MYUNG K KIM ACUPUNCTURE PC

196 Main Street
Nanuet, NY 10954
(845) 501-7878
mkkim.acu@gmail.com

This is a confidential questionnaire that will help us determine the optimal treatment plan specific to your needs.
If you have any questions or concerns, please do not hesitate to ask us. Thank you.

NEW PATIENT INTAKE FORM

Today's Date: _____ / _____ /_____

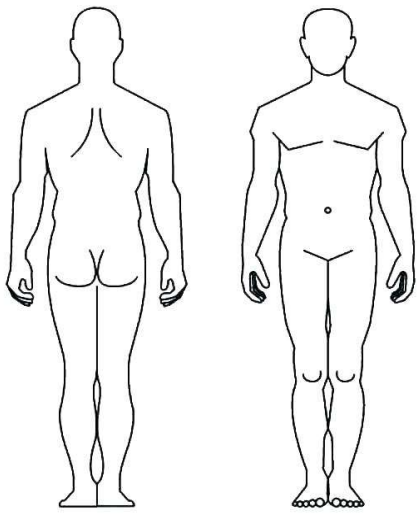
Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____
Email: _____ Date of Birth: ___ /___ /____ Age: _____
Occupation: _____ Employer: _____
Gender: □ Male □ Female Height: _____ Weight: _____
Relationship Status: □ Single □ Married □ Divorced □ Separated □ Widowed □ Minor
Emergency Contact: _____ Phone #: _____ Relationship: _____
How did you hear about us? _____

Have you had Acupuncture before? □ Yes □ No For what condition? _____
How was your experience with Acupuncture? □ Good □ Very Good □ No change
Are you presently under a physician's care? □ Yes □ No For what condition? _____
Physician's Name: _____ Phone #: _____
Address: _____
Did your primary care physician refer you to us? □ Yes □ No
Can we contact these providers to ensure coordination of your care? □ Yes □ No
Do you have a pacemaker? □ Yes □ No Metal implants? □ Yes □ No Where? _____
Are you taking blood thinners? □ Yes □ No

HEALTH INFORMATION

Reason for seeking care at our office? _____
_____
Have you received a medical diagnosis? □ Yes □ No
Please list: _____
Are you experiencing pain right now? □ Yes □ No
Describe your pain? □Dull □Sharp □Stabbing □Shooting
□Burning □Other: _____
What was the initial cause? _____
How long have you had this problem? _____
What makes your symptoms improve? _____
What makes your symptoms worse? _____
List any other providers you have seen for your condition:
_____
Other Comments: _____

On the diagram below, please circle areas where you feel symptoms associated with your complaints.



LIFESTYLE

Do you smoke tobacco? □ Yes □ No How many per day? _____ Age started? ____ Age quit? _____
Do you smoke e-cigarette? □ Yes □ No How many per day? _____ Age started? ____ Age quit? ____
Do you drink alcohol? □ Yes □ No How many per week? _____
Do you use recreational drugs? □ Yes □ No Type? _____ Frequency? _____
Do you exercise regularly? □ Yes □ No Please describe: _____

MEDICAL HISTORY

Check those that apply to your past medical history

☐ Alcoholism / Substance Abuse	☐ High/Low blood pressure	☐ Hepatitis / Liver disease
☐ Allergies	☐ HIV/AIDS	☐ Multiple sclerosis
☐ Autoimmune disorder	☐ Kidney disorder	☐ Obesity
☐ Arthritis / Rheumatism	☐ Emphysema	☐ Pneumonia
☐ Asthma	☐ Fibromyalgia	☐ Sinus infections
☐ Bleeding/Blood disorder	☐ GERD / Ulcer	☐ Skin disorders
☐ Cancer / Tumor	☐ Lyme's disease	☐ Stroke
☐ Diabetes	☐ Lupus	☐ Thyroid disorder
☐ Eating disorder	☐ Mental illness	☐ Tuberculosis
☐ Epilepsy / Seizures	☐ Meningitis	☐ Trauma (fall, car accident, etc.)
☐ Headaches / Migraine	☐ Mononucleosis	☐ Venereal disease / STD
☐ Heart attack/disease	☐ Mumps	☐ Other: _____

FAMILY MEDICAL HISTORY

Check those that apply to your past family medical history

☐ Allergies	☐ Diabetes	☐ Liver disease
☐ Autoimmune disorder	☐ Epilepsy/Seizures	☐ Mental illness
☐ Arthritis / Rheumatism	☐ Heart attack/disease	☐ Skin disorders
☐ Asthma	☐ High/Low blood pressure	☐ Stroke
☐ Cancer	☐ Kidney disease	☐ Other: _____

List any serious diseases, illnesses, injuries, surgeries or hospitalizations you have had (include date):	List any allergies or adverse reactions, especially to food or drugs:

List current Medications, Vitamins, Herbs, Supplements (including over the counter medications)

Name	Reason	Dosage	How Long
.			

