Hawthorn Holistic Health
2969 Whitney Ave., Suite 3B, Hamden, CT 06518
PHONE(203) 553-7392 FAX (203) 553-7393

Dr. Lindsay Chimileski ND, LAc
Dr. Matthew Robinson ND

NEW PATIENT INTAKE FORM		Today's Date:
Name		Birthday
Full Address		Phone
	Zip Code	Email
Occupation		Email or Phone Appointment reminders?
Who do you live with?		Gender
How did you hear about us?		Pets?
Is this your first time getting Acupuncture?		Pregnant or trying?
Chief Complaint 1:		
Chief Complaint 2:		
Chief Complaint 3:		
Chief Complaint 4:		
Chief Complaint 5:		
Primary Care Physician		phone
Emergency Contact		phone
List ALL Known Allergies		
		History of anaphylaxis?
Current Medications		
Current Supplements		
Past Hospitalizations & Surgeries		
Existing Medical Conditions		
FAMILY HEALTH HISTORY Major illnesses, age or age of death		
Mother & her parents		
Father & his parents		
Sibling(s)		
Children		

Hawthorn Holistic Health
2969 Whitney Ave., Suite 3B, Hamden, CT 06518
PHONE(203) 553-7392 FAX (203) 553-7393

Dr. Lindsay Chimileski ND, LAc
Dr. Matthew Robinson ND

INTAKE & CRAVINGS

☐ Warm drinks	☐ Cold drinks
☐ Big gulps	☐ Little sips
☐ High thirst	☐ No thirst
☐ High hunger	☐ No appetite
☐ Big meals	☐ Small meals
☐ Cravings?	

BODY TEMP

*Run hot or cold?	
*Best season?	
☐ Feverish	☐ Cold hands/feet
☐ Night sweats	☐ Chills
☐ Hot Flashes	☐ Cold nose
☐ Sweat easily or at rest	

STRESS & MOOD

*Describe your mood	
*Rate your stress (1-10 scale)	
*How do you relieve your stress	

Women's Health

*Last Menstrual Period:	
☐ PMS/ mood changes	Menstrual clots
☐ Irregular cycles	Fibroids
Cramping	Cysts
Headaches	Bodyaches
☐ Bloating	Acne
☐ Vaginal Discharge- color?	
☐ Menopause	Night Sweats
☐ Hot flashes	Vaginal Dryness

THORAX & ABDOMEN

☐ Palpitations	☐ Anxiety
☐ Reflux/ Heartburn	☐ Cough
☐ Tightness	☐ Fullness
☐ Shortness of breath	☐ Nausea/Vomiting
☐ Gas/Belching	☐ Pain
☐ Irritable Bowel	☐ Bloating

REPRODUCTIVE

☐ Libido Changes	
☐ Fertility Issues	
☐ Erectile Dysfunction	

ELIMINATION

*Feel better or worse after eating?	
*Bowel movements per day?	
Pain with stool	
☐ Constipation	Diarrhea
☐ Urinary Incontinence	☐ Pain
☐ Urine Copious	☐ Scanty

SLEEP & ENERGY

*Hours of sleep per night?	
*What time do you wake up?	
*Do you wake feeling rested?	
*Rate energy (1-10 scale)	
☐ Can't fall asleep	☐ Vivid Dreams
☐ Can't stay asleep	☐ Racing thoughts
☐ Energy highs and lows	☐ Afternoon crash
☐ "Morning person"	☐ "Night owl"
☐ Tired after eating	☐ Night Sweats

Health Goals Any Additional Important Information:

Hawthorn Holistic Health
2969 Whitney Ave., Suite 3B, Hamden, CT 06518
PHONE(203) 553-7392 FAX (203) 553-7393

Dr. Lindsay Chimileski ND, LAc
Dr. Matthew Robinson ND

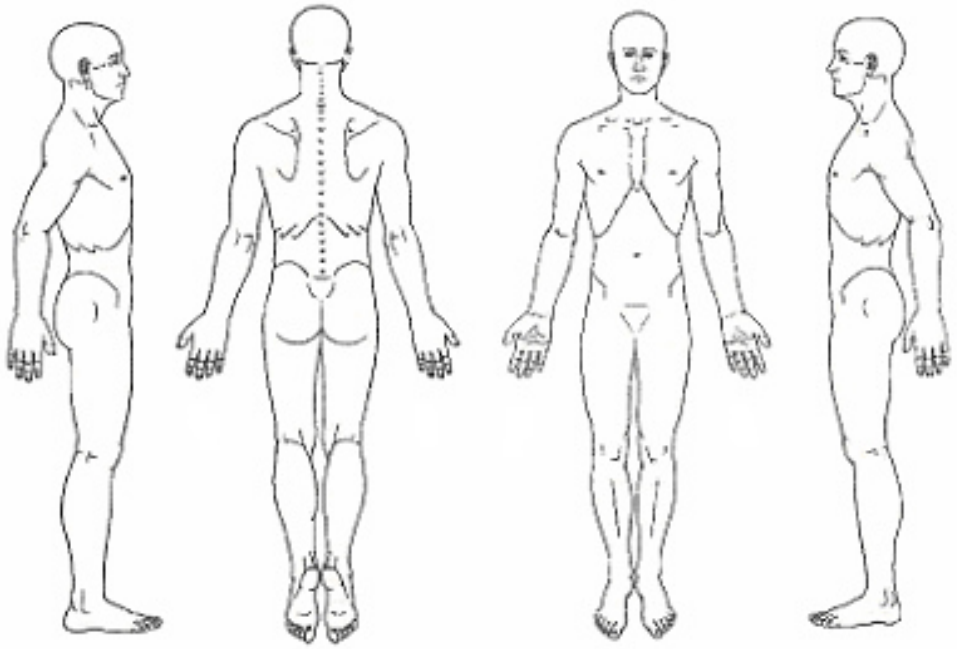
Headaches:

Frequency
Intensity (scale 1-10)
Known Triggers:
Seasons worst:
Time of day worst:
What makes it better:
What makes it worse:
Left or right:
Visual effects:

Mark the location of your headaches

Detailed PAIN Intake

Please mark the figures below anywhere you experience pain with descriptions including the:
Quality of the pain (dull, sharp, stabbing, burning, itching, numb etc)
A pain rating on a scale from 1-10 (10 being the worst)



Explain any known details, injuries or causes of the pains listed above.

Hawthorn Holistic Health
2969 Whitney Ave., Suite 3B, Hamden, CT 06518
PHONE(203) 553-7392 FAX (203) 553-7393

Dr. Lindsay Chimileski ND, LAc
Dr. Matthew Robinson ND

Community Acupuncture Fees & Patient Financial Responsibility

Initial Visit: $35

Return Visits: $25

Community Acupuncture is not billed to your insurance. Cash, check or credit card only.

Fees must be paid, in full, by the patient, at the time of service.

Patient or Guardian Print Name:_____Date:_____

Community Acupuncture CONSENT TO TREAT:

Hawthorn Holistic Health, LLC is pleased to offer you a variety of in-office procedures and medical therapies.

Please read and initial the following statements to indicate you understand and consent to treatment:

Acupuncture & Traditional Chinese Medicine

_____ **Acupuncture**: insertion of sterile, one time use, solid needles to specific medically safe locations.

- I hereby request and consent to the performance of Acupuncture and Traditional Chinese Medicine (TCM) procedures by Dr. Lindsay Chimileski, ND. I have had the opportunity to discuss and understand the nature and purpose of Acupuncture and TCM treatments with the acupuncturist named above and/or with other office or clinic personnel. I have been informed that Acupuncture is a safe method of treatment, but occasionally there may be some bruising, itching or tingling near the needling sites that can last a few days. I realize that although rare, there have been few instances fainting, infections, scarring, spontaneous abortion and pneumothorax.
- I understand it is imperative to tell the acupuncturist if I am PREGNANT or trying to get pregnant because although safe with pregnancy, specific rules and cautions must be used by the practitioners.
- I realize that Acupuncture and TCM is based on a different medical system than conventional doctors and visits to your primary care provider are still recommended. I wish to rely on the acupuncturist to exercise judgment based on his formal training to guide course of the treatment.

_____ **Cupping** : using glass or plastic cups to create suction to remove stagnation and adhesions in the underlying tissue. This often leaves the appearance of bruising (ecchymosis) and/or local tenderness that can last 2-7 days.

_____ **Moxibustion**: burning *Artemisia vulgaris*, or Mugwort, near or directly on the skin or acupuncture needle to promote circulation and warm the tissues. Rarely, this may cause first degree burning or skin blistering.

_____ **Gua Sha** : using massage tools to dredge superficial soft tissue (fascia and muscles) and remove adhesions in the underlying tissue. This often leaves the appearance of bruising (ecchymosis) that can last 2-7 days.

_____ **Tui-Na Chinese Massage**: using hands on soft tissue massage, active range of motion and acupressure to move qi and blood, remove stagnation and treat underlying disharmonies.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient or Guardian Print Name:_____Date:_____

Patient or Guardian Signature:_____ Date:_____

Hawthorn Holistic Health
2969 Whitney Ave., Suite 3B, Hamden, CT 06518
PHONE(203) 553-7392 FAX (203) 553-7393

Dr. Lindsay Chimileski ND, LAc
Dr. Matthew Robinson ND

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

(This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("**HIPAA**"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I consent to the use or disclosure of my protected health information by Hawthorn Holistic Health LLC (HHH), for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of HHH. I understand that diagnosis or treatment of my by any of the physicians at HHH may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. HHH's *Notice of Privacy Practices* is also available in our waiting room.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing, except to the extent that action has already been taken in reliance thereon.

Patient Name:_____Relationship to Patient: _____

Signature: _____Date: _____