Lindsay Chimileski ND LAc   Matthew Robsinon ND

Hawthorn Holistic Health

NEW PATIENT INTAKE FORM

Name	**Birthday**
Address	**Gender & Pronouns**
Phone	**Are we authorized to leave a message? Yes or No**
Email Circle Yes to sign up for our newsletter for upcoming events, hours & seasonal health info (max 15 emails a year)	We use email for patient portal and appointment reminders.
Primary Care Physician	In Connecticut, NDs are specialist, not PCP.
Emergency Contact, Relationship & Phone Number	
How did you hear about us	

Medical History
List ALL Known Allergies (medications, foods, insects, environmental, chemicals). Rate mild, moderate, or severe **Any history of anaphylaxis?**
History of Hospitalizations, Surgeries, Major Accidents or Traumas:
Any Pre-existing Medical Conditions:
Are you pregnant or trying to conceive:
FAMILY HEALTH HISTORY All known major illnesses, diseases, cancers, addictions, age, and cause of death, if deceased
Mother & her parents
Father & his parents
Sibling(s)
Children
Are you interested in any specific therapy? Circle Options below or write in *Acupuncture* *Nutritional Counseling* *Physical Medicine* *Alternative Lab Testing* *Homeopathy* *"Whatever the doctor thinks is best"*

What brings you in today?
Chief Concerns:
Health Goals:

Medications and Supplements
List all medicines and supplements you are currently taking. Include how long you have been taking it and dose or strength.

Lifestyle & Nutrition **Describe in your own words or Rate on a scale 1-10(10 being the highest)**
Occupation
Physical Activity level
Restrictions to Physical Activity
Relationship status & living situation
What do you do for fun
Connection to community and support systems
Are you fast or slow paced? Uptight or easy going?
Do you use any of the following? If so, how many times: daily, 1x/week, 1x/month, 1x/year Tobacco — Caffeine (Coffee, Tea, Soda, Energy drinks, Preworkout etc) Alcohol, if so what kind — Recreational drugs Cannabis — Psychedelics Kratom, Opiates, Pain Medication — Other daily substances
Describe your diet (circle any that apply): *Vegan* *Vegetarian* *Pescatarian* *Gluten Free Halal* *Dairy Free* *Low Fat* *Kosher* *Standard American* Any specific foods you avoid?

Quality of Life Rate on a scale from 1 to 10, 10 being the best, or describe in your own words		
Sleep Quality	Do you Dream?	
Stress Level	Where and how do you feel it in your body?	
Energy levels	What time is energy the highest?	What time is energy the lowest?
Appetite	Libido & Sex Drive	
Baseline Daily Mood:		

Detailed Pain Information	
Rate the pain on a scale from 1-10 (10 being the worst):	*RIGHT SIDE or LEFT SIDE*
Where do you have body pain?	
How long have you had the pain? When was the initial Injury?	
Any pattern and timing you have noticed? Write in or circle *When I wake up In bed at Night With Movement Stress induced Weather Changes Hormonally Changes* *Day after use/activity Sitting Standing Seasonal changes*	
How would you describe the pain? *Ache Burning Stabbing Stiffness Electric Unbearable Other:*	
Specific triggers?	
Other symptoms & details you experience with it?	
What makes it better?	What makes it worse?
Headaches: How often? How long has this been a problem? Rate 1-10, 10 being the worst	
Location?	*RIGHT SIDE or LEFT SIDE*
Sinus Behind eyes Top of head Temples Whole head Band around head Base of skull/ top of neck	
Any pattern and timing you have noticed?	
When I wake up In bed at Night With Movement Stress induced Weather changes Seasonal changes	
Hormonally Changes Day after use/activity Sitting Standing Other:	
How would you describe the pain? *Ache Burning Stabbing Stiffness Electric Unbearable Other:*	
What makes it better?	What makes it worse?

Please complete the checklist, marking off the symptoms you experience now or have been a significant part of your health history in the past. Elaborate when necessary.

