# Seacoast Acupuncture and Wellness
## Catherine Markovsky, LAc.

| PATIENT INFORMATION | | | | |
|---|---|---|---|---|
| **Name** *(Last, First, M.I.):* | | | **Today's Date** | |
| **Address** *(Street.):* | | | **Date of Birth** | |
| *(City, State, Zip.):* | | | **Occupation** | |
| **Email** | | | **Employer** | |
| **Phone** | H: | M: | W: | |
| **Marital status:** | ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | | | |
| **Children** *(Names, Ages)* | | | | |
| **EMERGENCY CONTACT INFO** | **Name** *(Last, First, M.I.):* | | | |
| **Phone** | H: | M: | W: | |
| **Relationship to Patient** | | | | |
| **Primary Care Physician:** | | **Physician's Phone Number:** | | |
| **How did you hear about Bloom Integrative Health?** | | | | |

| MEDICAL HISTORY | | | |
|---|---|---|---|
| **Integrative Medical Healthcare is possible only when the physician has the complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.* | | | |
| **Please comment about your major health and wellbeing concerns in order of importance to you. It will help if you include to what extent they affect your daily life now.** | | | |
| **1.** | | **Date of Onset:** | |
| **2.** | | **Date of Onset:** | |
| **3.** | | **Date of Onset:** | |
| **4.** | | **Date of Onset:** | |
| **When and where did you last receive medical healthcare?** | | | |
| **For what reason?** | | | |

| Medications & Supplements | |
|---|---|
| **Please list all prescription medications that you are currently taking, the doses and for what conditions:** | |
| | |
| | |
| | |
| **Please list all natural supplements that you are currently taking, the doses and for what conditions:** | |
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| | |

| Personal Past & Current Medical History | | |
|---|---|---|
| **Please specify diagnosis** | **Date of Onset** | **Treatments** |
| | | |
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| | | |
| **Have you undergone a course of antibiotics recently?** | | |

| General | | | | | |
|---|---|---|---|---|---|
| **Height:** | | **Weight (lbs):** | | **Weight 1 year ago:** | |
| **Maximum Weight (lbs):** | | | **When?** | | |

| Hospitalizations, Surgery, Imaging | | | |
|---|---|---|---|
| **What hospitalizations, surgeries, X-Rays, CT Scans, EEG, EKG have you had?** | | | |
| **Procedure** | **Year** | **Procedure** | **Year** |
| | | | |
| | | | |
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| Daily Routines | | | |
|---|---|---|---|
| Please describe your daily activities from when you awake until you go to sleep.<br>**Include a "typical" meal or types of foods you eat, as well as your exercise, work and other activities.** | | | |
| **MORNING** | **Time** | **Food, Activities, Routines** | **Variation** |
| **Awaken** | | | |
| **Breakfast** | | | |
| **Activities after Breakfast** | | | |
| **MIDDAY** | **Time** | **Food, Activities, Routines** | **Variation** |
| **Lunch** | | | |
| **Activities after Lunch** | | | |
| **EVENING** | **Time** | **Food, Activities, Routines** | **Variation** |
| **Dinner** | | | |
| **Activities after Dinner** | | | |
| **NIGHT** | **Time** | **Food, Activities, Routines** | **Variation** |
| **Activities** | | | |
| **Bed Time** | | | |
| **List other regular activities not included above. These could be exercise, meditation, spiritual practices, etc.** | | | |
| | | | |
| | | | |
| **Water amount in ounces or cups per day:** | | | |
| **Alcohol beverages per week:** | | **Caffeinated beverages per day:** | |
| **Dietary restrictions or type of diet:** | | | |

| Lifestyle & Habits | | | | | |
|---|---|---|---|---|---|
| **For the following, please mark: Y= Condition you have now N= Never Had P= Significant problem of the Past** | | | | | |
| **Main interests and hobbies?** | | | | | |
| **What are the major stressors in your life?** | | | | | |
| **Do you exercise?** | ☐**Y** / ☐**N** | **Length of time** | | **Times per week** | |
| **Type(s) of exercise?** | | | | | |
| **Average 6-8 hours of sleep?** | ☐**Y** / ☐**N** | **Enjoy your work?** | ☐**Y** / ☐**N** | | |
| **Sleep well?** | ☐**Y** / ☐**N** | **Take vacation** | ☐**Y** / ☐**N** | | |
| **Awaken rested?** | ☐**Y** / ☐**N** | **Spend time outside?** | ☐**Y** / ☐**N** | | |

| | | | |
|---|---|---|---|
| Time(s) you awaken? | | How many hours of TV/week? | |
| History of abuse? | ☐Y / ☐N / ☐P | How many hours of reading/week? | |
| Any major traumas? | ☐Y / ☐N / ☐P | How many hours of computer/week? | |
| Been treated for drug dependence? | ☐Y / ☐N / ☐P | Do you go on diets often? | ☐Y / ☐N / ☐P |
| Use of alcoholic beverages? | ☐Y / ☐N / ☐P | Do you drink coffee? | ☐Y / ☐N / ☐P |
| Treated for alcoholism? | ☐Y / ☐N / ☐P | Drink black tea? | ☐Y / ☐N / ☐P |
| Smoked previously | ☐Y / ☐N / ☐P | Do you drink cola/other sodas | ☐Y / ☐N / ☐P |
| How many years smoking? | | Do you eat refined sugar? | ☐Y / ☐N / ☐P |
| Do you have a religious practice? | ☐Y / ☐N | If yes, what? | |
| On a scale of 1-10 (10 being the best), how committed are you to improving your health? | | | |
| On a scale of 1-10, how much change are you willing to make at this time for improving your health? | | | |

| Childhood Illnesses | | | | | |
|---|---|---|---|---|---|
| Have you had any of the following childhood illnesses? (mark if yes) | | | | | |
| ☐ Scarlet Fever | ☐ Diphtheria | ☐ Rheumatic Fever | ☐ Mumps | ☐ Measles | ☐ German Measles |
| Have you had any immunizations? | ☐Y / ☐N | | Did you have any negative reactions? | ☐Y / ☐N | |

| Allergies | | | |
|---|---|---|---|
| Please list if you are hypersensitive or allergic to the following: | | | |
| Drugs: | | | |
| Foods: | | | |
| Environmentals or chemicals: | | | |

| Family Medical History | | | | | |
|---|---|---|---|---|---|
| Please specify: M = mother, F = father, S = sister, B = brother, A = aunt, U = uncle, PGM = paternal grandmother, PGF = paternal grandfather, MGM = maternal grandmother, MGF = maternal grandfather | | | | | |
| Cancer | | Diabetes | | Epilepsy | |
| Heart Disease | | High Blood Pressure | | Stroke | |
| Anemia | | Kidney Disease | | Glaucoma | |
| Allergies | | Asthma | | Mental Illness | |
| Arthritis | | Tuberculosis | | Alzheimer's Disease | |

| REVIEW OF SYSTEMS | | | |
|---|---|---|---|
| **RESPIRATORY** | | | |
| ☐ Common Colds | ☐ Asthma | ☐ Wheezing | ☐ Difficulty Breathing |
| ☐ Shortness of Breath | ☐ Emphysema | ☐ Pneumonia | ☐ Persistent Cough |
| ☐ Pleurisy | ☐ Tuberculosis | ☐ Other: | |
| **SKIN** | | | |
| ☐ Eczema | ☐ Psoriasis | ☐ Hives | ☐ Itching |
| ☐ Acne | ☐ Boils | ☐ Melanoma | ☐ Other: |
| **HEAD** | | | |
| ☐ Headaches | ☐ Migraines | ☐ Head Injury | ☐ Jaw / TMJ / Clicks |
| **EYES** | | | |
| ☐ Impaired Vision | ☐ Glasses or Contacts | ☐ Blurriness | ☐ Eye Pain / Strain |
| ☐ Spots in Vision | ☐ Color Blindness | ☐ Double Vision | ☐ Tearing or Dryness |
| ☐ Glaucoma | | | |
| **EARS** | | | |
| ☐ Impaired Hearing | ☐ Earaches | ☐ Ringing | ☐ Dizziness |
| **NOSE AND SINUSES** | | | |
| ☐ Nose Bleeds | ☐ Stuffiness | ☐ Hay Fever | ☐ Sinus Problems |
| ☐ Loss of Smell | | | |
| **MOUTH AND THROAT** | | | |
| ☐ Frequent Sore Throat | ☐ Copious Saliva | ☐ Dry Mouth | ☐ Gum Disease / problems |
| ☐ Teeth Grinding | ☐ Dental Cavities | ☐ Hoarseness | ☐ Sore Tongue / Lips |
| **NECK** | | | |
| ☐ Goiter | ☐ Lumps | ☐ Swollen Glands | ☐ Pain or Stiffness |
| **CARDIOVASCULAR** | | | |
| ☐ Anemia | ☐ Hearth Disease | ☐ High Blood Pressure | ☐ Poor Circulation |
| ☐ Palpitations | ☐ Stroke | ☐ Chest Pain | ☐ Heart Murmurs |
| ☐ Rheumatic Fever | ☐ Varicose Veins | ☐ Irregular Heart Beat | ☐ Mitral Valve Prolapse |
| ☐ Angina | ☐ Fainting | ☐ Swelling in Ankles | ☐ Blood Clots |

| | | | |
|---|---|---|---|
| ☐ Deep Leg Pain | ☐ Cold Hands / Feet | ☐ Easy Bleeding or Bruising | |
| **GASTROINTESTINAL** | | | |
| ☐ Nausea / Vomiting | ☐ Abdominal Pain | ☐ Ulcers | ☐ Heartburn |
| ☐ Belching | ☐ Passing Gas | ☐ Bloating | ☐ Changes in Appetite |
| ☐ Epigastric Pain | ☐ Gall Bladder Disease | ☐ Liver Disease | ☐ Hepatitis B or C |
| ☐ Hemorrhoids | ☐ Crohn's Disease | ☐ Gluten Sensitivity | ☐ Irritable Bowel Syndrome |
| ☐ Changes in Thirst | ☐ Changes in Appetite | | |
| **GENITO-URINARY** | | | |
| ☐ Painful Urination | ☐ Frequent Urination | ☐ Frequent UTI | ☐ Interstitial Cystitis |
| ☐ Heavy Flow | ☐ Impaired Urination | ☐ Blood in Urine | ☐ Urination at Night |
| ☐ Kidney Stones | ☐ Kidney Disease | | |
| **MUSCULOSKELETAL** | | | |
| ☐ Neck Pain | ☐ Shoulder Pain | ☐ Arm Pain | ☐ Upper Back Pain |
| ☐ Mid-Back Pain | ☐ Low Back Pain | ☐ Leg Pain | ☐ Muscle Spasms / Cramps |
| ☐ Joint Pain | If Joint Pain, where? | | |
| **NEUROLOGICAL** | | | |
| ☐ Vertigo / Dizziness | ☐ Paralysis | ☐ Loss of Balance | ☐ Numbness / Tingling |
| ☐ Seizures / Epilepsy | ☐ Loss of Memory | | |
| **ENDOCRINE** | | | |
| ☐ Hypothyroid | ☐ Hashimoto's | ☐ Hyperthyroid | ☐ Diabetes Type I or Type II |
| ☐ Hypoglycemia | ☐ Polycystic Ovarian Syndrome (PCOS) | ☐ Metabolic Syndrome | ☐ Night Sweats |
| ☐ Feeling Hot or Cold | ☐ Other: | | |
| **EMOTIONAL** | | | |
| ☐ Mood Swings | ☐ Nervousness | ☐ Depression | ☐ Anxiety |
| ☐ Mental Tension | ☐ Eating Disorder | ☐ Insomnia | ☐ Suicidal |
| ☐ Frustration | ☐ Irritability | ☐ Anger | ☐ Over Thinking |
| ☐ Sadness | ☐ Grief | ☐ Fear / Fright | |
| **ENERGY & IMMUNITY** | | | |
| ☐ General Fatigue | ☐ Awakens Unrested | ☐ Fatigue After Meals | ☐ Irritable Before Meals |
| ☐ Slow Wound Healing | ☐ Chronic Infections | ☐ Chronic Fatigue Syndrome | ☐ Frequent Colds |
| ☐ Autoimmune Disease | ☐ Allergies | ☐ Hay Fever | ☐ Chronically Swollen Glands |
| ☐ Other: | | | |

| **MALE REPRODUCTIVE** | | | |
|---|---|---|---|
| ☐ Prostate Problems | ☐ Penile Discharge | ☐ Inguinal Hernias | ☐ Venereal Disease |
| ☐ Low Libido | ☐ Sexual Difficulties | ☐ Impotence | ☐ Testicular Pain / Swelling |
| Sexual Orientation: | Are you sexually active? ☐Y / ☐N | | |
| **FEMALE REPRODUCTIVE / BREASTS** | | | |
| ☐ Irregular Menstrual Cycles | ☐ Painful Menses | ☐ Heavy Menstrual Flow | ☐ Bleeding Between Cycles |
| ☐ Clotting | ☐ Spotting | ☐ Vaginal Discharge | ☐ Premenstrual Problems |
| ☐ Endometriosis | ☐ Ovarian Cysts | ☐ Cervical Dysplasia | ☐ Difficulty Conceiving |
| ☐ Menopausal Symptoms | ☐ Sexual Difficulties | ☐ Low Libido | |
| ☐ Regular Self Breast Exam | ☐ Breast Lumps | ☐ Breast Tenderness | ☐ Nipple Discharge |
| Sexual Orientation: | | Number of male partners in the past 3 years? | |

| **MENSTRUAL / BIRTHING HISTORY** | | | | | |
|---|---|---|---|---|---|
| Age of First Menses: | | Are your cycles regular? | ☐Y / ☐N / ☐P | **Date of Last Menstrual Period** | |
| Length of cycle from one cycle to the next (days)? | | | How many days of bleeding during cycle? | | |
| Type of Birth Control: | | Dose: | | Length of Use: | |
| Type of Birth Control(s) used in Past: | | | Contraceptive Difficulties? | | |
| **Date of last PAP exam:** | | Abnormal PAP exam? | ☐Y / ☐N / ☐P | If yes, when? | |
| Are you pregnant now? | ☐Y / ☐N | | If yes, how many number of weeks? | | |
| Number of Pregnancies: | | | Any complications with pregnancy? | | |
| Number of Live Births: | | Number of Abortions: | | Number of Miscarriages: | |

*Thank you for your time and effort.*

*We look forward to providing you with the best possible medical care.*

Dear New Patient,

Welcome to our clinic! We look forward to providing for your health needs and encourage your questions and participation in all aspects of your health care.

***Please Initial each line item and Sign below.**

| | |
|---|---|
| | Payment for all services and dispensary items is due at the time of the visit. Our initial visit is $125 and follow up visits are $75. |
| | Our office **does not call** Insurance companies to verify benefits for services provided.<br>**We recommend reviewing your Insurance policy to confirm your policy coverage.**<br>Please check with your insurance company to find out if there are any exclusions in your policy. |
| | Some insurance companies within New Hampshire offer plans that provide a **percentage discount** for Acupuncture services. Please call to verify your Insurance company's policy plan coverage.<br>Catherine Markovsky, LAc, MTOM is in-network with a variety of Insurance companies and offers this percentage discount for patients whom have this type of plan coverage, for provided Acupuncture services only.<br>Payment outside of the insurance discount provided is due at the time of service. |
| | Out of courtesy for our wait list patients, please call the office to **cancel your appointment at least 48 hours in advance.** This allows us to provide care to our patients that need our services as soon as possible.<br>If you fail to comply, you will be responsible for your office visit **payment in full.** |
| | I give permission for the staff at Seacoast Acupuncture and Wellness to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available. |

