



GRAND ISLAND CHIROPRACTIC  
 2283 GRAND ISLAND BLVD  
 GRAND ISLAND, NY 14072  
 (Town Hall Plaza)  
 (716) 773-2222  
 FAX (866) 907-6157

NOTARO CHIROPRACTIC  
 10158 NIAGARA FALLS BLVD  
 NIAGARA FALLS, NY 14304  
 (Como Airport Plaza)  
 (716) 298-0368  
 FAX (866) 907-6157

NOTARO CHIROPRACTIC  
 4754 N. French Road  
 East Amherst, NY 14051  
 (The Commons)  
 (716) 688-8815  
 FAX (866)907-6157

Welcome! Please take the time to fill out this questionnaire fully. Your answers are strictly confidential. If you have any questions, please feel free to ask.

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ E-mail \_\_\_\_\_

Tel: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Ok for me to send you appointment reminders via text message and/or call?  Y  N

Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex:  M  F

Occupation \_\_\_\_\_ Who referred you? \_\_\_\_\_

Name & Tel # of Physician \_\_\_\_\_

OK for me to contact?  Y  N

Emergency Contact Name & Tel# \_\_\_\_\_

Relationship \_\_\_\_\_

**Insurance Information:**

Name of Primary Insurance \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Subscriber ID /Member Number \_\_\_\_\_

Subscriber's Birthday \_\_\_\_\_ Patient's Relationship to Subscriber \_\_\_\_\_

Telephone Number of Insurance \_\_\_\_\_

Name of Secondary Insurance \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Subscriber ID/ Member Number \_\_\_\_\_

Subscriber's Birthday \_\_\_\_\_ Patient's Relationship to Subscriber \_\_\_\_\_

Telephone Number of Insurance \_\_\_\_\_

\*\*\*\*\*

Are you currently pregnant? \_\_\_\_\_ Are you presently trying to become pregnant? \_\_\_\_\_

Have you received acupuncture before? \_\_\_\_\_ If so, for what condition? \_\_\_\_\_

What was the outcome? \_\_\_\_\_

What would you like treated by acupuncture? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ The onset was  Sudden or  Gradual?

What were the circumstances? \_\_\_\_\_

What medical diagnosis have you received, if any? \_\_\_\_\_

What kinds of treatment or therapy have you tried? \_\_\_\_\_

How has this condition affected your daily activities? \_\_\_\_\_

What makes this condition better? \_\_\_\_\_ worse? \_\_\_\_\_

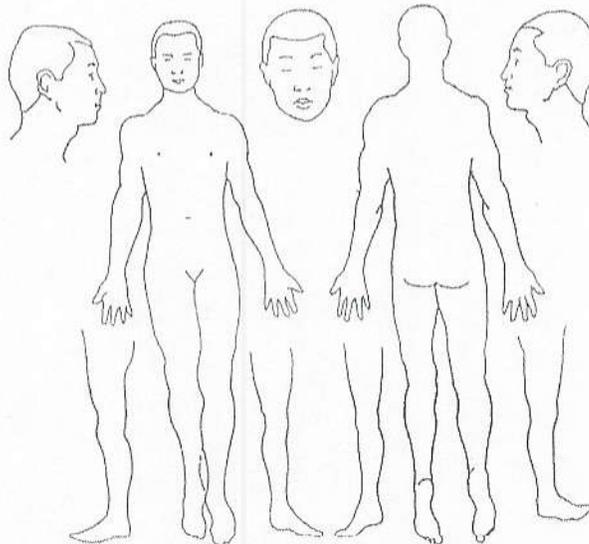
Rate the intensity of the physical discomfort of this condition:

(None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

How emotionally distressed are you by this condition?

(Not at all) 0 1 2 3 4 5 6 7 8 9 10 (Extremely)

**Please shade any areas of pain or distress on the diagram below:**



**Medical History** Please check off any current or former conditions and include dates as well as any relevant information.

- AIDS/HIV \_\_\_\_\_ any neuropathies? \_\_\_\_\_
- Alcoholism/ Drug Abuse \_\_\_\_\_
- Allergies \_\_\_\_\_  Anemia \_\_\_\_\_
- Asthma/ Bronchitis \_\_\_\_\_  difficulty inhaling  difficulty exhaling
- Bell's Palsy \_\_\_\_\_  Blood clotting disorder \_\_\_\_\_
- Bipolar disorder \_\_\_\_\_  Cancer/Tumor \_\_\_\_\_
- Chron's Disease & / or colitis \_\_\_\_\_

