411 West Main Street, Suite 2R
Northborough, MA 01532
www.opencirclehealing.com

Name: ..... Date: .....

Address:..... City:..... State: ..... Zip: .....

Email: .....

Primary Phone: ..... Date of Birth: .....

Emergency Contact & Phone: .....

Occupation: ..... Have you received acupuncture before? ❑ Yes ❑ No

Who is your current primary care physician or healthcare specialist? .....

## NOTICE OF RECEIPT OF PRIVACY POLICIES

As mandated by federal and state legal requirements, your health information must be protected. As part of these regulations, we are required to ensure that you are aware of privacy policies, legal duties, and your rights to your protected health information.

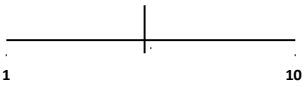
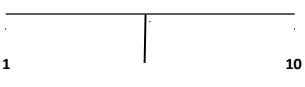
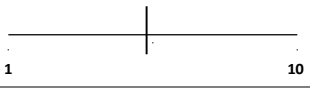
I have received, read, and understood Open Circle Acupuncture's Privacy Policy Notice. I understand how this health care office and its health care providers may use or disclose my health information. I understand when this health care office may not use or disclose my health information. I understand my health information rights and understand that the office reserves the right to change the Privacy Policies Notice. I also understand how to place a complaint regarding this Notice and have also been provided the opportunity to review and question the privacy policies of this health care office.

**By signing below you acknowledge that you have received and read a copy of our privacy policies information.**

(This is included on this clipboard, under the health history forms, for you to read, or you may request a copy to read at the clinic if you downloaded paperwork online.)

Signature:_____

*Patient or guardian*

| **Primary Concerns or Goals** | | | | |
|---|---|---|---|---|
| Please list your top three concerns/goals in order of importance to you. | Mark an X on the scale to indicate the severity of the condition. | When did this start? | What makes it better? | What makes it worse? |
| 1. |  | | | |
| 2. |  | | | |
| 3. |  | | | |

**Health History** — Check the "Self" box if you have or had the condition and the year it began and the "Family" box if there is a family history.

| *Condition* | *Self /Year* | *Family* | *Condition* | *Self /Year* | *Family* |
|---|---|---|---|---|---|
| Cancer *(specify:.....)* | ❑..... | ❑ | Osteoporosis | ❑..... | ❑ |
| Diabetes | ❑..... | ❑ | STD *(specify: .....)* | ❑..... | ❑ |
| Hepatitis | ❑..... | ❑ | Rheumatic fever | ❑..... | ❑ |
| High blood pressure | ❑..... | ❑ | Substance dependency | ❑..... | ❑ |
| Heart Disease | ❑..... | ❑ | Allergies *(specify:.....)* | ❑..... | ❑ |
| Stroke | ❑..... | ❑ | Psychological | ❑..... | ❑ |
| Seizure disorder | ❑..... | ❑ | *(specify:.....)* | | |
| Thyroid disease | ❑..... | ❑ | Kidney disease | ❑..... | ❑ |
| Asthma | ❑..... | ❑ | Anemia | ❑..... | ❑ |
| Eating disorder | ❑..... | ❑ | History of Trauma | ❑..... | ❑ |

**Injuries & Surgeries** (including dental) — Please list what happened to what body area and when it occurred.

| *Date* | *Issue* |
|---|---|
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |

**Medications —** Please list any medications, herbs or supplements that you take regularly**.**

| *What* | *For what* |
|---|---|
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |

Mark an X on the scales and check any boxes of symptoms or conditions you have had **in the past month**, in any applicable sections.

**Temperature** — How warm or cold you feel relative to other people (e.g., do you usually need to wear more layers or fewer)?

COLD ——— HOT

- ❑ Cold hands or feet
- ❑ Chills
- ❑ Cold "in the bones"
- ❑ Numbness
- ❑ Hot flashes
- ❑ Hot at night
- ❑ Night sweats
- ❑ Unusual sweats — specify when & where on body:

.....

## Digestion

- ❑ Indigestion
- ❑ Gas
- ❑ Bloating
- ❑ Belching
- ❑ Poor appetite
- ❑ Nausea
- ❑ Obesity
- ❑ Vomiting
- ❑ Bad breath
- ❑ Heartburn
- ❑ Hernia
- ❑ Hemorrhoids
- ❑ Food intolerances or allergies
- ❑ Excess hunger

DIARRHEA ——— CONSTIPATION

BM: How often?

