

The Center for Integrative Health and Healing
Ronald L. Stram, MD, Director
388 Kenwood Ave, Delmar, NY 12054 Tel: (518-689-2244)/Fax:689-2081/www.cihh.net

Client Contact Information

MR# _____ (Office Use)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Gender: _____

Phone: (day) _____ (evening) _____ (cell) _____

E-Mail Address: _____

(Email may be used for communication between patient and practitioner)

Do you wish to receive email newsletters from the Center? ___yes ___no

Place of Employment: _____

Address: _____

Telephone: _____

Emergency Contact: _____

Emergency Contact Phone: _____

Emergency Contact Relationship: _____

Primary Care Physician: _____

Health Insurance Company: _____ ID# _____

Referred By: Check One:

___friend; ___doctor; ___print ad; ___radio ad; ___internet search; ___tel book; ___walkby

STATEMENT REGARDING CRISIS MANAGEMENT and EMERGENCY MEDICAL CARE

As a CIHH client, I understand that the Center for Integrative Health and Healing does not provide physical or mental health crisis management. I understand if I am experiencing a physical or mental health crisis, I must obtain services that are appropriate to the type of crisis I am experiencing. If I am experiencing severe acute symptoms or a feel of life-threatening illness, I will call:

- 911
- My local hospital emergency room
- My local police or fire department
- Albany County Mobile Crisis Team 518-447-9650 (mental or emotional distress)

FINANCIAL AGREEMENT

As a CIHH client, I understand that I am responsible for the payment of services received through CIHH. I agree to keep my account current and will pay at the time of service unless I make some other arrangement.

I will notify the office 24 hours in advance if a cancellation is necessary.

Client Signature: _____ Date: _____

Acupuncture Intake Form

Name: _____ Date of Birth: _____ Date: _____

What are your goals or health concerns you'd like to address with acupuncture?

Please be Specific

What alleviates your condition(s)? _____

Worsens with? _____

How long have you had this condition? _____

Personal History

Childhood Health _____

Describe your Family environment growing up _____

Current predominant emotion _____

Current relationship quality _____

Occupation _____ Do you enjoy? _____

Hobbies _____

What do you do for exercise? _____ How often? _____

Medical History

Surgeries/Surgical implants: _____

Illnesses: _____

Significant trauma (emotional or physical) _____

Hospitalizations _____

Current medications and supplements _____

Allergies (environmental or food) _____

Family Medical History

Mother's side _____

Father's side _____

Siblings _____

If any of the above have passed on, what was the cause? _____

Pregnancy & Gynecology

Age at first menses _____

Last period _____

Is it irregular? _____ Heavy? _____ Light? _____ Moderate? _____

Any pain? _____ When? _____ Clots? _____ How many days is the flow? _____

How many pregnancies? _____ births? _____ miscarriages? _____ abortions? _____

Other reproductive health information? _____

Acupuncture Intake Form Part 2

Name: _____ Date of Birth: _____ Date: _____

Please Check if You Have Experienced Any of the Following In the Last 3 Months:

General

- Fatigue
- Nightsweats
- Day sweats
- Insomnia
- Weight loss/gain
- Poor appetite
- Headache
- Bruising

Cardiovascular

- High blood pressure
- Low blood pressure
- Palpitations
- Swelling of hands/feet
- Difficulty breathing
- Varicose veins
- Dizziness
- Fainting
- Chest pain
- Bleeding disorder
- Clotting disorder
- Other _____

Respiratory

- Asthma
- Cough
- Nasal discharge
- Bronchitis
- Coughing blood
- Shortness of breath
- Difficulty breathing
- Other _____

Gastrointestinal

- Nausea
- Vomiting
- Indigestion/reflux
- Bad breath
- IBS
- Parasites
- Abdominal pain
- Hemorrhoids
- Constipation
- Loose stools
- Ulcer
- Other _____

Musculoskeletal

- Arthritis
- Sprain
- Muscle weakness
- Spasms
- Fibromyalgia
- Other _____

Genitourinary

- Urinary problems
- Impotence
- Kidney stones
- Blood in urine
- Urinary tract infection
- Infertility

Neuropsychological

- Seizures
- Concussion
- Dizziness
- Migraines
- Chronic Stress
- Numbness
- Balance problems
- Anxiety
- Poor memory
- Anger easily
- Depression

CIHH Therapeutic Agreements

STATEMENT OF COLLABORATION

As a CIHH practitioner, I agree to use my knowledge, skill and experience to the best of my ability in the best interest of the people who I work with. I believe it is my responsibility to:

- Assess each person's situation based on the information they provide
- Assist them to sort through their health-related challenges
- Provide information and options about treatment modalities that are available
- Support them to make conscious decisions regarding their health
- Develop, implement and support a plan of care that will promote physical, mental and spiritual health
- Evaluate the effectiveness of a plan of care
- Make referrals to community resources as appropriate

As a CIHH client, I agree to use my knowledge, skill and experience to the best of my ability in the best interest of my own physical, mental and spiritual health. I believe it is my responsibility to:

- Provide my CIHH practitioner(s) with information that is relevant to my health
- Be willing to sort through my health-related challenges
- Ask questions related to treatment options and information that is provided
- If supplements are mutually agreed as part of my treatment plan , take them only according to directions given to me and discontinue use if side effects ensue and report this to my CIHH practitioner(s)
- Work together with my CIHH practitioner(s) to develop a plan of care that incorporates goals that are meaningful to me and will promote my physical, mental and spiritual health
- Make conscious decisions to nurture intrinsic healing and promote balance in my life
- Evaluate the effectiveness of my plan of care
- Participate in all scheduled treatment sessions

CONFIDENTIALITY STATEMENT

As a CIHH client, I understand that what I discuss with my CIHH practitioner(s) will be treated confidentially in accordance with law and recognized professional standards. I understand that only I can give up my right to privacy by signing a release of information.

I understand that if my safety or the safety of someone else is at risk, my CIHH practitioner(s) are legally obligated to respond by sharing this information with the appropriate resources. For example:

- Licensed Social Workers, Nurses and Physicians are mandated by New York State Law to report any suspicion of child abuse to the New York State Registry
- Inform someone close to the client if they feel the client might harm him/herself or anyone else

CIHH practitioners believe that the concept of integrative medicine works best when CIHH practitioner discuss their work in team meetings, peer review, and/or supervision. This allows each client to benefit from the combined insight, knowledge, skill and experience of CIHH practitioners and those who supervise them. I understand that discussions of this nature would not include identifying information beyond a "need to know" basis, and such discussions would have the same privilege of confidentiality as sessions with each individual practitioner.

Client Signature: _____ Date: _____

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Procedures

The following procedures may be used during treatments. By initialing in the spaces provided you are stating that you are aware of the risks and benefits of each method described. If you have questions regarding any treatment method please ask your practitioner.

_____ Acupuncture involves subcutaneous insertion of fine needles into predetermined points on the body. Acupuncture is relatively painless and uses pre-sterilized disposable needles. Side effects are minimal. They may include a small bruise/soreness at site of needle insertion or lightheadedness. Organ puncture, pneumothorax, vessel puncture, and infection around the needling sight have also been reported, but are very rare.

_____ Chinese Herbs are a service offered separately from acupuncture services. The herbs used are tested for pesticide residue and heavy metals. Side effects from herbs are minimal and may include nausea, constipation, loose stools, or rash. Most Chinese herbs do not interfere with synthetic drugs and vice versa. Please inform your Chinese medicine practitioner of all prescription and over the counter medications you are taking. If you are taking prescribed medication, please inform your prescribing physician of the herbs that you will be taking before you begin taking them.

_____ Tui Na is Chinese massage. Techniques vary from pushing and kneading along meridian pathways of the body, to pressure applied at specific points. In some cases, soreness and bruising may occur. Your practitioner will request feedback during this procedure, and will work within your boundaries of comfort.

_____ Cupping involves use of plastic or glass "cups" that are applied to skin surface to create suction. Cupping is used to release "stagnation" and heat from the body. A bruise may develop where the cup was placed on the skin.

_____ Moxibustion is the use of the herb mugwort (known as "ai ye" in mandarin Chinese) in order to warm areas of the body. It may be applied indirectly or directly on the skin. To avoid burns please inform your practitioner of the intensity of heat during treatments. Burns and scarring have been reported with the use of moxa, however they are infrequent in the United States.

_____ TDP Lamp is used to warm areas of the body. Please inform your Chinese medicine practitioner of comfort of heat intensity during treatments. TDP lamps use infrared heat, which can cause temporary redness of the skin, and in rare cases can cause burns.

_____ Electro-acupuncture is the electrical stimulation of acupuncture needles using a 9-volt battery operated unit that closely regulates the intensity and frequency of the stimulation. Over-stimulation may occur on rare occasions, and lead to muscle spasm. Please inform your practitioner of your comfort level during electro-stimulation.

As practitioners of traditional Chinese medicine, we assess and approach individuals based upon the principles of traditional Chinese medicine. We do not make medical diagnoses, and suggest that you consult your physician regarding the condition or conditions for which you are seeking treatment.

Informed Consent

I, the undersigned, am aware of the benefits and risks of acupuncture, Chinese herbs, tui na, cupping, moxibustion, TDP lamp, and electro-acupuncture. I fully understand that there is no implied or stated guarantee of the effectiveness of a specific treatment or a series of treatments. I also do affirm that Rebecca Rice or Chris Reilly, Licensed Acupuncturist has advised me to consult a physician regarding the condition or conditions for which I am seeking treatment.

FOR COMMUNITY ACUPUNCTURE PATIENTS: I consent to being seen in a group setting, in which others may be within listening distance. I am aware that private sessions are available to me as well.

PATIENT'S SIGNATURE _____ DATE _____

ACUPUNCTURIST'S SIGNATURE _____ DATE _____