

Seacoast Acupuncture and Wellness
Catherine Markovsky, L.Ac.



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

MEDICAL HISTORY			
<i>*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.</i>			
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:	

Personal Past & Current Medical History		
Please specify diagnosis	Date of Onset	Treatments
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

Daily Routines

Please describe your daily activities from when you awake until you go to sleep.

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.

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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?	<input type="checkbox"/> Y / <input type="checkbox"/> N	Length of time		Times per week	
Type(s) of exercise?					
Average 6-8 hours of sleep?	<input type="checkbox"/> Y / <input type="checkbox"/> N	Enjoy your work?	<input type="checkbox"/> Y / <input type="checkbox"/> N		
Sleep well?	<input type="checkbox"/> Y / <input type="checkbox"/> N	Take vacation	<input type="checkbox"/> Y / <input type="checkbox"/> N		
Awaken rested?	<input type="checkbox"/> Y / <input type="checkbox"/> N	Spend time outside?	<input type="checkbox"/> Y / <input type="checkbox"/> N		

Time(s) you awaken?		How many hours of TV/week?	
History of abuse?	<input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> P	How many hours of reading/week?	
Any major traumas?	<input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> P	How many hours of computer/week?	
Been treated for drug dependence?	<input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> P	Do you go on diets often?	<input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> P
Use of alcoholic beverages?	<input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> P	Do you drink coffee?	<input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> P
Treated for alcoholism?	<input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> P	Drink black tea?	<input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> P
Smoked previously	<input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> P	Do you drink cola/other sodas	<input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> P
How many years smoking?		Do you eat refined sugar?	<input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> P
Do you have a religious practice?	<input type="checkbox"/> Y / <input type="checkbox"/> 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)					
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Mumps	<input type="checkbox"/> Measles	<input type="checkbox"/> German Measles
Have you had any immunizations?	<input type="checkbox"/> Y / <input type="checkbox"/> N	Did you have any negative reactions?	<input type="checkbox"/> Y / <input type="checkbox"/> 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			
<input type="checkbox"/> Common Colds	<input type="checkbox"/> Asthma	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Persistent Cough
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other:	
SKIN			
<input type="checkbox"/> Eczema	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Hives	<input type="checkbox"/> Itching
<input type="checkbox"/> Acne	<input type="checkbox"/> Boils	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Other:
HEAD			
<input type="checkbox"/> Headaches	<input type="checkbox"/> Migraines	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Jaw / TMJ / Clicks
EYES			
<input type="checkbox"/> Impaired Vision	<input type="checkbox"/> Glasses or Contacts	<input type="checkbox"/> Blurriness	<input type="checkbox"/> Eye Pain / Strain
<input type="checkbox"/> Spots in Vision	<input type="checkbox"/> Color Blindness	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Tearing or Dryness
<input type="checkbox"/> Glaucoma			
EARS			
<input type="checkbox"/> Impaired Hearing	<input type="checkbox"/> Earaches	<input type="checkbox"/> Ringing	<input type="checkbox"/> Dizziness
NOSE AND SINUSES			
<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Stuffiness	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Loss of Smell			
MOUTH AND THROAT			
<input type="checkbox"/> Frequent Sore Throat	<input type="checkbox"/> Copious Saliva	<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Gum Disease / problems
<input type="checkbox"/> Teeth Grinding	<input type="checkbox"/> Dental Cavities	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Sore Tongue / Lips
NECK			
<input type="checkbox"/> Goiter	<input type="checkbox"/> Lumps	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Pain or Stiffness
CARDIOVASCULAR			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Poor Circulation
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Stroke	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heart Murmurs
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Angina	<input type="checkbox"/> Fainting	<input type="checkbox"/> Swelling in Ankles	<input type="checkbox"/> Blood Clots

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

MALE REPRODUCTIVE			
<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Penile Discharge	<input type="checkbox"/> Inguinal Hernias	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Low Libido	<input type="checkbox"/> Sexual Difficulties	<input type="checkbox"/> Impotence	<input type="checkbox"/> Testicular Pain / Swelling
Sexual Orientation:	Are you sexually active? <input type="checkbox"/> Y / <input type="checkbox"/> N		
FEMALE REPRODUCTIVE / BREASTS			
<input type="checkbox"/> Irregular Menstrual Cycles	<input type="checkbox"/> Painful Menses	<input type="checkbox"/> Heavy Menstrual Flow	<input type="checkbox"/> Bleeding Between Cycles
<input type="checkbox"/> Clotting	<input type="checkbox"/> Spotting	<input type="checkbox"/> Vaginal Discharge	<input type="checkbox"/> Premenstrual Problems
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Ovarian Cysts	<input type="checkbox"/> Cervical Dysplasia	<input type="checkbox"/> Difficulty Conceiving
<input type="checkbox"/> Menopausal Symptoms	<input type="checkbox"/> Sexual Difficulties	<input type="checkbox"/> Low Libido	
<input type="checkbox"/> Regular Self Breast Exam	<input type="checkbox"/> Breast Lumps	<input type="checkbox"/> Breast Tenderness	<input type="checkbox"/> Nipple Discharge
Sexual Orientation:		Number of male partners in the past 3 years?	
MENSTRUAL / BIRTHING HISTORY			
Age of First Menses:		Are your cycles regular? <input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> 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? <input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> P	If yes, when?
Are you pregnant now?	<input type="checkbox"/> Y / <input type="checkbox"/> 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. We recommend reviewing your Insurance policy to confirm your policy coverage. 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. 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. 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. 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, and 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	
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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	
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