GOLDEN LIGHT ACUPUNCTURE, P.C.

Pediatric Health History Form

Dear Patient,

Welcome to our practice. We are delighted to work with you to meet your health goals. We are committed to supporting you as best we can.

Please note our personal cell phone numbers and keep them in your phone. Please feel free to contact us via call or text with questions about appointments or to set up a phone call if any questions arise during your course of treatment - please do not send personal health information via text.

Michael: (516) 353-2412 | Marika: (845) 663-8853

Please complete the health history questionnaire and read the following information carefully, as it relates to the treatment that you may receive and our office policies. It is important to us that you are informed.

Thank you,

Golden Light Acupuncture, PC

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GOLDEN LIGHT ACUPUNCTURE, P.C.

Pediatric Health History Form

Patient Information

Patient Full Name _____ DOB _____

Mailing Address_____

Guardian Email Address_____ Cell Phone Number_____

Primary Care Doctor_____ Date of last visit _____

Parents are: married/ partnered separated divorced widowed single

Guardians Names, Ages, and Occupations_____

Siblings names and ages: _____

Reason for Seeking Acupuncture

Please describe your primary reason for seeking acupuncture - is there a specific pain, injury, or illness?

_____

_____

If there is pain associated with this condition please rate it 1 (least) - 10 (most): _____

When did this begin? What makes it better/what makes it worse? Have you had a medical diagnosis or receive any treatments for this either in the past or currently?

_____

_____

Are there any other conditions or complaints? _____

Have you ever received acupuncture treatments before? If so, when and with whom? What was your experience? _____

_____

GOLDEN LIGHT ACUPUNCTURE, P.C.

Pediatric Health History Form

Personal Health History

What screen tests has your child had? (blood, hearing, vision, speech, etc…)

_____

Please circle all past or present conditions that your child has experienced:

Chicken pox Ear Infections Impetigo Measles Mononucleosis
Mumps Pneumonia Rheumatic fever Roseola Rubella
Scarlet fever Strep throat Whooping cough
Other_____

How would you describe child's mental/emotional health and temperament?_____

_____

Is the child currently taking any medications, vitamins, supplements?

Name	*Reason*	*Dosage*	*Prescribed by?*

Any minor or major accidents, injuries, surgeries, or hospitalizations?

Date	*Incident/Reason*	*Anything to report about the experience?*

Please list any past prescription medications:

_____

Immunization History - *please circle all that your child has received*

D TaP Hep A Hep B Influenza Influenza B (Hib) MMR
PCV Polio Varicella (chicken pox) Rotavirus
Other_____

Any adverse reactions to vaccines: no yes If yes, please describe:

_____

Allergies

Are there any allergies to foods, environment, medication, other_____

_____

Personal or Family History *(circle if present in child or family)*

Asthma Arthritis Asthma Birth abnormality Cancer
Celiac Disease Diabetes Eczema Heart Disease Hypertension
Mental illness Tuberculosis
Other_____

Birth Mother's Prenatal History

Mother's age at child's birth? _____ Birth number amongst siblings_____

Mother's health during pregnancy? *Please circle all that apply*

Generally well Bleeding Consumption Depression/Anxiety
Gest. Diabetes Nausea/Vomiting Other_____

Any medications during pregnancy for any reason?_____

Any cigarettes/drugs/alcohol consumption?_____

Any physical or emotional trauma during pregnancy?_____

Anything else to report?_____

Child's Birth History

Term: _____weeks/months Weight at birth: _____Length of labor: _____

Place of birth_____ vaginal C-section Induced
Forceps Suction Anesthesia used

Did your child have any of the following problems shortly after birth? *(circle all that apply)*

Birth abnormality Birth injury Blue baby Cerebral palsy Colic
Fever Jaundice Rashes Seizure
Other:_____

Feeding/Development

Breastfed? no yes how long?

_____

Formula? no yes, what was given:

_____

Age began solids: _____ Which foods?

_____

Age began sitting _____ crawling _____ walking _____ talking _____

Typical Day's Food Intake:

Breakfast: _____

Lunch: _____

Dinner:_____

General types of snacks: _____

Sleep

General sleep hours: _____

Any sleep issues?_____

Recreation

Does the child do any form of exercise or play any sports? Please describe:

_____

_____

How much screen time per day? (iPhone, TV, computer, etc..)_____

Please use this space for any additional comments or information you would like to share:

I hereby declare that the information given in this intake is accurate to the best of my knowledge and recollection. If anything changes, I will notify Golden Light Acupuncture.

Guardian Signature_____ Date_____

(please indicate relationship)

Signature of practitioner _____

Please read the following pages carefully and initial at the conclusion of each paragraph to acknowledge that you have read and understood the information provided. Thank you.

INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments (as described above) on me or the patient name listed below, for which I am legally responsible, by licensed acupuncturists who are employed or contracted by Golden Light Acupuncture.

