Becky La Plante, L.Ac.
15R Hartford Ave
Granby CT, 06035
860.341.1227

Date:_____

Please note that all information is strictly confidential

Name:: _____ **Primary Phone:_____**

Email Address: _____ **Secondary Phone:_____**

Address: _____ **City/Postal Code:_____**

Date of Birth: _____ **Age: _____** **Marital Status: _____** **No. of Children: _____**

Occupation: _____ **Primary Physician: _____**

Emergency Contact: _____ **Phone #: _____**

Reason for Today's Visit/Chief Complaint:

How, when and where did this condition begin?

What types of treatments have you tried, if any?

What makes it better?

What makes it worse?

Please list any other health problems you would like to address in order of importance:

Surgeries, Major Illnesses, Hospitalizations, Major Accidents (include dates):

Immediate Family Medical History (Mother, Father, Siblings):

Do you have any drug or food allergies? If so, what?

Please list any medications you are taking

Current medications	**Dosage:**	**Reason for Using:**

Diet & Lifestyle

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much
Coffee				Water Intake			
Tobacco				Rec. drugs			
Alcohol				Soda			

Appetite: ☐ Low ☐ Moderate ☐ High **Thirst:** ☐ Low ☐ Moderate ☐ High

I prefer: ☐ Hot ☐ Cold foods and drinks **I tend to crave:** ☐ Sweets ☐ Sour ☐ Bitter ☐ Salty ☐ Spicy

I regularly consume: ☐ Artificial Sweeteners ☐ Sugar ☐ White Flour ☐ Dairy ☐ Canned/Frozen Food ☐ Fast Food

Exercise? Yes No How often? _____ What type_____

Women Only: Circle your answers.

Are you currently pregnant? _____ **Are you on the birth control pill? _____**

# of pregnancies_____ # of live births_____ # of miscarriages_____ # of abortions_____

How old were you when you had your first period? _____

Have you experienced menopause? Yes No When? _____

If you are experiencing menopausal symptoms, please describe:

Vaginal Discharge? Yes No

Is your period regular?_____ When was the first day of your last period?_____

# of days from the start of one period to the start of the next _____

Average number of days of flow: _____ Flow is: Light Normal Heavy

Color is: Pale Normal Dark Bright Red Brown Purple

Blood clots? Yes No

Do you get pain or cramps? Yes No **Severe?** Yes No **What day do the cramps start**?

Nature of pain (circle): Sharp Dull Constant Intermittent Burning Aching

Do you experience any of the following before or during your menstrual period?

Water retention Breast tenderness/swelling Depression Irritability Migraines

Insomnia Diarrhea Constipation Nausea Hot flashes Night sweats

---

Men Only:

Date of last prostate check up: _____ Results: _____

Circle all that apply: Groin pain Decreased libido Testicular pain Impotence

Painful urination Difficult urination Dribbling urination Incontinence Premature ejaculation

Nocturnal emissions Increased libido

Other:_____

_____

Cold/Flu (only if applicable)

Date Started _____ ☐ Chills ☐ Fever ☐ Muscle/body aches ☐ Sweating ☐ Sore Throat
☐ Ear Congestion/ache ☐ Sneezing ☐ Chest Congestion
Coughing: ☐ Dry ☐ Productive **Nasal Discharge:** ☐ Green ☐ Yellow ☐ White ☐ Clear
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation

JIN
☐ Shortness of breath ☐ Spontaneous Sweating ☐ Lack of Sweating ☐ History of asthma
☐ Catch Colds/Flus easily ☐ Chronic Cough ☐ History of bronchitis
☐ History of dry skin, acne or other skin conditions _____

SHUI
☐ Low Back Pain ☐ Weak/Sore Knees ☐ Cold Hands/Feet ☐ Night Sweating ☐ Heel Pain
☐ Fearful ☐ Afternoon Fever ☐ Chronic Sore Throat ☐ Poor Hearing ☐ Poor Memory
☐ Frequent Urination ☐ Night Time Urination If yes #of Times_____
☐ Burning/Painful urination ☐ History of Urinary Tract Infections
☐ Premature Hair Loss/ Graying of Hair Sex Drive: ☐ Normal ☐ High ☐ Low
Ear Ringing: ☐ High Pitched ☐ Low Pitched

MU
☐ Easy to anger ☐ Irritability ☐ Moody ☐ Neck/Shoulder Tension
☐ Easily Stressed **Stress Level:** ☐ Low ☐ Moderate ☐ High
☐ Night Sweating ☐ Vertigo/ Dizziness ☐ Rib Pain
☐ Swollen Glands ☐ Grinding Teeth ☐ TMJ ☐ Alternating Constipation/ Diarrhea
Eyes: ☐ Red ☐ Dry ☐ Itchy ☐ Spot in Eyes ☐ Poor Vision ☐ Blurred Vision
Headaches: How often? _____ Location:_____
Pain Quality _____ Pain Severity (1/10)_____

HUO
☐ Insomnia ☐ Dream-Disturbed Sleep ☐ Heart Palpitations
☐ Chest Pain ☐ Irregular/ Rapid Heartbeat ☐ Anxiety
☐ Mouth/ Tongue Ulcers ☐ Easily Startled