Check all SIGNS/SYMPTOMS that you are CURRENTLY experiencing AND/OR experience FREQUENTLY

GENERAL

☐ Poor appetite	☐ Insomnia	☐ Sudden energy loss
☐ Change in appetite	☐ Localized weakness	☐ Low energy/Fatigue
☐ Chills	☐ Poor balance	☐ Peculiar taste/smells
☐ Fevers	☐ Night sweats	☐ Weight loss/gain
☐ Bleed/Bruise Easily	☐ Strong thirst (cold/hot drinks)	

SKIN & HAIR

☐ Rashes	☐ Dandruff	☐ Moles
☐ Hives/Allergic dermatitis	☐ Change in skin/hair texture	☐ Dry skin
☐ Eczema / Psoriasis	☐ Itching	☐ Acne
☐ Hair loss	☐ Skin discolorations	☐ Other: _____

HEAD, EARS, NOSE, THROAT

☐ Dizziness	☐ Eye pain	☐ Dental/Gum problems
☐ Eye Strain	☐ Poor vision	☐ Recurrent sore throat/Colds
☐ Color Blindness	☐ Blurred vision	☐ Sinus problems
☐ Ringing in Ears	☐ Teeth grinding	☐ Facial pain
☐ Nosebleeds	☐ Jaw clicks/locks	☐ Facial flushing
☐ Headache / Migraines	☐ Poor hearing	☐ Sores on lips/tongue
☐ Difficulty swallowing	☐ Earaches	☐ Other: _____

CARDIOVASCULAR

☐ Chest pain	☐ Irregular heartbeat	☐ Fainting
☐ Cold hands/feet	☐ Swelling of hands/feet	☐ Varicose / spider veins
☐ Pressure in chest	☐ Palpitations	☐ Other: _____

RESPIRATORY

☐ Cough	☐ Phlegm production	☐ Wheezing
☐ Difficult to inhale/exhale	☐ Chest tightness	☐ Pain with deep inhalation
☐ Coughing blood	☐ Shortness of breath	☐ Other: _____

GASTROINTESTINAL

☐ Nausea	☐ Bloating	☐ Constipation / Diarrhea
☐ Belching / Gas	☐ Changes in appetite	☐ Black Stools
☐ Gas	☐ Abdominal Pain/cramps	☐ Blood in stools
☐ Indigestion	☐ Acid reflux	☐ Other: _____

UROGENITAL

☐ Pain on urination	☐ Frequent / Urgent urination	☐ Burning urination
☐ Unable to hold urine	☐ Kidney stones	☐ Blood in urine
☐ Dribbling after urination	☐ Urinary tract infections	☐ Other: _____

NEUROPSYCHOLOGICAL

☐ Seizures / Tremors	☐ Confusion	☐ Difficulty Concentrating
☐ Lack of coordination	☐ Loss of balance	☐ Bad temper / Irritable
☐ Anxiety/ panic attacks	☐ Paralysis	☐ Emotional changes
☐ Depression / PTSD	☐ Poor memory	☐ Easily susceptible to stress
☐ Vertigo	☐ Area of numbness	☐ Other: _____

MUSCULOSKELETAL

☐ Neck pain	☐ Tendonitis	☐ Muscle weakness/pain
☐ Shoulder pain	☐ Hand / Wrist pain	☐ Muscle spasms/cramps
☐ Knee pain	☐ Foot / Ankle pain	☐ Muscle stiffness
☐ Back Pain	☐ Bursitis	☐ Sciatica
☐ Joint pain	☐ Sprains / Strains	☐ Other: _____

FOR MEN ONLY

☐ Infertility ☐ Premature ejaculation ☐ Prostate disorders ☐ Low sperm count/motility	☐ Sexual dysfunction ☐ Testicular masses ☐ Testicular pain ☐ Unusual discharge	☐ Hernia ☐ Genital sores ☐ Other: _____

FOR WOMEN ONLY

☐ Painful menses ☐ Irregular menstruation ☐ Ovarian cysts ☐ Vaginal sores	☐ Vaginal discharge ☐ Vaginal dryness ☐ Painful intercourse ☐ Breast lumps	☐ Fibrocystic breast ☐ Fibroid tumors ☐ Infertility ☐ Other: _____

- Are you currently pregnant? □ Yes □ No Are you trying to become pregnant? □ Yes □ No
- # of pregnancies: _____ # of births: _____ # of miscarriages: _____ # of premature births: _____
- Age of first menses: _____ Date of last menses: _____
- Abdominal cramping? □ Yes □ No If yes, □ Before menses □ During menses □ After menses
- Length of cycle (days): _____ Same day of cycle each month? □ Yes □ No Length of period (days)? ____
- Color: □ Light □ Normal □ Dark
- Amount: □ Heavy menstrual flow □ Normal □ light, scanty flow
- Consistency: □ Thick □ Normal □ Thin
- Clots? □ Yes □ No
- Vaginal discharge between periods? □ Yes □ No If yes, □ white □ yellow □ other: _____
- Do you practice birth control? □ Yes □ No What type? _____ How long? _____

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PATIENT ADVISORY TO CONSULT A PHYSICIAN

Myung K Kim Acupuncture PC is committed to your health and well-being. While Traditional Chinese Medicine modalities, such as Acupuncture and Herbal Medicine, have a great deal to offer as a health care system, it cannot entirely replace the services available from biomedical practitioners. Therefore, it is recommended that you consult a physician regarding any condition(s) for which you are seeking acupuncture or herbal treatment.

To comply with Article 160, Section 8211.1 (b) of New York State Education law, please read and sign the following statement:

I, _____ (print name) do affirm that I have been advised by Myung K Kim Acupuncture PC and their licensed acupuncturists, to consult a physician regarding the condition or conditions for which I seek acupuncture treatment.

Patient Signature: _____Date: _____

FINANCIAL POLICY

I, _____ (print name) do affirm that I am financially responsible for payment of all medical services received at this office, and that full payment for all services and products is required at the time of service. There will also be a $35.00 fee charged for any returned checks.

I also understand that all scheduled appointments are my responsibility and I will give the courtesy of at least 24 hours prior notice for cancellation. Otherwise, I am responsible for any fees associated with any missed appointments.

Patient Signature: _____Date: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent.

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 with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I, _____ (print name) do affirm that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I also have read and understand your Notice of Privacy Practices. 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 and disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Signature: _____Date: _____