Becky LaPlante MSTOM, Dipl. AC, L.Ac
Address of Service:15 Hartford Ave STE G, Granby CT 06035
Phone: 860.709.1131 www.ElementalTransformation.com

New Patient Information

Name _____ Today's Date _____

Street Address _____ Unit _____ City

_____ State _____ Zip _____ Preferred

Phone _____ Email _____ Birth Date

(include year) _____ Age _____ Gender

_____ Height _____ Weight _____

Occupation _____ Employer _____

Marital Status _____ Referred by _____

Emergency Contact: Name _____ Phone _____

Primary Care Physician: Name _____ Phone _____

Other Practitioners Involved In Your Care:

Name _____ Phone _____

Name _____ Phone _____

Cancellation Policy:

If you need to change or cancel your appointment please notify us within a minimum of 24 hours notice. Failure to do so will result in being charged the equivalent of the cash rate of the missed appointment to your account.

☐ **I understand the cancellation policy.**

Signature:_____ Date: _____/_____/_____

Health History:

Have you had acupuncture before? _____ If so, for what reason? _____

Main issue(s) you are seeking treatment for and length of time experiencing each: _____

_____

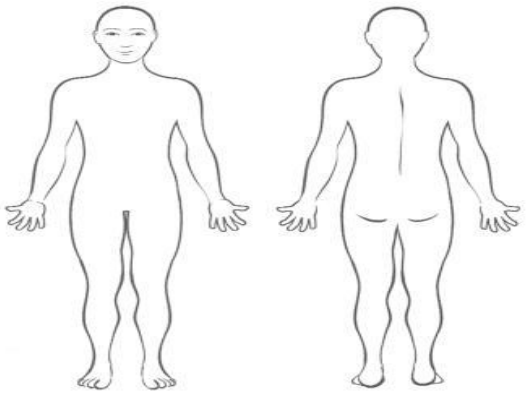
_____

Diagnoses from medical professional and approximate dates of diagnosis (if applicable):

_____

_____

_____



Please mark any areas of pain or discomfort:

Please list areas of pain or discomfort below with the 1-10 pain scale and a brief history:

(1: barely noticeable pain, 10: excruciating pain)

_____

_____

_____

_____

Please check any symptoms that you have experienced in the past or currently experience:

	past	**current**		**past**	**current**
sweating easily during the day	☐	☐	loss of appetite	☐	☐
weight loss/gain	☐	☐	increase in appetite	☐	☐
brain fog or confusion	☐	☐	trouble falling asleep	☐	☐
dizziness/vertigo	☐	☐	trouble staying asleep	☐	☐
fatigue during the day	☐	☐	swollen/sore lymph nodes	☐	☐
fevers	☐	☐	bleed or bruise easily	☐	☐
chills	☐	☐	autoimmune disease	☐	☐

Please elaborate:

_____

_____

Skin & Hair

	past	**current**		**past**	**current**
rashes/hives	☐	☐	psoriasis	☐	☐
eczema	☐	☐	itchy skin	☐	☐
dry skin	☐	☐	acne	☐	☐
oily skin	☐	☐	loss of hair/thinning hair	☐	☐

Head, Ears, Eyes, Nose & Throat

	past	current		past	current
earaches/pressure in the ears	☐	☐	headaches/migraines	☐	☐
ringing in the ears	☐	☐	sinus pressure	☐	☐
hearing loss	☐	☐	nose bleeds	☐	☐
eye floaters	☐	☐	dizziness/vertigo	☐	☐
itchy eyes	☐	☐	teeth/jaw clenching	☐	☐
blurry vision	☐	☐	sore throat	☐	☐
vision loss	☐	☐	swollen throat	☐	☐

Cardiovascular/Circulatory

	past	current		past	current
chest pain	☐	☐	swelling/edema	☐	☐
fainting	☐	☐	high blood pressure	☐	☐
lightheadedness	☐	☐	low blood pressure	☐	☐
cold hands & feet	☐	☐	palpitations	☐	☐
heart arrhythmia	☐	☐	heart murmur	☐	☐
shortness of breath	☐	☐			

Respiratory

	past	current		past	current
pain on inhaling	☐	☐	sneezing	☐	☐
chest tightness	☐	☐	seasonal/other allergies	☐	☐
cough	☐	☐	phlegm production	☐	☐
asthma	☐	☐	nasal congestion	☐	☐
wheezing	☐	☐	difficulty swallowing	☐	☐
pain behind the eyes	☐	☐			