Anxiety, Worry, Nervous
Overthinking
Tired, Weak, Low Energy
Depression, Melancholy,
Moodiness
Anger, "Road rage", Irritability
Apathy, Hopelessness
Self harm
Bottled up emotions
Overstimulation
Manic, Impulsive
Difficulty making decisions
Grief
Worry
Fear
Insomnia or Waking frequently
Vivid Dreaming or Nightmares
Frequent Infections
Headaches
Inability to sweat
Excessive sweating,
Night sweats
Hot flashes
Dizziness or loss of balance
Seizures or convulsions
Concussion or Head Trauma
Weight Gain
Weight Loss
Hands tingling, Feet tingling
Thyroid disorder
Glasses or Contacts
Blurred or Poor Vision
Dry, Itchy, Burning Eyes

Runny or Watery Eyes
Light sensitivity
Night Blindness or Halos
Red or Puffy Eyes
Ear aches & infections
Ringing in the ears
Diminished hearing
Wax buildup
Hair Loss, breaking, thinning
Easy bruising
Acne, Pimp les, Cysts
Rashes
Ulcers or sores
Dry, Rough, Cracking, Scaling
Ulcers or sores
Brown spots or bronzing
Facial rash or rosacea
Flushing, Hives
Moles, Warts, Skintags,
Slow healing cuts
Scaring, Keloid
Runny Nose, Hay fever, Sinusitis
Nosebleeds
Dry or chapped lips
Sore throat or tonsillitis
Clearing throat often
Red, Sore, Cracked tongue
Cold sores, Herpes or Shingles
Diminished smell or taste
Many Cavities or dental work
Bleeding gums
Horse or raspy voice

Spitting up mucus or blood
Difficulty breathing
Chest pain
Loss of appetite
Cough
Difficulty swallowing
Nausea, Vomiting
Bad breath, thick tongue coat
Excessive appetite, binge
Heart burn, reflux
Digestive Pain after eating
Indigestion
Digestive Pain, empty stomach
Difficulty digesting fats
Stool dark colored
Light colored stool
Food or Blood in stool
Constipation
Incomplete elimination
Loose stool, diarrhea
Foul odors
Hemorrhoids
Cramping Pains
Bloating
Belching, Gas
Headache/Angry if meal skips
Palpitations,
Racing heart, Irregular
Dizziness upon standing
Altitude sickness
Chest Tightness
Swollen feet or ankles
Cold hands or feet

Muscle Pain or tightness
Joint Pain or stiffness
Bone Pains
Tremors, twitches
Loss of strength
Hernia
Leg pains, Leg cramps
Hands or feet turn white or blue
Varicose veins
Tendency to Anemia
High blood pressure
Low blood pressure
Shortness of breath walking upstairs
Frequent urination
Nighttime urination
Pain with urination
Blood in urine
Cloudy urine
Foamy urine
Urinary Tract Infections
Bladder or Kidney infection
Kidney stones
Low Back Pain
Enlarged Prostate
Low libido
High libido
Pain with intercourse
Genital pain or discomfort
Difficulty completing intercourse

Menstrual Cycle & Hormones	
☐ *Pain before period* ☐ *Pain during period* ☐ Irregular cycles (not monthly) ☐ Short Cycles (less than 28 days) ☐ Long Cycles (over 32 days) ☐ Emotional Before Periods (circle which apply) *Sad, Tearful Irritable, Angry, Depressed* *Melancholy, Weeping, Anxious, Insomnia* ☐ Fibroids ☐ Ovarian cysts, Pain with Ovulation ☐ Vaginal discharge, odor or itching ☐ Frequent yeast infections ☐ Heavy periods, Large clots	☐ Painful, tender, swollen, lumps in breasts ☐ Nipple discharge or Lactation ☐ Fertility ☐ Working with fertility specialists / IVF ☐ Currently pregnant Week: ☐ Morning sickness ☐ Number of pregnancies to child ______ ☐ Number of miscarriages or abortions _____ ☐ Number of segregate or adopted children _____ ☐ Menopausal Hot flashes ☐ Pain with intercourse ☐ Current birth control method:
Last menstrual period: Last PAP smear: Do you track your periods? History of sexual trauma?	Length of cycle: History of Abnormal PAP smear? Circle which methods you use: tampons, cup, disc, menstrual panties, other:

Additional space for overflow and anything else you think is important for us to know before starting:

CONSENT TO TREAT:

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

Please sign below to indicate you understand and consent to following treatments:

Naturopathic Medicine, Nutritional, Vitamin, Supplement & Lifestyle Counseling

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:____________

Physical Medicine, 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.