SLEEP
Hours per night _____ Rested in AM? _____Trouble falling asleep? _____ Trouble staying asleep? _____

TU
☐ Bloating after eating ☐ Tired after Eating ☐ Abdominal Distention ☐ Nausea ☐ Vomiting
☐ Belching ☐ Bruise/Bleed Easily ☐ Fatigue, What time of the Day? _____ ☐ Lack of Strength
☐ Flatulence ☐ Hiccup ☐ Bad Breath ☐ Heartburn ☐ Acid Regurgitation
☐ Body Heaviness ☐ Worry
Bowel Movements: #times/day _____ loose_____ normal_____ hard_____
☐ Constipation ☐ Diarrhea ☐ Intestinal Pain/ Cramping
☐ Burning anus/ itchy anus ☐ Hemorrhoid ☐ Blood/ Mucous in Stools

I am committed to your health and well-being. While Chinese Medicine is a very thorough health care system, it is not a replacement for western medical treatment, including regular check ups with your primary care physician. I recommend that you consult a physician regarding any condition for which you are seeking acupuncture or herbal treatment.

We, the undersigned, do affirm that _____ (print patient name) has been advised by Becky La Plante, L.Ac. to consult a physician regarding the conditions for which such patient seeks herbal medicine of acupuncture treatment.

I consent to acupuncture treatment. I have discussed the nature of my treatment with my practitioner. I acknowledge that in chronic conditions, results can take up to within two to three weeks to be seen unlike acute conditions where effects can be felt in days. I acknowledge that with chronic conditions the course of treatment could last anywhere from 3 weeks to a few months or more.

Patient Signature: _____ Date:_____

Becky La Plante, L.Ac., MTOM
Licence # CT 000576, CA 12069
15 Hartford Ave, Granby CT 06035
860-341-1227

Acupuncture Information and Informed Consent

Please read this information carefully, and ask your practitioner if you have any questions. Acupuncture is performed by the insertion of sterile, disposable acupuncture needles through the skin, and/or the application of heat or electrical stimulation to the skin at the certain points on the body. Your treatment may include acupuncture, moxibustion, cupping, electric or magnetic stimulation, acupressure, gua-sha, infra-red heat lamp, Chinese herbs, therapeutic exercises and dietary counseling based on the principles of Chinese Medicine. Your practitioner will explain the nature of each type of treatment, as needed. The World Health Organization (WHO) lists 43 conditions, which may effectively be treated by Asian medical methods. These include muscular-skeletal injuries, digestive disorders, respiratory diseases, women's health issues, etc.

Acupuncture is generally very safe. Although rare, certain side effects may result from acupuncture, and each procedure or treatment has specific risks and benefits. These potential risks may include, but are not limited to: Discomfort or minor pain at the site of needle insertion during treatment.

- Localized, minor bleeding, bruising, or swelling
- Minor burns with the use of moxa
- Possible, temporary aggravation of symptoms that existed prior to treatment, then rapid recovery (known as a healing crisis)
- Infection and the risks from needling in the vicinity of an infection
- "Needle sickness" (dizziness, fainting, nausea)

Please notify the acupuncturist if you have any adverse effect from treatment. Some herbs and acupuncture points are contraindicated for certain conditions. Please inform your practitioner if you have any of the following conditions:

- If you are pregnant
- If you have ever experienced fits, faints, or panic attacks
- If you have a pacemaker or any other electrical implants
- If you have HIV/AIDS, Hepatitis, or other infectious disease

To reduce the possibility of infection from acupuncture, all needles are pre-sterilized, single-use, disposable needles made of surgical stainless steel. After each treatment the needles are disposed of as medical waste, and are never reused. Additionally, the acupuncturist has been trained in Clean Needle Technique and Universal Precautions.

I have been advised to consult a physician regarding the condition for which I am undergoing acupuncture treatment. The benefits and risks of receiving acupuncture and Oriental medical treatment have been explained to me. I understand that my signature in this form indicates that I have read and understand the preceding the information regarding my treatment. I understand that if I have any questions about this information I should ask Becky La Plante, L.Ac. I hereby release Becky La Plante, L.Ac. from any and all liability that may occur in connection with the above mentioned procedures, except for the failure to perform the procedures with appropriate medical care.

Patient's Name: _____ Date _____

Guardian if under 18 years of age: _____

Patient's signature: _____

24 Hour Notice of Cancellations

Becky La Plante, L.Ac. has a 24 hour cancellation / rescheduling policy. If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be charged the full appointment fee. (excluding emergencies)

This policy is in place out of respect for both the Acupuncturists and other patients. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone that may have needed treatment, from being able to schedule into that time slot and it is a loss for our small business.

By signing below, you acknowledge that you have read and understand the Cancellation Policy as described above. Thank you for your understanding and cooperation.

Printed Name _____

Signature _____Date:_____

Becky LaPlante, L.Ac.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

 Protected health information may be disclosed or used for treatment, payment, or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

This consent was signed by: _____

(PRINT NAME)

Signature: _____ Date: _____

Witness: _____ Date: _____