..... *x every* ..... *days*

Stools keep shape?

❑ Yes ❑ No

- ❑ Alternating diarrhea & constipation / IBS
- ❑ Dry stools
- ❑ Difficult to pass
- ❑ Tired After BM
- ❑ Pain with BM
- ❑ Foul-smelling stools

## Sleep

.....# hours per night

- ❑ Difficulty falling asleep
- ❑ Disturbing dreams
- ❑ Restless sleep
- ❑ Not rested upon waking
- ❑ Sleep Apnea
- ❑ Wake ..... *x per night at ..... am / pm*
- ❑ Wake to urinate: *how often: :.....*

**Emotions** — What emotions are troubling to you or dominate your experience?

- ❑ Anger
- ❑ Irritability
- ❑ Anxiety
- ❑ Worry
- ❑ Obsessive Thinking
- ❑ Sadness
- ❑ Seasonal Depression
- ❑ Grief
- ❑ Depression
- ❑ Joy
- ❑ Fear
- ❑ Timidness / Shyness
- ❑ Indecisiveness

## Energy

LOW ——— HIGH

- ❑ Sudden energy drop *time of day:.....*
- ❑ Energy drop after eating
- ❑ Fatigue
- ❑ Dependence on caffeine/stimulants
- ❑ Wired or ungrounded feeling
- ❑ Body or limbs feel heavy
- ❑ Body or limbs feel weak
- ❑ Shortness of breath
- ❑ Heart palpitations
- ❑ Blood pressure high / low
- ❑ Bleed / bruise easily
- ❑ Difficulty concentrating
- ❑ Poor memory
- ❑ Dizziness / lightheadedness
- ❑ Headaches: ..... *x per week*

## Women

Age at first menses: .....

Average length of full cycle: ..... days (i.e. 28)

Average length of menses: ..... days (i.e. 3-4)

Last menses start date: .....

Are you pregnant?: Y / N (circle one)

# of pregnancies: ..... # of births: ..... # premature: .....

# of abortions:..... # of miscarriages: .....

Do you use hormonal birth control? ❑ Yes ❑ No

Have you seen any specialists to assist in getting pregnant?

❑ Yes ❑ No

If so what assisted interventions have you tried?

(e.g., IUI, IVF, etc).....

### Periods

- ❑ Heavy
- ❑ Light
- ❑ Painful
- ❑ Irregular
- ❑ Clots

### Cramps

- ❑ before bleeding
- ❑ first day
- ❑ during period

### Menopause

Age at last menses: .....

Year changes began: .....

- ❑ Vaginal dryness
- ❑ Loss of sex drive
- ❑ Hot flashes ……x per day
- ❑ Nightsweats……x per week

### During cycle

- ❑ Changes in body/psyche prior to menstruation
- ❑ Fatigue
- ❑ Breast tenderness
- ❑ Mood changes
- ❑ Digestive Changes
- ❑ Mid-cycle spotting

### Men

- ❑ Prostate enlargement
- ❑ Infertility
- ❑ Impotence
- ❑ Decreased Sex Drive
- ❑ Genito-urinary problems

Check any boxes of symptoms or conditions you have had **in the past month**, in any applicable sections

RESPIRATORY

| | | | |
|---|---|---|---|
| ❑ Cough | ❑ Allergies | ❑ Frequent Colds/Flus | ❑ Tight sensation in chest |
| ❑ Production of Phlegm. Color?..... | ❑ Sinus Issues | ❑ Bronchitis/Pneumonia | ❑ COPD/Emphysema |

SKIN & HAIR

| | | | |
|---|---|---|---|
| ❑ Rashes | ❑ Dry Skin | ❑ Fungal Infection | ❑ Face Flushing |
| ❑ Eczema | ❑ Psoriasis | ❑ Itching | ❑ Change is skin or hair texture |
| ❑ Loss of Hair | ❑ Hives, Dermatitis | ❑ Rosacea | ❑ Acne |

CARDIOVASCULAR

| | | | |
|---|---|---|---|
| ❑ Bruise Easily | ❑ Dizziness | ❑ Heart Murmur | ❑ Swelling of Hands/Feet |
| ❑ Chest Pain/Pressure | ❑ High Blood Pressure | ❑ Pacemaker | ❑ Varicose/Spider veins |
| ❑ Cold Hands/Feet | ❑ Low Blood Pressure | ❑ Palpitations | ❑ Spontaneous Sweating |
| ❑ Blood Clots | ❑ Fainting | ❑ Diagnosed HT Problem | ❑ High Cholesterol |

GENITO-URINARY

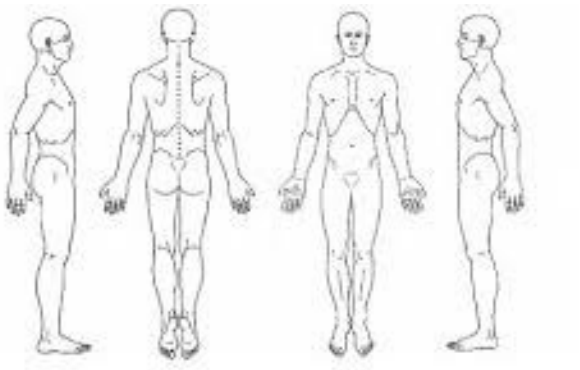
| | | | |
|---|---|---|---|
| ❑ Blood in Urine | ❑ Decreased Urination (< 5x/day) | ❑ Frequent Urination (>10x/day) | ❑ Kidney Stones |
| ❑ Burning Urination | ❑ Painful Urination | ❑ Stress Incontinence | ❑ Prolapsed Bladder |
| ❑ Urination at Night | Time?..... | How Often?..... | ❑ Incomplete Urination |

MUSCULOSKELETAL: PAIN OR TIGHTNESS IN AREAS OF THE BODY

| | | | |
|---|---|---|---|
| ❑ Ankle/Foot Pain | ❑ Loss of Sensation | ❑ Sciatica | ❑ Shoulder Pain |
| ❑ Muscle Spasms | ❑ Tendonitis | ❑ Hand/Wrist Pain | ❑ Muscle Weakness |
| ❑ Hip Pain | ❑ Neck Pain | ❑ Swelling | ❑ Knee Pain |
| ❑ Numbness/Tingling | ❑ Pelvic Pain | ❑ Back Pain Low…… | Middle……..Upper…… |

NEUROLOGICAL

| | | | |
|---|---|---|---|
| ❑ Change in Gait | ❑ Loss of Sensation | ❑ Slow or Slurred Speech | ❑ Lack of Coordination |
| ❑ Numbness | ❑ Tremors | ❑ Loss of Balance | ❑ Seizures |
| ❑ Concussion | ❑ Vertigo/Dizziness | ❑ Tinnitus | ❑ Migraine |



Place an X on any areas of the body to show locations of pain, tightness or discomfort

## Patient Informed Consent

I agree to receive acupuncture treatment by the licensed acupuncturists of Open Circle Acupuncture & Healing. I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and in rare cases dizziness or fainting. On rare occasions, current symptoms may worsen before they find relief. I also understand there is always a possibility of unexpected complications and I understand that no guarantee can be made concerning the results of the treatment.

If I am pregnant or become pregnant, I will notify my practitioners *immediately*.

I understand that the acupuncturists of Open Circle Acupuncture & Healing use only sterile, disposable, single-use needles, practice safe needling techniques, and maintain a clean and safe environment. I understand that other modalities may be used including cupping therapy, acupressure balls, press needles, magnets, electro-acupuncture therapy and laser therapy.

I understand that the Open Circle Acupuncture & Healing practice may reach out to medical providers to introduce our services. No confidential information will be released. I understand that the clinical and medical staff may review my files, but all my records will be kept confidential and can only be released under my personal written consent, or when required by law.

I have read this form and have also had an opportunity to ask questions about its content. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I agree:

..... .....

Signature Date

## Cancellation Policy

I understand that Open Circle Acupuncture will charge the full session fee or one treatment off a package when a session is broken either by not providing 24 hours' notice of cancellation, not showing, or showing up 5 minutes after my appointment start time. We require a credit card on file to hold your appointment. Cancellation fees will be charged to the card on-file. *Packages already in use are non-refundable but can be shared, gifted, or donated.*

…… ……..

Signature Date

…… ……

Credit Card # Expiration Date

**How Did You Hear About Us?**

- ❑ Friend or Family:…… (we want to thank them!)
- ❑ Health Practitioner:…… (we want to thank them!)
- ❑ Picked up Postcard, Coupon or Misc Print Material
- ❑ Drove by or Live in the Neighborhood
- ❑ Google or Internet Search
- ❑ Yelp
- ❑ Facebook/Twitter/Instagram
- ❑ Other……