Date___________

Health Questionnaire

Name__________________________________ Date of Birth_____________ Gender_____________

Preferred Phone__________________________ Alternate Contact Phone_________________________

Address_________________________________ City_________________ State_____ Zip_________

Email___________________________________ SS#_________________ Marital Status__________

Emergency Contact________________________ Relationship___________ Phone________________

Primary Insurance________________________ Group #_______________ ID #________________

Subscriber______________________________ Subscribers Date of Birth_______________________

Relationship to Subscriber_________________ Effective Date_________________________________

Referring Doctor_____________________ Address_____________________ Phone_______________

Primary Care Doctor__________________ Address_____________________ Phone_______________

Have you ever had acupuncture before? Y_____ N_____ Condition & Practitioner___________________

CHIEF HEALTH CONCERN (Please describe the reason you are seeking acupuncture treatment.)

____

____

____

How long have you had this condition?_______________ Was the onset sudden or gradual?______________

Have you seen a physician for this condition?________ If yes, what is diagnosis?______________________

Have you sought other forms of treatment for this condition?_______ If yes, indicate what forms of treatments

____

What makes it better?____

What makes it worse?____

Other issues you would like addressed

____

____

CURRENT MEDICATIONS (Prescription, OTC, Vitamins, Herbs, etc). _____________________________

____

____

ALLERGIES____

Date and description of any accidents, surgeries, and hospitalizations_____________________________

____

____

CHECK ANY THAT APPLY

____Pacemaker ____Defibrillator ____Metal surgical implant ____Take Coumadin/Warfarin/daily aspirin

____Pregnant or may be pregnant ____Allergic to latex Other____________________________________

____

SOCIAL HISTORY(please indicate if you have in the (**P**ast), (**C**urrent), or (**N**ever) any of the following

	P	C	N	
Do you smoke				If past or current, how many packs a day? How many years?
Do you drink alcohol				If past or current, how much per week?
Caffeine usage				If past or current, how many cups per day?
Marijuana or Drug use				If past or current, how often?

Do you follow a certain Diet?________ If so, please explain_______________________________________

Do you exercise regularly?_________ If so, please explain______________________________________

How much water do you drink per day?_____________________ Soda/other__________________________

YOUR MEDICAL HISTORY & FAMILY HISTORY (Please check any that apply currently or in the past)

Illness	You	Relative	Date	Illness	You	Relative	Date
Cancer specify				Diabetes Type			
Lung Disease Type				Heart Disease Type			
High Blood Pressure				Blood Clotting Disorders			

OTHER (Please indicate if you've had in the **P**ast, **C**urrent, or **N**ever)

	P	C	N		P	C	N		P	C	N
Hepatitis A/B/C				Herpes				Covid			
HIV/AIDS				Tuburculosis							

Other____

WOMAN'S HEALTH

Age at first menses_______ Age at menopause______

Duration of Menses________Length of cycle(Day 1 to Day 1)_______

Amount of Blood flow? Excess____ Moderate____ Slight____

Clots?____ Pain with period?_______ Before____ During____ After____

Nature of Pain? Sharp___ Stabbing___ Dull___ Bloated___ Other______________________________

Please indicate whether you've had any of the following

Abnormal Pap Smear____ Hot Flashes____ Breast Lump____ Vaginal infections____

Miscarriage____ Painful intercourse____ Nipple discharge____ Uterine fibroids____

Fibrocystic Breasts____ Endometriosis____ Ovarian cysts____ Other____________________________

MEN'S HEALTH

Please indicate if you've had any of the following

Breast Lump____ Dribbling____ Delayed stream____ Erectile difficulties____ Incontinence____

Lump in testicles____ Prostate problem____ Sore on penis/Penile discharge____ Urine retention____

Other____

GENERAL (Please circle any that apply)

Difficulty falling asleep Difficulty staying asleep If you wake up with insomnia the middle of night, what time?___________

How many hours of sleep per night?________ Frequent nightmares Fatigue Fever Chills Night sweats Sweats easily

Bleed/Bruise easily Dental/gum problems

Sudden energy drop—if so what time?_________ Aversion to hot weather Aversion to cold weather

Recent use off antibiotics Other____

SKIN & HAIR (Please circle any that apply)

Rashes Ulcerations Hives/Allergic dermatitis Itching Eczema/psoriasis Dandruff Recent moles

Skin discolorations/Hyperpigmentation Melasma Acne Change in skin/hair texture Face flushing Warts Fungal infection Weak or ridged nails Wrinkles/Fine lines Other____

HEAD, EARS, EYES, NOSE, THROAT (Please circle any that apple)

Dizziness Difficulty swallowing Decreased Sense of Smell Eye Pain Poor Vision Night blindness Color blindness