- |   |  |
|---|--|
| <input type="checkbox"/> Chronic Fatigue Syndrome (CFIDS) | <input type="checkbox"/> Depression (Major)                    |
| <input type="checkbox"/> Diabetes-Type                    | <input type="checkbox"/> any neuropathies?                     |
| <input type="checkbox"/> Eczema                           | <input type="checkbox"/> Emphysema                             |
| <input type="checkbox"/> Endometriosis                    | <input type="checkbox"/> Fibroids                              |
| <input type="checkbox"/> Fibromyalgia                     | <input type="checkbox"/> Gallstones                            |
| <input type="checkbox"/> Heart Disease                    |  |
| <input type="checkbox"/> Hepatitis A/B/C - please specify |  |
| <input type="checkbox"/> Hernia                           | <input type="checkbox"/> Herpes - Type                         |
| <input type="checkbox"/> Hypertension                     | <input type="checkbox"/> Hypoglycemia                          |
| <input type="checkbox"/> Irritable Bowel Syndrome (IBS)   |  |
| <input type="checkbox"/> Joint Replacement                | <input type="checkbox"/> Kidney Stones and /or Disease         |
| <input type="checkbox"/> Lupus                            | <input type="checkbox"/> Lyme disease                          |
| <input type="checkbox"/> Lymph Nodes removed - where?     | can you have injections on that side?                          |
| <input type="checkbox"/> Mitral Valve Prolapse            | <input type="checkbox"/> Mood Disorder                         |
| <input type="checkbox"/> Multiple Sclerosis               | <input type="checkbox"/> Organ Transplant/ Removed             |
| <input type="checkbox"/> Osteoarthritis                   | <input type="checkbox"/> Osteoporosis                          |
| <input type="checkbox"/> Pacemaker                        |  |
| <input type="checkbox"/> Parkinson's Disease              | <input type="checkbox"/> Pelvic Inflammatory Disease           |
| <input type="checkbox"/> Polio                            | spinal segments involved                                       |
| <input type="checkbox"/> Psoriasis                        | <input type="checkbox"/> PTSD (Post-Traumatic Stress Disorder) |
| <input type="checkbox"/> Reflux Esophagitis (GERD)        | <input type="checkbox"/> Rheumatic or Scarlet Fever            |
| <input type="checkbox"/> Rheumatoid Arthritis             | <input type="checkbox"/> Seizures and/or Epilepsy              |
| <input type="checkbox"/> Shingles                         | <input type="checkbox"/> Stroke                                |
| <input type="checkbox"/> Schizophrenia                    | <input type="checkbox"/> Thyroid disease                       |
| <input type="checkbox"/> Tuberculosis                     | <input type="checkbox"/> Trigeminal Neuralgia                  |
| <input type="checkbox"/> Other                            |  |

Vaccination History: Any reaction that you remember? Any unusual vaccinations?

**Please describe any significant accidents, injuries, trauma, illnesses, and surgeries:**

Birth complications/trauma (your own), if any \_\_\_\_\_  
 Age \_\_\_\_\_  
 Age \_\_\_\_\_  
 Age \_\_\_\_\_  
 Age \_\_\_\_\_  
 Age \_\_\_\_\_

Scars from injury/surgery (even minor): \_\_\_\_\_

**Medications** Please list all medications (including over-the counter), herbs, vitamins and minerals you are taking and their indications. \_\_\_\_\_

## Family Medical history

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, hepatitis, high cholesterol, cancer, etc.

Mother \_\_\_\_\_  
Father \_\_\_\_\_  
Siblings \_\_\_\_\_  
Maternal Grandparents \_\_\_\_\_  
Paternal Grandparents \_\_\_\_\_

## Diet and Lifestyle

How is your appetite?  Good  Poor  No appetite  Hungry all the time

Any food cravings? \_\_\_\_\_

Any food intolerances? \_\_\_\_\_

Are you vegetarian? \_\_\_\_\_ How many years? \_\_\_\_\_

How do you feel emotionally around food? \_\_\_\_\_

Any history of an eating disorder? \_\_\_\_\_

Thirst:  Always thirsty  Never thirsty  Thirsty, but no desire to drink  Dry mouth  Bitter taste

Do you prefer  Hot or  Cold drinks? Do you more often feel  Hot or  Cold?

How much and how often do you have the following:

Meat \_\_\_\_\_ day/wk, Sugar/Sweets \_\_\_\_\_ day/wk, Caffeine (Coffee, Tea, Soda) \_\_\_\_\_ day/wk,

Dairy (milk, cheese, yogurt, ice cream) \_\_\_\_\_ day/wk, Water \_\_\_\_\_ day/wk,

Alcoholic beverages \_\_\_\_\_ day/wk

How is your energy? \_\_\_\_\_ What time of day is it highest? \_\_\_\_\_ lowest? \_\_\_\_\_

Are you a  Morning person?  Night owl?