- As the patient, you are responsible for the total charges incurred for each visit. We accept MasterCard, Visa, Debit Cards, checks and cash. There will be a **charge of $25.00 for every returned check(s).**
- You recognize, understand and agree that your health care provider is a sole practitioner and is not a partner or otherwise affiliated with any other health care provider who may be providing similar services at Whole Life Health Care. You further recognize, understand and agree that your health care provider is solely responsible for and shall provide all professional services to you, an you are relying solely on your practitioner's skill for the professional services rendered at Seacoast Acupuncture and Wellness.
- Your Acupuncturist may prescribe natural medicine, which may be purchased at Seacoast Acupuncture and Wellness or elsewhere. Most insurance companies do not cover the medicinary items that we prescribe or dispense.
- I have read and understand the above stated policies and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form. I agree to pay the copay, co-insurance, any remaining balance my insurance deems to be patient responsibility, and any fee for services rendered that are not covered by my insurance. I agree to notify this office should there be any change in my insurance coverage. I authorize the release of any medical or other information necessary to process any claims. I authorize payment of medical benefits to Catherine Markovsky, LAc, MTOM and/or Seacoast Acupuncture and Wellness for all services rendered.

**Patient's or Authorized Person's Signature:**

| Patient Name (please print): | Patient Signature | Date |
|---|---|---|
| | | |

**RESPONSIBLE PARTY**: fill out if you are not the patient but are responsible for the bill.

| | | | |
|---|---|---|---|
| **Responsible Party** | | **Relationship to Patient** | |

**Informed Consent and Request for Acupuncture & Classical Chinese Medicine Treatment**

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Catherine Markovsky LAc, MTOM having had the opportunity to discuss the potential benefits, risks and hazards involved.

I hereby request and consent to examination and treatment with Classical Chinese Medicine (CCM) by Catherine Markovsky LAc, MTOM and/or other licensed acupuncturists serving as backup for her, hereafter call *allied health care provider.* I can request that students and preceptors not be included in my evaluation and treatments.
I understand that I have the right to ask questions and discuss to my satisfaction with Catherine Markovsky LAc, MTOM and/or with the *allied health care provider* providing backup:

1. My suspected diagnosis(es) or condition (s)
2. The nature, purpose, goals and potential benefits of the proposed care
3. The inherent risks, complications, potential hazards or side effects of a treatment or procedure
4. The probability or likelihood of success
5. Reasonable available alternatives to the proposed treatment procedure
6. Potential consequences if treatment or advice is not followed and/or nothing is done

I understand that a Chinese Medicine evaluation and treatment may include, but are not limited to:

- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements)
- Botanical/herbal medicines (prescribing various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, topical creams, pastes, plasters, washes or other forms
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Exercise Therapy (including but not limited to standard physical therapy exercises, Gyrotonic exercises and stretches)

The scope of practice of acupuncture is outlined below. I understand that a Classical Chinese Medicine and Acupuncture evaluation and treatment may include, but are not limited to:

- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the body's surface)
- Use of electrical, mechanical and magnetic devices
- Moxibustion/Moxa (indirect burning of herbal material in the form of a loosely compacted herb or stick)
- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Gua Sha (rubbing on an area of the body with a blunt or round instrument)
- Dietary Advice (based on traditional Chinese medicine theory)
- Herbs (use of herbal formulas in the form of teas, powders, tinctures, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals and animal materials)

**Potential Risks:** Pain, discomfort, blistering, minor bruising, discoloration, infection, burns, itching, loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies. Allergic reaction to prescribed herbs, supplements, and prescription medications. Soft tissue or body injury from physical manipulations or exercises. Aggravation of pre-existing symptoms.

**Potential Benefits:** Restoration of the body's maximal and optimal function. Relief of pain and other symptoms associated with a condition or disease. Assistance with injury and disease recover. Prevention of disease or its progression.

**Notice to pregnant women:** All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor stimulating techniques or any labor inducing substances will not be used unless the treatment is specifically for the induction of labor and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such a treatment.

**Notice to individuals with bleeding disorders, pace makers, and/or cancer:** For your safety it is vital to alert your provider of these conditions.

I do not expect Catherine Markovsky, LAc, MTOM and/or any *allied health care provider* to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Catherine Markovsky LAc, MTOM explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

**Patient's or Authorized Person's Signature:**

| Patient Name (please print): | Patient Signature | Date |
|---|---|---|
| | | |

| **RESPONSIBLE PARTY**: fill out if you are not the patient but are responsible for the bill. | | | |
|---|---|---|---|
| **Responsible Party** | | **Relationship to Patient** | |