Cataracts Blurred Vision Migraines/headaches

Earaches Ringing in Ears Poor hearing spots in front of eyes Sinus problems Nose bleeds Recurrent sore throats/colds

Grinding teeth Facial pain Sores on lips or tongue Dental problems Jaw clicks/locks

Other____

CARDIOVASCULAR (Please circle any that apply)

Chest pain or pressure Irregular heart beat Palpitations Fainting Cold hands/feet Swelling of hands/feet Blood clots

Phlebitis Shortness of breath Varicose/spider veins Pressure in chest High blood pressure Low blood pressure

Spontaneous sweating Dizziness Edema/swelling of limbs Other____

RESPIRATORY (Please circle any that apply)

Chronic cough Wheezing Coughing blood Asthma Bronchitis Pneumonia Pain with deep inhalation Tight sensation in chest Shortness of breath Difficulty inhaling/exhaling Frequent colds Production of phlegm—what color?________________
Other____

GASTROINTESTINAL (Please circle any that apply)

Nausea Vomiting Diarrhea Constipation Flatulence/gas Belching Bloated after meals Black/tarry stools Blood in stools Loose stools Food retention # of stools per day__________ Indigestion Bad breath Rectal Pain Hemorrhoids Chronic laxative use Abdominal pain/cramps Changes in appetite Poor appetite Excessive appetite Heartburn/acid reflux/ GERD Hernia Recent weight loss Recent weight gain Significant thirst IBS Crohn's disease Ulcerative colitis
Other____

GENITO-URINARY (Please circle any that apply)

Frequent urinary tract infections Pain on urination Burning urination Frequent urination Blood in urine Unable to hold urine Kidney infections Kidney stones Scanty flow Copious flow Night urination Excessive libido/decreased libido
Other____

MUSCULOSKELETAL (Please circle any that apply)

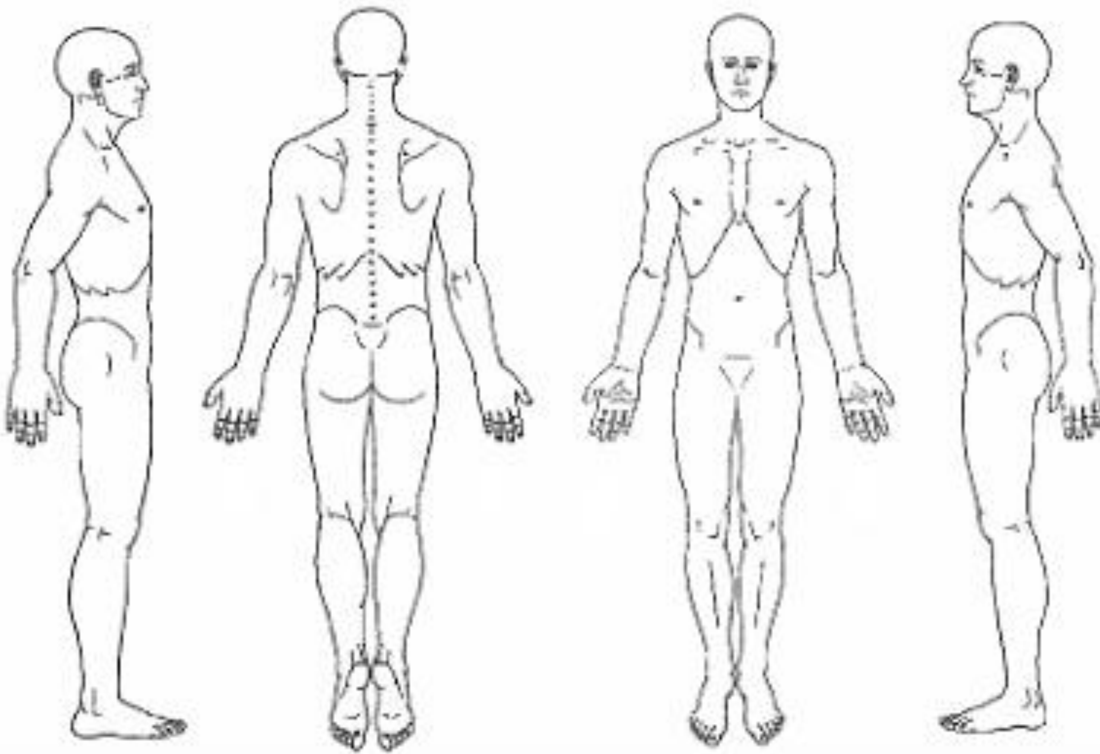
Neck Pain Hand/wrist pain Carpal tunnel Knee pain Sprains/strains Sciatica Foot/ankle pain Hip pain Muscle pain Muscle weakness Tendonitis Back Pain Low____ Middle____ Upper____ Herniated/bulging discs Bursitis Shoulder pain Osteoarthritis Rheumatoid arthritis Soreness/weakness in lower body Pins and needles Neuropathy
Other____

