STOMACH TENSION	~DIFFICULTY SWALLOWING	
~CONSTIPATION	~DIARRHEA	
~HEMORRHOIDS	~RECTAL BLEEDING	

~DISTRESS FROM FATS (NAUSEA, DIZZINESS, HEADACHES, ETC.)

PLEASE **LIST** ANY OTHER DIGESTIVE CONDITION, CURRENT OR PAST, NOT LISTED ABOVE:

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PLEASE **LIST** ANY FOODS OR TASTES YOU HAVE CRAVINGS FOR:

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PLEASE **LIST** ANY FOODS OR TASTES YOU HAVE ANY AVERSION TO:

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PLEASE **LIST** ANY FOODS YOU ARE SENSITIVE OR ALLERGIC TO:

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____

PLEASE **DESCRIBE** YOUR PROGRAM OF PHYSICAL FITNESS:

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FEMALES ONLY (MALES, PLEASE SKIP THIS SECTION AND CONTINUE WITH THE NEXT)

DATE OF LAST MENSTRUAL PERIOD:

____

HOW MANY DAYS DOES YOUR PERIOD LAST? ______________________________

HOW MANY DAYS IN YOUR MONTHLY CYCLE? ______________________________

AGE YOU FIRST BEGAN TO MENSTRUATE? __________ AGE AT MENOPAUSE? __________

DO YOU CURRENTLY TAKE BIRTH CONTROL PILLS? __________ FOR HOW LONG? ________

HAVE YOU EVER TAKEN BIRTH CONTROL PILLS, WHEN AND HOW LONG?________________

TYPE OF CONTRACEPTION NOW USED? ______________________________

PLEASE **CIRCLE** ANY PROBLEMS YOU HAVE HAD, ADD A * **TO INDICATE CURRENT** PROBLEMS:

~HEAVY BLEEDING
~CRAMPING W/ PERIOD
~BLEEDING B/W PERIOD
~GENITAL BURNING
~YEAST INFECTION
~INFERTILITY
~CRAMPING BEFORE PERIOD
~CLOTS W/ PERIOD
~GENITAL HERPES
~URINARY TRACT INFECTION
~VAGINAL DISCHARGE/ITCH
~BLEEDING AFTER INTERCOURSE
~PMS
~OVARIAN CYST
~PID
~BREAST LUMPS
~PAIN DURING INTERCOURSE

PLEASE LIST ANY GYNECOLOGICAL CONDITIONS, CURRENT OR PAST, NOT LISTED ABOVE:

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Males Only (Females please skip this section and continue with the next section)

Please **circle** any problems you have had, add a * **to indicate current** problems:

~Urine Stream Weak or Slow
~Frequent Urination w/ Small Amount
~Dribbling after Urination
~Burning Urination
~Waking at Night to Urinate
~Prostate Disorder
~Discharge from Penis
~Nocturnal Emission
~Loss of Sexual Activity
~Swelling or Lump on Testicles
~Genital Burning
~Urinary Tract Infection
~Yeast Infection
~Genital Itching
~Infertility
~Genital Herpes
~Pain during Intercourse
~Premature Ejaculation
~Hernia
~Painful Testicles or Penis

Please **list** any other conditions, current or past, not listed above:

____

____

Type of contraception used? ____

Have you ever had a prostate examination? If so, when?

____

Stress, Emotions, and Traumas (to be completed by everyone)

Describe the levels of stress in your life. How does stress impact you, and how do you deal with stress?

____

____

____

What type of acute illness do you get and how often have you experienced them during the last two years?