Please Initial here:_____

I understand that acupuncture involves the insertion of sterilized, single-use filiform needles, sometimes with e-stim (electrical stimulation). I understand that, although very rare, acupuncture has the risk of causing unintentional bleeding, bruising, fainting, infection, pneumothorax, miscarriage, organ puncture, and nerve damage. I understand that certain acupuncture techniques may cause intentional bleeding, based on the theories of Chinese Medicine, and that I will be informed and my specific consent will be sought. I will notify my acupuncturist immediately if anything happens that is painful or unusual.

Please Initial here:_____

I understand that there are certain treatment procedures that are inappropriate for women who are pregnant & that **it is my responsibility to immediately tell my acupuncturist if I become pregnant**, so that proper precaution is taken.

Please Initial here:_____

I understand that massage, cupping, and Gua Sha might be performed. Cupping and GuaSha will result in visible marks that appear like bruises on the skin. These are healthy, physiological responses to the treatment.

Please Initial here:_____

I understand that moxibustion and/or infrared therapy may be used and incurs the possibility of burns and/or scars and it is my responsibility to notify the practitioner in the event of any sensation of heat at the site of therapy.

Please Initial here:_____

I understand that the profession of acupuncture includes recommendation of dietary supplements and natural products including, but not limited to, the recommendation of diet, herbs and other natural products, and their preparation in accordance with traditional & modern practices of East Asian medical theory.

Please Initial here:_____

Privacy

I acknowledge that I have read and understand the HIPAA privacy agreement provided to me by the Practice. They are available on GoldenLightAcupunctureNY.com

I understand that Golden Light Acupuncture will keep all communications and records confidential, unless I consent in writing to share this information with others. However, I consent to the Practice's use and disclosure of my Protected Health Information (PHI) for the purpose of providing treatment to me, for the purposes relating to the payment of services rendered to me and for Golden Light Acupuncture' general healthcare operations purposes. PHI relates to any information created or received by Golden Light Acupuncture, that relate to my past, present or future physical and mental health or condition, that either identifies me or where there is a reasonable basis to believe the information can be used to identify me.

Cancellation Policy

Cancellation within 24 hours of an appointment will incur a charge of $50.

Please Initial here:_____

I further agree to hold Golden Light Acupuncture harmless from any and all liabilities and claims which may arise as a result of my participation in the acupuncture sessions. I will not hold Golden Light Acupuncture responsible for the consequences of any decisions I may make, or any actions I may take, or may choose not to take, following any recommendation made by Golden Light Acupuncture.

While there have been no warranties, assurances, or guarantees made to me, I consent and freely agree to receive acupuncture treatment from Golden Light Acupuncture. I understand that while Golden Light Acupuncture may make certain recommendations to me during the sessions, it is entirely my own decision whether or not to accept and follow these recommendations. I have read and understood the information provided in this Consent Form, as well as all materials provided to me. I have asked any and all questions that I may have about the sessions and these questions have been answered to my full satisfaction.

I, the undersigned, do affirm that I have been advised by Golden Light Acupuncture to consult a licensed physician regarding the condition or conditions for which I seek acupuncture treatment and under no circumstances should I forego any medical treatment recommend by a doctor. In signing, I am voluntarily agreeing to all the above descriptions, terms, and conditions.

Patient Name_____ Date_____

_____ _____

Patient or Guardian Signature (note relationship please) Practitioner Signature

FINANCIAL AGREEMENT & AUTHORIZATION

In-Network Acupuncture Benefits with NYSHIP | UHC's Empire Plan
Golden Light Acupuncture, P.C. is an in-network provider with the NYSHIP Empire Plan. Members of this plan are required to provide payment of their copayment at each visit. Please provide the following information if you are insured under this Plan:

Policy Holder Name_____ Policy Holder DOB_____

Member ID _____

Fee-for Service
Payment in full is due at the time of service. We accept the following forms of payment:

- Cash
- Check
- Credit Card
- Venmo (@GoldenLightAcu)*

*Please note that Venmo is not a confidential or HIPAA (Health Insurance Portability and Accountability Act) compliant platform to pay for acupuncture. In signing below, you acknowledge that you are voluntarily choosing Venmo and are responsible for the privacy settings.

Out of Network Acupuncture
We will work to provide necessary documentation to you in order to submit a claim. Our office will not enter into a dispute with your insurance company over any claim. We will work to provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise, and will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company. Our office does not guarantee that your insurance company will pay for treatment you receive from our office.

Authorization
I authorize the release of any medical information necessary to process insurance claims and the release of information back to my physician. I also authorize payment of medical benefits to Golden Light Acupuncture, PC for services rendered. In the event that my medical insurance does not pay for the services rendered, I agree to be responsible for any balance due. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS.

Patient or Guardian Signature_____ Date_____