Physical Medicine & Hands-on therapies including massage, stretching, craniosacral, biocranial, myofascial release, Naturopathic Manipulation Therapy, hot/packs, contrast hydrotherapy, e-stim, ultrasound and joint mobilization.

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Patient or Guardian Print Name:____Date:____________

Patient or Guardian Signature:____ Date:____________

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: ___________________________

Appointment Cancellation & Financial Policies

Please familiarize yourself with our cancellation policy and missed appointment fees.

When we schedule an appointment, we agree to show up for one another.
Each visit is a commitment of the doctors' time. Late cancellations and missed appointments limit the accessibility of our doctors for other patients in need.
In the event that you must cancel or change your appointment, please contact us, at (203) 553-7392, at least 2 business days in advance of the appointment. Cancellations that occur in less than 2 business days and no-shows will be charged a fee. These fees are not covered by insurance. For Monday appointments, please contact us by Friday at 12pm.

If you cancel with less that 48 hour hours notice, you will be responsible for a $75 late cancellation fee. If you do not call or reschedule and do not show up for your appointment, you will responsible for a $95 no show fee.

In the event of multiple missed appointments, after two missed appointments (no call or same day cancellations) you will be required to keep a credit card on file and it will be charged the $95 missed appointment fee on the day of any missed appointment in the future.

Individuals who have not shown for two consecutive appointments, will have their remaining appointments canceled and must call the office if they would like to reschedule. The missed appointment fees must be paid before the start of your next office visit.

I understand that my account will be charged $25.00 for any failed payments or checks returned due to non-sufficient funds.

I hereby acknowledge that I am personally responsible for all fees. I agree to pay all applicable charges and to promptly pay any balance in full. I also agree that I am responsible for any collection and/or attorney fees.

____ Date: ____________________.
Name and Signature of Responsible Party:

PATIENT FINANCIAL RESPONSIBILITY FORM

Welcome and thank you for choosing Hawthorn Holistic Health as your healthcare provider. The doctors of Hawthorn Holistic Health (HHH) are participating providers with most insurance companies. Each insurance company sells many different policies, and these policies vary greatly regarding what they will cover.

As a courtesy, HHH will file your claim. After a claim has been filed the insurance company will respond with their decision about what they will cover. It has been our experience that insurance companies do not cover all of the services offered by naturopathic doctors. When insurance does not cover a provided service then you, the patient, will be billed for any charges not covered. You are also financially responsible for co-pays, deductible amounts, telephone consultations, lab work, missed appointment fees and supplements. There are some treatments offered at Hawthorn Holistic Health that are routinely not covered by most insurance companies.

These services include but are not limited to: Acupuncture, Hydrotherapy, Thermal Imaging
The fact that your insurance carrier may not pay for a particular item or service does not mean that you should not receive it. Your doctor may recommend it because it is a medically useful course of action. Please ask your doctor any questions regarding receiving services that may not be covered. You may elect to receive non-covered services with the understanding that you are ultimately financially responsible.

I hereby authorize Hawthorn Holistic Health LLC, to directly receive payment of pertinent insurance benefits; to release information including protected health information to insurance companies and other related third parties as needed in relation to patient diagnosis and treatment; and to convey information through various means as needed in accordance with the Notice of Privacy Practices, a copy of which was made available to me.

I acknowledge that I must give 48 hours notice to cancel an appointment. If I do not call within 48 hours of my appointment, a $50.00 charge (not billable to my insurance) will be billed to my account. I understand that this fee must be paid before I reschedule any appointment.

I hereby acknowledge that I am personally responsible for all co-payment, deductibles, non-covered services and required referrals according to my insurance policy. I agree to pay all applicable charges accrued and to promptly pay any balance in full. I understand that my account will be charged $25.00 for any checks returned due to non-sufficient funds. I also agree that I am responsible for any collection and/or attorney fees. I agree that I am responsible to promptly alert Hawthorn Holistic Health LLC., should there be any changes related to my insurance and other information I provided above.

____ Date:____________________.
Name and Signature of Responsible Party: