Acupuncture Solutions
Cory Walsh DeLise, M.S., Lic.Ac.
978-210-3177 • cory@corywalsh.com
357 Whitney Avenue, #G-03 • New Haven, CT 06511
528 Loring Avenue • Salem, MA 01970

Today's Date _____

Complete this form to the best of your ability. Some of the questions may seem unrelated to the condition for which you are seeking treatment, but the information will help the practitioner develop a precise diagnosis and treatment plan.

Full Name _____ **Birth Date** _____ **Age** _____
Complete Address _____ **Zip**_____
Occupation _____
Home Phone _____ **Work Phone** _____
Cell Phone _____ **Email** _____

Primary Care Physician _____
Primary Care Telephone _____
Emergency Contact Name _____
Emergency Contact Phone Number(s) _____
Referred By _____

Are you under a medical doctor's care for any specific physical/mental condition? Yes/No
If yes, is it related to the purpose of your visit today? Yes/No

Please note any physical or dietary restrictions: _____
_____

Do you have any allergies to medications? Yes/No **If yes, please describe:** _____
_____
_____

Other allergies or intolerances: _____
_____

Current Medications:

Name of Medication	**Dose**	**Frequency**	**Start date**

If you need more space, please list other medications on the back of this sheet.

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Reason(s) For Today's Appointment: _____

_____

_____

Do you have a diagnosis for this condition? Yes/No **If yes, what is the name of your condition?** _____
When did this condition begin? _____
Is it intermittent or constant? _____

Diagnostic exams (+ for positive results, - for negative results):
❒ **MRI** ❒ **X-Ray** ❒ **CT** ❒ **Blood test** ❒ **Sonogram/Ultrasound** ❒ **PET** ❒ **Physical**

Previous treatments you've received (herbal medicine, homeopathy, chiropractic, reiki, vitamins, etc.) specifically addressing condition: _____

_____

Is there anything you would like to add about this condition? _____

_____

_____

_____

MEDICAL HISTORY

Have you ever had any of these conditions now or in the past? (check all that apply):

Cardiovascular
❒ **High blood pressure** ❒ **Low blood pressure** ❒ **Chest pain** ❒ **Irregular heartbeat**
❒ **Dizziness** ❒ **Fainting** ❒ **Cold hands and/or feet** ❒ **Heart attack** ❒ **Blood clots**
❒ **Congestive heart problems** ❒ **Heart murmurs** ❒ **Varicose veins** ❒ **Spider veins**
❒ **Swelling of hands and/or feet** ❒ **Difficulty breathing** ❒ **Stroke**❒
❒ **Heart palpitations** ❒ **Other:** _____

Respiratory
❒ **Cough** ❒ **Phlegm** ❒ **Frequent colds/flu** ❒ **Bronchitis** ❒ **Pneumonia** ❒ **Pleurisy**
❒ **COPD** ❒ **Asthma** ❒ **Difficult inhale** ❒ **Difficult exhale** ❒ **Shortness of breath**
❒ **Difficulty breathing lying down** ❒ **Sinusitis** ❒ **Post-nasal drip**
❒ **Other** _____

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Gastrointestinal
❒ **Nausea** ❒ **Vomiting** ❒ **Diarrhea** ❒ **Belching/burping** ❒ **Gas/flatulence**
❒ **Constipation** ❒ **Ulcerative colitis** ❒ **Irritable bowel syndrome** ❒ **Crohn's disease**
❒ **Celiac's disease** ❒ **Abdominal pain/cramps** ❒ **Bowel obstruction** ❒ **Poor appetite**
❒ **Acid reflux** ❒ **Stomach ulcer** ❒ **Black/tarry stools** ❒ **Blood in stools** ❒ **Parasites**
❒ **Hemorrhoids** ❒ **Stool softener used frequently** ❒ **Bad breath** ❒ **Eating disorder**
❒ **Other** _____

Chronic/Systemic
❒ **Diabetes** ❒ **Lupus** ❒ **EBV** ❒ **Systemic infections** ❒ **Cancer** ❒ **Thyroid disease**
❒ **Rheumatoid arthritis** ❒ **Adrenal problems** ❒ **Chronic Fatigue Syndrome**
❒ **Fibromyalgia** ❒ **ALS** ❒ **MS** ❒ **Lyme's Disease** ❒ **Bell's Palsy** ❒ **HIV** ❒ **AIDS**
❒ **Other:** _____

Genitourinary
❒ **Blood in urine** ❒ **Kidney stones** ❒ **Erectile difficulty** ❒ **BPH** ❒ **Sores on genitals**
❒ **Kidney infection** ❒ **Bladder infection** ❒ **Chronic cystitis** ❒ **Kidney disease**
❒ **Sexually transmitted disease(s)** ❒ **Yeast infections** ❒ **Pain with intercourse**
❒ **Other:** _____