What kind of exercise do you do? \_\_\_\_\_

How often? \_\_\_\_\_ Does exercise:  give you energy or  make you tired?

Any unusual sweating? \_\_\_\_\_ Dizziness? \_\_\_\_\_

How do you feel emotionally? \_\_\_\_\_

Do you have:  depression  anxiety  panic attacks  insomnia  irritability/short temper

poor memory  difficult concentration  feeling overwhelmed  extreme mood swings

extreme lack of emotion  other \_\_\_\_\_

Single,  Stable relationship,  Married,  Divorced/ Separated,  Widowed

How do you feel about your relationship? \_\_\_\_\_

How is your sexual energy? \_\_\_\_\_

How do you feel about your work? \_\_\_\_\_

What aspect of your life do you find most stressful? \_\_\_\_\_

How / where do you hold stress? \_\_\_\_\_

How do you relax? \_\_\_\_\_

How many hours do you generally sleep per night? \_\_\_\_\_ Do you have night sweats? \_\_\_\_\_

Do you have trouble  falling asleep  staying asleep  dream disturbed sleep

Do you wake at the same time every night? What time \_\_\_\_\_

Do you use prescription or recreational drugs to help you relax or sleep? \_\_\_\_\_

Please **circle** any condition you have now, and **underline** any condition you have had in the past:

**Musculoskeletal:** Muscle pain/ tightness/ cramping. Spasms. Weakness. Repetitive strain. Tendonitis. Arthritis/Joint pain. Joint clicking. Limitation of movement. Rheumatism. Swollen joints. Bone pain. Where? \_\_\_\_\_

Pain is: Sharp. Burning. Dull/Aching. Deep. Superficial. Shooting. Tingling. Numb. Better with heat. Better with cold. Better with rest. Better with movement or massage. Worse in AM/ PM.

**Gastro-intestinal:** How often do you move your bowels? \_\_\_\_\_

Difficult or painful bowel movement. Constipation. Diarrhea/Loose stool. Alternating constipation/diarrhea. Hard stool. Burning. Undigested food in stool. Abdominal pain. Distention/Bloating. Gas. Nausea. Vomiting. Vomiting with blood. Foul breath. Belching. Acid reflux. Lack of stomach acid. Heartburn. Indigestion. Blood in stool. Black stool. Hemorrhoids. Chronic laxative use. Feel bloated/ tired after eating. Ulcer. Other \_\_\_\_\_

**Respiratory, Eyes, Ears, Nose, Throat, & Head:**

Do you smoke cigarettes? \_\_\_\_\_ day/wk, for \_\_\_\_\_ years

Chronic cough. Coughing blood. Coughing mucus. Asthma/Wheezing. Shortness of breath on exertion/at rest. Difficulty breathing lying down. Excessive phlegm. Frequent colds. Nose bleeds. Chronic runny nose. Chronic stuffy nose. Post-nasal drip. Sinus Infections. Yellow mucus.

Painful/Red eyes. Poor vision. See spots/Floaters. Night blindness. Blurry vision. Problems with balance (vertigo). Ear pain/infections. Poor hearing. Ringing in ears. Sore throat. Streptococci infections. Bleeding gums. Sores on lips or tongue. Gum problems. Dental abscess. Facial pain. TMJ /Jaw pain.

Other \_\_\_\_\_

Frequent headaches/migraines describe \_\_\_\_\_

**Cardiovascular:** Have you been diagnosed with any heart trouble? \_\_\_\_\_

What is your blood pressure? \_\_\_\_\_ Fast pulse >100 bpm. Slow pulse <60 bpm. Chest pressure or pain. Shortness of breath. Palpitations/Arrhythmia. High blood pressure. Low blood pressure. Flushed face. Dizziness/Vertigo. Fainting. Diabetic neuropathy. Varicose veins. Cold hands and feet. Cold sweats. Poor circulation. Blood clots. Bruise easily. Swelling of the ankles or legs. Edema. Other heart or blood vessel problems \_\_\_\_\_

**Skin, Hair, Nails:** Dry skin. Rashes. Itching. Hives. Acne. Red face. Face flushes. Dry hair. Dandruff. Hair loss. Premature graying. Brittle nails. Fungal infections. Sweaty hands/ feet/ everywhere. No sweat. Night sweating. Other \_\_\_\_\_

**Misc:** Fatigue/Exhaustion. Motion sickness. Tremors/Tics. Dizziness. Poor balance. Fever. Chills. Headache with nausea. Hormone Imbalance. Thyroid imbalance. Hypoglycemia. Autoimmune disease. Emotional problem. Difficulty waking up in morning. Energetic all evening. Confusion. Changes in consciousness. Car/Sea/Air sickness. Teeth grinding.