NEUROPSYCHOLOGICAL (Please circle any that apply)

Seizures Loss of Balance Vertigo/Dizziness Lack of coordination Poor memory Areas of numbness or pins and needles-If so, where?____ Concussion Depression Anxiety/panic attacks Irritable Easily susceptible to stress Seasonal Affective Disorder Nervousness ADD/ADHD Bipolar

PAIN ASSESSMENT (Please shade any area of pain or distress on the diagram below)

Please describe nature of pain/discomfort(sharp, dull, stabbing, constant, intermittent, pins and needles etc)____



I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD PRACTITIONER OR ANY MEMBERS OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

PATIENT SIGNATURE______________________________ **DATE**__________________

Acupuncture Information and Informed Consent

Voluntary

I hereby voluntarily consent to be treated with acupuncture and other asian medicine procedures within the scope of practice of acupuncture. I understand acupuncture is the insertion of sterile, single-use needles. Other treatment methods may include, but are not limited to cupping, electrical stimulation, gua sha, Tui-Na(Chinese massage), and nutritional counseling.

I understand that the practice of acupuncture and Oriental medicine is not an exact science and there are no guarantees that have been made to me as a result of treatment.

Possible Side effects/Healing response

I have been informed that acupuncture is generally a safe method of treatment, but that it may have some side effects including bruising, numbness/tingling near the needle sites that last a few days, dizziness, or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involve the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture(pneumothorax). Infection is another possible risk, although we always use sterile disposable needles and maintain a clean safe environment.

Infectious Disease/Clean Needle Technique

I understand that infectious organisms can be carried through the air, through physical contact, and through body fluids. I understand that my acupuncture practitioner uses the Universal Precautions to guard against the spread of infection and follows strict clean needle procedures. Only sterile, single-use disposable acupuncture needles are used and are discarded in a biohazard container.

Patient Responsibility

I understand that it is my responsibility as a patient to inform my acupuncture practitioner about all aspects of my health and that as treatment progresses, to inform my practitioner of any changes that occur. I have carefully read and understand the above information. I am aware that I am signing and have felt free to ask any questions.

Patient's Printed Name____

Patient's Signature____ Date________________

(or patient representative or guardian, indicate relationship if signing for patient)

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

New Day Acupuncture and Aesthetics LLC ("Practice") is required by law to maintain the privacy of protected health information ("PHI"), to provide individuals with notice of its legal duties and privacy practice with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information. New Day Acupuncture and Aesthetics LLC is committed to maintaining the privacy of your protected health information, which includes information about your health condition and the care and treatment you receive from New Day Acupuncture and Aesthetics LLC and its practitioners. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected at all times and maintained in the office(s) of New Day Acupuncture and Aesthetics, LLC.

NO AUTHORIZATION REQUIRED

The Practice *may* use or disclose your personal health information for the purposes of:
(a) **Treatment** - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. *Example*: Information obtained from you will be recorded in your record and may be shared with a physician or other member of your healthcare team to help determine your diagnosis or the course of treatment that should work best for you.
(b) **Payment** - In order to obtain information regarding your potential health care coverage benefits or to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. *Example:* A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.
(c) **Health Care Operations** - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. *Example:* Members of New Day Acupuncture and Aesthetics, LLC may use information in your health record to assess the care and outcomes in your case and others like it.

The Practice is also permitted or may be required to use or disclose your protected health information *without* your written authorization in the following additional instances:
(d) **Public Health Activities** - To a public health authority that is authorized by law to collect or receive such information for the purposes of preventing or controlling disease, injury or disability.
(e) **Abuse, Neglect or Domestic Violence** - Upon reasonable belief that an individual is a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect or domestic violence, to the extent the disclosure is required by law.
(f) **Health Oversight Activities** - For oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions or other actions or activities necessary for appropriate oversight of the health care system or compliance therewith, subject to various restrictions and limitations.
(g) **Judicial and Administrative Proceeding** - In response to an order of a court or administrative tribunal, provided only the protected health information expressly authorized by such order is disclosed, or in response to a subpoena, discovery request or other lawful process following satisfactory assurances that the protected health information will be properly secured by the party seeking such information.
(h) **Law Enforcement Purposes** - In certain instances, your protected health information may have to be disclosed to a law enforcement official. For example, your protected health information may be the subject of a grand jury subpoena, or necessary for the purpose of identifying or locating a suspect, fugitive, material witness, missing person, or may be a victim of a crime.
(i) **Coroner or Medical Examiner** - To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as authorized by law.
(j) **Organ, Eye or Tissue Donation** - If you are an organ donor, your personal health information may be disclosed to the entity to whom you have agreed to donate your organs.
(k) **Research** - We can use or share your protected health information for health research when the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
(l) **Avert a Threat to Health or Safety** - Consistent with applicable law and standards of ethical conduct, use or disclose protected health information if it is believed that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
(m) **Specialized Government Functions** - The protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, subject to certain requirements. Also covers National Security and Intelligence Activities and Correctional Institutions.
(n) **Workers' Compensation** - If you are involved in a Workers' Compensation claim, your protected health information may be disclosed as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
(o) **Business Associates** - There are some services provided to Centered Self, LLC through contracts with business associates such as our accountants, consultants and attorneys. The Practice may disclose your health information to them so that they can perform the job they are required to do. However, the Practice requires that its the business associates appropriately safeguard your information