Neurological
❒ **Alzheimer's disease** ❒ **Dementia** ❒ **Chronic Depression** ❒ **Schizophrenia**
❒ **Manic disorders** ❒ **Situational depression** ❒ **Post traumatic stress disorder**
❒ **Sadness/melancholy** ❒ **Anger/hostility** ❒ **Mourning** ❒ **Paranoia** ❒ **Obsessive**
❒ **Compulsive** ❒ **Drug/alcohol addiction** ❒ **Food addiction** ❒ **Sexual addiction**
❒ **Headaches** ❒ **Strokes** ❒ **Migraines** ❒ **Poor memory** ❒ **ADHD** ❒ **ADD** ❒ **Autism**
❒ **Other learning disorders** _____
Are you in counseling for any mental health issues? Yes/No

Skin/Ears/Hair/Mouth/Eyes
❒ **Dermatitis** ❒ **Skin infections** ❒ **Boils** ❒ **Warts** ❒ **Fungal conditions** ❒ **Herpes**
❒ **Skin abrasions** ❒ **Acne** ❒ **Rash** ❒ **Rosacea** ❒ **Basal Cell Carcinoma** ❒ **Ear infections**
❒ **Deafness** ❒ **Ringing in ears** ❒ **Trouble hearing** ❒ **Moles monitored by doctor**
❒ **Itching scalp** ❒ **Psoriasis** ❒ **Unwanted facial hair** ❒ **Dandruff** ❒ **Premature hair graying** ❒ **Hair Loss** ❒ **Dental caries** ❒ **Gum disease** ❒ **Root canals** ❒ **Bleeding gums**
❒ **Loose teeth** ❒ **TMJ** ❒ **Teeth pain** ❒ **Teeth sensitivities** ❒ **Jaw clicking** ❒ **Teeth grinding** ❒ **Mouth sores** ❒ **Gum ulcers** ❒ **Cold sores** ❒ **Eyes sensitive to light**
❒ **Glaucoma** ❒ **Night blindness** ❒ **Cataracts** ❒ **Myopia** ❒ **Blurry vision** ❒ **Twitching**
❒ **Red eyes** ❒ **Sore eyes** ❒ **Stabbing pain behind eyes** ❒ **Other** _____

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Social History

Do you have a significant partner? Yes/No
Do you have children Yes/No **If so, how many** ____
Do you feel like you have a person or network of people to go to for emotional support and general mental health? Yes/No
Do you have pets that give you emotional support? Yes/No
Do you have significant stresses in your life? Yes/No **If yes, please explain:** _____

_____

_____

For Females: Menstrual/Sexual History

Pregnancies _____ **Premature births** _____ **Miscarriages** _____
Therapeutic abortions _____**Age at first period** _____ **Age of menopause**____
Date and result of last PAP _____ **Date and result of last Mammogram** _____

If you have in the past or are now taking birth control pills or hormone replacement therapy please list in medications section on the first page of medical history.

Have you had problems with fertility that you are aware of? Yes/No
If yes, please explain _____

Are you currently sexually active? Yes/No

Do you have any concerns with the following (check all that apply): ❒ Vaginal odor ❒ Vaginal sores ❒ Vaginal soreness or pain with intercourse ❒ Vaginal dryness

Do you bleed every month with your menses? Yes/No **If no, how often?** _____
How many days does your bleeding last? _____

Do you have any of the following related to your period? ❒ Excess bleeding ❒ Irritability ❒ Breast tenderness/soreness ❒ Breast distention ❒ Breast masses ❒ Mood swings ❒ Weepiness ❒ Food cravings ❒ Painful cramps ❒ Taste/smell changes ❒ Other pain ❒ Other _____
What (if anything) makes these symptoms feel better? _____
What (if anything) makes these symptoms feel worse? _____

Do you or did you ever have these symptoms related to menopause?
❒ Irregular periods ❒ Taste/smell changes ❒ Night sweats ❒ Hot flashes ❒ Sadness ❒ Depression ❒ Weight gain ❒ Elation ❒ Other _____

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For Males

Have you had problems with fertility that you are aware of? Yes/No
If yes, please explain _____

Are you currently sexually active? Yes/No

Have you been diagnosed with prostate problems? Yes/No
If yes, please explain _____

Family Medical History

Are you adopted? Yes/No

Please list major illnesses:

Mother's side of family	**Father's side of family**
_____	_____
_____	_____
_____	_____

Surgeries and dates (include dental): _____
_____

Significant traumas (falls, auto accidents, bike accidents, sports injuries) and approximate year of incident: _____
_____

Please list past medications no longer taking (for example DES, HRT, steroids, birth control pills), for how long and reason stopped: _____
_____

Significant toxic exposures (household cleaning products, hair/skin products, tainted water supply, on the job, neighborhood, chemical spills): _____
_____

Please use the back of this sheet to add any additional information that you feel might be relevant to the practitioner in developing an accurate and complete diagnosis.