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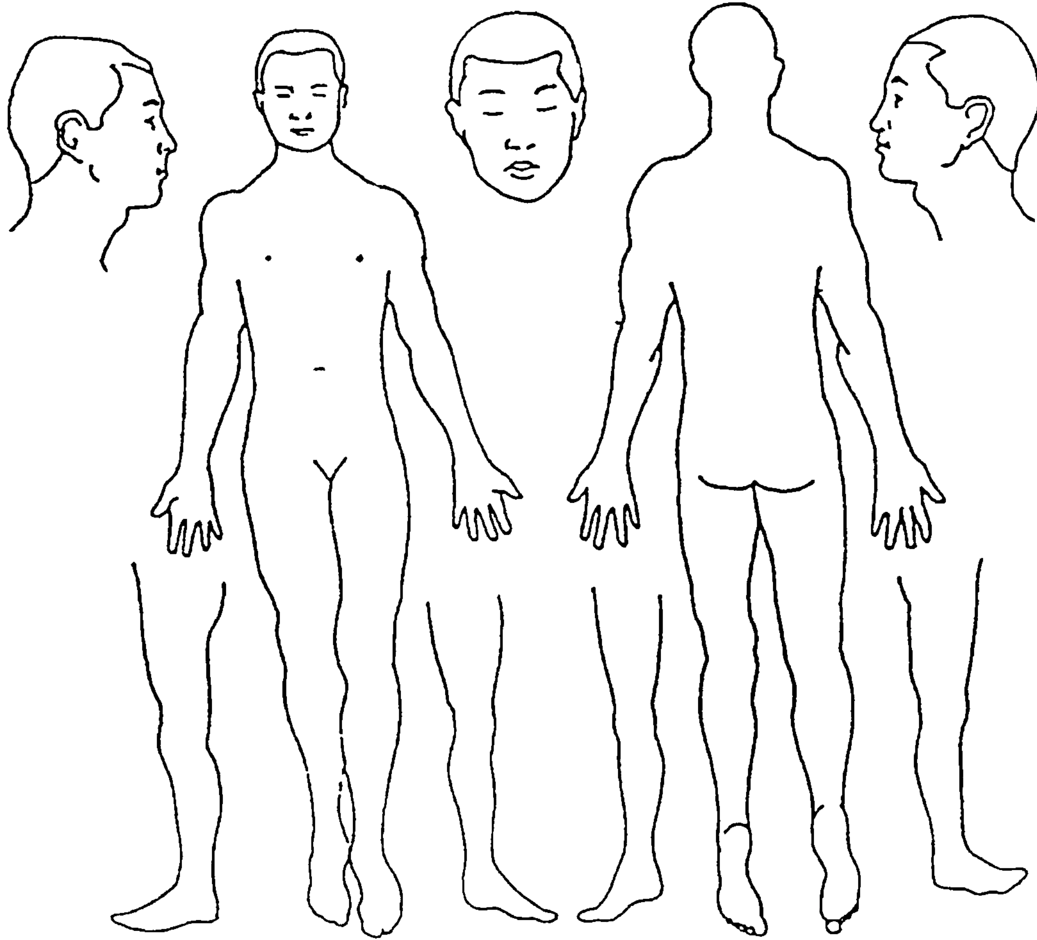
____

____

____

PLEASE **MARK** ANY AREAS OF PAIN ON THE DIAGRAMS BELOW:



THANK YOU FOR YOUR HONESTY, AS IT WILL HELP US BETTER UNDERSTAND YOUR CURRENT STATE AND ALLOW US TO MOVE MORE ACCURATELY TOWARD YOUR IMPROVED HEALTH.

All patients are advised under New York State Law to consult a physician regarding the condition or conditions for which they are seeking acupuncture treatment. In addition, patients are responsible for seeking the advice and treatment of a physician should their symptoms change for the worse, or should any new condition arise.

PATIENT SIGNATURE **DATE**

PRACTITIONER SIGNATURE

Mark Thompson Acupuncture

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SERVICES AND FEES

INITIAL VISIT $150.00
A thorough history and evaluation is followed by a full treatment. The plan of treatment will be determined at this time. Please allow one hour and 45 minutes.

FOLLOW UP VISITS $95.00 – $125.00
Acupuncture's effects are cumulative. For most patients, two sessions for the first several weeks are recommended. Following this, a weekly session is appropriate until all issues resolve.

Many people use acupuncture for health maintenance or to address chronic health concerns. The schedule of these treatments varies from twice a month to four times per year, at the change of seasons.

The fee range reflects a continuum of services:
The fee for an acupuncture treatment with Mark Thompson is $125, with Nancy Park is $95.00.

All herbal formulas are supplied in either granules or tablets. They are either manufactured in the United States or Taiwan and have been certified to be free of toxic elements. Any herbal formulas that are ordered specially for you must be paid for prior to being ordered.

Any appointments missed or cancelled with less than 24 hours notice will incur the full service fee billed to your account.

I have read the above and agree to pay the fees listed at the time of service. I understand that if I miss an appointment or cancel with less than 24 hour notice I will pay for that visit.

CREDIT CARD TYPE: ____(VISA/MC ONLY)

CREDIT CARD #: ____

EXPIRATION DATE: ___________________________ ZIP CODE: ____________________________

____
SIGNATURE

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice summarizes how the health data about you may be used and shared and how you can get access to this data.

I. How we may use and share health data about you:

a) Treatment – To give you medical treatment or other types of health services.
b) Payment – To bill you or a third party for payment for services provided to you.
c) Health Care operations – For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a) To you
b) As required by a federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement(to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a) Patient directories – You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care – We may share your health data with your family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to health data we keep about you:

a) Right to inspect your health record and to receive a copy upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

Signature of patient or representative Date

Print patient name Patient Birth Date