AUTHORIZATION REQUIRED

The Practice *may not* use or disclose your personal health information in regards to:
(a) **Psychotherapy Notes** - The Practice must obtain an authorization for any use or disclosure of psychotherapy notes except in limited circumstances to carry out treatment, payment or health care operations.
(b) **Marketing** - The Practice must obtain an authorization for any use or disclosure of protected health information for marketing, except in limited circumstances.
(c) **Sale of Protected Health Information** - An authorization must be obtained for any disclosure of protected health information which is a sale of protected health information.

- USES AND/OR DISCLOSURES, OTHER THAN THOSE DESCRIBED IN THIS NOTICE, WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION.

- YOU MAY REVOKE YOUR AUTHORIZATION AT ANY TIME; HOWEVER, YOUR REVOCATION MUST BE IN WRITING.

Appointment Reminders

New Day Acupuncture and Aesthetics, LLC or its employees may disclose some personal protected health information when contacting you to provide appointment reminders. If you are not at home to receive an appointment reminder, a telephone message will be left on your answering machine, voice mail, or with the person who answers the call, *or,* if such contact information is available, a text message or e-mail may be sent to you regarding your appointment. As these reminders may result in the disclosure of certain protected health and personal information, you have the right to refuse or limit the Practice's authorization to contact you regarding appointment reminders. If you refuse such authorization, it will in no way affect the treatment or care you are provided.

Restrictions

You may request restrictions on certain use and/or disclosure of your protected health information as provided by law. However, the Practice is not obligated to agree to any requested restrictions, except to the extent that it involves disclosure to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the information pertains solely to a health care item or service for which you or someone other than the health plan has paid the covered entity in full.
To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment

YOU HAVE A RIGHT TO

Request a Restriction on certain uses and disclosures of protected health information, as provided by 45 CFR 164.522(a)(1)(vi).

Receive confidential communications or protected health information by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

Inspect and obtain a copy your protected health information as provided by 45 CFR 164.524. To inspect and copy your protected health information, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Amend your protected health information or a record about you in a designated record set for as long as the protected health information is maintained in the designated record set, pursuant to 45 CFR 164.526. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your protected health information maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. You have the right to submit a written statement of disagreement.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Request copies of your personal health information in electronic format if this office maintains your records in that format.

Receive notice of any breach of confidentiality of your protected health information.

DUTIES OF New Day Acupuncture and Aesthetics, LLC
- New Day Acupuncture and Aesthetics LLC Is required by law to maintain the privacy of protected health information, to provide you with this Privacy Notice detailing its legal duties and privacy practices with respect to your protected health information, and to notify any affected individuals following a breach of unsecured protected health information.

- New Day Acupuncture and Aesthetics LLC is required to abide by the terms of this Privacy Notice as of its Effective Date.

- New Day Acupuncture and Aesthetics, LLC reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all the protected health information it maintains. Any new or revised Privacy Notice will be mailed to you or handed to you at your next visit prior to its implementation.

COMPLAINTS
Any individual may complain to New Day Acupuncture and Aesthetics, LLC, 268 Southview Drive, New Jersey, 08075, and/or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov, if you believe your privacy rights have been violated. All complaints must be in writing.
New Day Acupuncture and Aesthetics LLC will not retaliate against you for filing a complaint.

CONTACT
The Practice's Privacy Officer and Contact for New Day Acupuncture And Aesthetics LLC, is Kristen Otto, 268 Southview Drive New Jersey 08075. Phone (856) 979-2719.

EFFECTIVE DATE
Effective Date of This Notice: July 01, 2020

I acknowledge that I was provided a copy of this Notice of Privacy Practices and that I have read it and understand my rights. I understand that this form will be placed in my patient chart and maintained, along with my records, for seven years pursuant to New Jersey law. After seven years from the date of my last treatment, any and all records and files may be destroyed.

Patient Signature:_________________________________
Date: ___________________