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Office Policies

In order to ensure that your care is as efficient and effective as possible, we have adopted the following policies and procedures:

Appointments
We make every effort to provide you with the appointment time of your choice and to remain on schedule throughout the day. We believe that respect between patient and practitioner includes respect for one another's time. If you are late, your remaining time may not be sufficient for a full treatment, and the treatment will be tailored to fit within the time available. On occasion, there are situations that arise which cause us to run over. If we are late, it will not affect the time of your treatment. If you have time constraints, please let us know so that we may respond accordingly.

Cancellations
The courtesy of a 24-hour notice of cancellation for any appointment is expected and appreciated. The patient is responsible for payment of a cancellation made without notice of 24-hours.

Confidentiality
All information gathered within the context of treatment is held in strict confidence and will **not** be released without your written consent. However, if your insurance is covering your treatments, they have the right to request copies of all records pertaining to your treatment.

Fees, Payment and Insurance Billing
Our fees are currently $100 for the initial visit. Follow-up treatments are $75 per visit. Acupuncture treatments that include massage or herb consultations are $85 plus the cost of herbs. Follow-up consultations for herbal medicine are $45 for 1/2 hour plus the cost of herbs.

Payment is expected at the time of the visit unless other arrangements have been made in advance. We accept cash, checks and credit cards. Acupuncture is covered by worker's compensation, auto insurance and a number of private insurance policies. Should you not have coverage, we can discuss the procedure for billing and payment.

I have read and agree to the policies outlines above.

Patient Acknowledgement:

Signature: _____ **Date:** _____

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Protecting Your Confidential Health Information

Your health information 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 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 doctor 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.
- **Obtain payment.** We will use your health information with an invoice to collect payment for treatment you received in this office. We may do this with insurance forms filed for you in the mail. We only work with companies that share a similar commitment to the confidentiality of your health information.

You have the right to:

- **Inspect and copy your health information.** You may read, review and copy your health information, including your chart, X-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you 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 you 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 7 years.
- **Request a paper copy of this notice.** You may obtain a copy of this privacy notice policy for your records at any time.

Patient Acknowledgment:

Signature: _____ **Date:** _____

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Consent to Treat

I, _____, hereby authorize the above practitioner to administer treatment relevant to my Oriental medical diagnosis, including but not limited to the following:

1. Insertion of sterile acupuncture needles into various points on my body.
2. Heat treatments using moxa/mugwort lit and burned on or near the needles or on the skin; or the use of a heat lamp in conjunction with needle therapy. Moxa is not burned directly on the skin, but on top of an ointment which will conduct the heat and prevent burning the skin. On rare occasions a blister will occur. The acupuncturist will explain the procedure as it is performed and the patient will be asked to give feedback on the degree of heat being experienced at all times.
3. Static stimulation of the needles using a battery operated tool to stimulate a needle and create a current connecting a number of needles.
4. Bloodletting, when appropriate, can be an excellent adjunct to treatment of injuries, both acute and chronic, and can expedite the recovery process from an injury/illness. This is a technique where a point is pricked and a few drops of blood drawn from it.
5. Cupping is a form of treatment where the practitioner applies suction cups to the skin to release congestion, generally in the form of tension. Over time, tight muscles will reduce the amount of blood flow to and through the muscles, a condition called ischemia. Cupping applies suction to the muscle which, when released, causes a release of the stagnant blood in the tissue and encourages an influx of fresh new blood into the area. At times, this can leave a red or purplish mark on the skin (resembling a bruise) that will disappear within a few days. This technique is also used for acute respiratory conditions to help clear the lungs.
6. The use of patent or personalized Chinese herbal formulas to treat my condition.

I am aware that I have the right to refuse any form of treatment. After reading the above, I understand the nature of the treatments that the practitioner may use. I understand that, like all medical procedures, there are risks associated with acupuncture and herbs. I am aware that I am always free to ask questions pertaining to my treatment. I am also aware that there are no guarantees made as to the result of treatment.

I further understand that any diagnosis given in the context of acupuncture treatment does not constitute a western medical diagnosis and recommendations may be made to pursue further medical advice or intervention if necessary.

Patient Acknowledgement:

Signature: _____ **Date:** _____