Genito-Urinary

	past	current		past	current
difficulty urinating	☐	☐	urgent/frequent urination	☐	☐
blood in urine	☐	☐	sores on genitals	☐	☐
pain upon urination	☐	☐	genital pain	☐	☐
STD	☐	☐	yeast infections/Vaginosis	☐	☐

Neurological/Psychological

	past	current		past	current
anxiety	☐	☐	poor memory	☐	☐
depression	☐	☐	quick temper	☐	☐
loss of balance/coordination	☐	☐	easily susceptible to stress	☐	☐
areas of numbness/paralysis	☐	☐	mood swings	☐	☐
irritability	☐	☐	ADD/ADHD	☐	☐
Parkinsons	☐	☐	Multiple Sclerosis	☐	☐

Digestive

	past	current		past	current
heartburn	☐	☐	gas	☐	☐
belching	☐	☐	diarrhea	☐	☐
bloating	☐	☐	constipation	☐	☐
nausea	☐	☐	abdominal pain/cramps	☐	☐
vomiting	☐	☐	mucus in stool	☐	☐
chronic bad breath	☐	☐	blood in stool	☐	☐
sores on lips/tongue	☐	☐	hemorrhoids	☐	☐

For Women Only:

	past	current		past	current
irregular periods	☐	☐	breast pain	☐	☐
painful periods	☐	☐	vaginal discharge	☐	☐
bleeding between periods	☐	☐	vaginal sores	☐	☐
period clots	☐	☐	hot flashes	☐	☐
menstrual cramping	☐	☐	night sweating	☐	☐

age of first menses _____ duration of typical period _____

duration of typical cycle _____ date of last PAP _____

# of pregnancies _____ # of live births (+ years) _____

# of miscarriages _____ # of abortions _____

Are you currently pregnant or breastfeeding? _____

Have you been through menopause? Age? _____

Did you experience a difficult menopause?

_____

Have you ever taken birth control pills? When and for how long? _____

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

_____

For Men Only:

	past	**current**		**past**	**current**
erectile dysfunction/impotence	☐	☐	ejaculatory pain	☐	☐
varicocele	☐	☐	BPH	☐	☐

Please elaborate:

_____

Lifestyle:

Current medications/herbs/supplements (please list dosages and how long you have been taking each):

_____

_____

Do you follow any certain diet or way of eating? (vegetarian, gluten-free, paleo, etc.)

_____

How much water do you drink per day? Is it filtered and if so, which type of filter do you use?

_____

Have you used antibiotics in the past? If so, when and how often?

_____

Current exercise routine:

_____

Do you or have you ever used tobacco? If so, how often?

_____

Do you or have you ever drank alcohol heavily? If so, how many drinks/week?

_____

Do you or have you ever taken recreational drugs? If so, how often?

_____

Are you currently taking any of the following medications? *(circle if yes and indicate how often)*

Advil/Motrin/Ibuprofen	Aleve/Naproxen	Prednisone/Prednisolone
Celebrex/Celecoxib	Bayer/Aspirin	Acetaminophen/Tylenol

Allergies (medications/foods/chemicals/etc.):

_____

_____

Have you ever had a seizure? If yes, indicate date of last: _____

Please circle any significant illnesses and indicate date:

Cancer	Hepatitis	Diabetes
High blood pressure	Epilepsy	Heart Attack
Stroke	Ulcer Disease	Liver Disease
Colon Polyps	Other _____	

Please list any major surgeries/hospitalizations and approximate dates:

_____

_____

Family Medical History:

□ Cancer □ Seizures □ High blood pressure □ Stroke □ Diabetes

□ Heart Attack □ Hepatitis □ Asthma □ Other _____

What are your goals for your health?

Please list any other relevant information or issues you would like to discuss:

Informed Consent for Acupuncture Treatment and Care

Your treatment may include acupuncture, moxibustion, cupping, electric or magnetic stimulation, acupressure, gua-sha, infra-red heat lamp, Chinese herbs/supplements, therapeutic exercises and dietary counseling based on the principles of Chinese Medicine.

The 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 □
- "Needle sickness" (dizziness, fainting, nausea)
- 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 □

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

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. 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.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been suggested are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

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 _____

Patient's/Patient Representative's Signature _____

Today's Date _____/_____/_____

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: _____