Other \_\_\_\_\_

**Urinary:** Frequent urination. Painful urination. Burning urination. Blood in urine. Trouble starting stream. Urgency to urinate. Incontinence. Urinary tract infections. Pale urine. Dark yellow urine.

Do you wake at night to urinate? \_\_\_\_\_ other \_\_\_\_\_

**Women:**  Currently using birth control medication.  Used in past. For how many years? \_\_\_\_\_

What type? \_\_\_\_\_

Age of onset of menses \_\_\_\_\_ days between cycles \_\_\_\_\_ duration of flow \_\_\_\_\_

Color/quality of blood \_\_\_\_\_

Irregular menstruation. Long/ Short cycle. Pain before/During/ After menses.

Heavy/ Light/ No bleeding. Spotting between periods. Clots.

Number of pregnancies \_\_\_\_\_ deliveries \_\_\_\_\_ abortions/miscarriages \_\_\_\_\_ age at menopause \_\_\_\_\_

Pregnancy complications \_\_\_\_\_

Vaginal discharge: amount \_\_\_\_\_ color \_\_\_\_\_ quality \_\_\_\_\_ frequency \_\_\_\_\_

Vaginal itching/burning/ Discharge/ Pain. Yeast infection.

PMS symptoms: Emotional. Irritability. Breast tenderness. Breast lumps. Cramps. Related Headache. Low back pain. Other \_\_\_\_\_

Uterine Fibroids. Uterine Cysts. Hysterectomy. Tubal Ligation. Discharge from breasts.

Infertility. Menopausal symptoms. Reduced sexual energy. Genital sores. Genital pain. Abnormal vaginal bleeding. Pelvic pain.

Other \_\_\_\_\_

**Men:** Prostatitis. Impotence. Premature ejaculation. Seminal emission. Reduced sexual energy. Genital sores. Genital pain. Blood/mucus discharge. Vasectomy. Low sperm count/ motility.

Other \_\_\_\_\_

Type of contraception used? \_\_\_\_\_

Have you ever had a prostate examination? \_\_\_\_\_

Is there anything else you wish to bring to our attention?

Please describe your goals, hopes and expectations for acupuncture treatments:

**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 a new condition arise.

Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

I authorize my insurance benefits to be directly paid to the acupuncturist. I understand that I am financially responsible for any balance. If my insurance carrier sends payment to me for services incurred in this office, I agree to send or bring those payments to this office upon receipt. I authorize Frank S. Tang, L.Ac. or the insurance company to release any information required to process my claims. I agree that I will pay the reduced fee of \$79 for an initial treatment and \$65 for each follow-up treatment due to financial difficulties if my insurance does not cover acupuncture treatments.

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**Signature of Patient or Patient Representative**

**Date**

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**Practitioner Signature**

### **Cancellation Policy**

I understand that there is a 24-hour cancellation policy. I agree to pay the full price of a session if I cancel less than 24 hours within the scheduled appointment time.

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**Signature of Patient or Patient Representative**

**Date**

### **Informed Consent**

I consent to acupuncture treatments and related procedures, associated with Oriental Medicine, by Frank S. Tang, L.Ac. I have discussed the nature and purpose of my treatment with her and I understand that the methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, gua sha, and electrical stimulation.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, tingling, numbness or mild pain near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and gua sha. An unusual risk of acupuncture includes spontaneous miscarriage, nerve damage, and organ puncture. Infection is another possible risk, although this office uses only sterile, disposable needles while maintaining a clean and safe environment. Burns and scarring are potential risks of using moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgments during the course of treatment, and decide what she thinks is in my best interest, based upon the facts that are known at the time.

Since everyone responds to acupuncture differently, outcome of the treatment cannot be guaranteed. Some individuals may experience total or partial relief of their pain or symptoms after the first few treatments, while others may notice a steady, gradual improvement. In some cases, no relief may be felt at all until after several days go by. Some people may notice that their pain actually seems to be worse before it gets better.

I will notify the acupuncturist, who is caring for me, if I become pregnant.

By voluntarily signing below, I show that I have read or have had read to me, this consent to treatment. I have been told about the risks and benefits of acupuncture and other procedures and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for both the present condition and for any future conditions for which I seek treatment(s).

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Signature of patient or patient representative

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Date

### Notice of HIPAA Privacy Practice

I have received the HIPAA privacy notice of Frank S. Tang

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Signature of patient or patient representative

---

Date

## 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