Hawthorn Holistic Health LLC
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

Name	**Birthday**
Street Address	**Gender**
Town, City & Zip Code	**Cell Phone**
Occupation	**Home Phone**
How did you hear about us? Who can we thank for the referral?	**Email**
Would you like to be automatically added to our mailing list? Circle YES or NO	**Which number are we authorized to leave a message?**
Primary Care Physician & Phone Number	**Circle your preferred Method for Appointment Reminders:**
Emergency Contact, Relationship & Phone Number	*EMAIL CELL HOME*
Insurance Information	
Name of Insurance Company:	Name of Insurance Policy Holder
ID# GROUP#	

FAMILY HEALTH HISTORY List all known major illnesses, diseases, cancers, addictions, age and cause of death if deceased

Mother & her parents
Father & his parents
Sibling(s)
Children

Medical History

List ALL Known Allergies (medications, foods, insects, environmental, chemicals).	**Rate Mild, Moderate or Severe**
Any history of anaphylaxis?	
History of Hospitalizations, Surgeries or Major Accidents:	
Any Pre-existing Medical Conditions:	
Are you pregnant or trying to get pregnant?	

Please initial each page: _____*date*____

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Chief Concern for Today's Visit:

Chief Concern & Complaints:

Health Goals:

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"

Medications and Supplements

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

Nutrition & Lifestyle

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?

Describe your activity and exercise level:

Restrictions on activity?

Relationship status & living situation?

What do you do for fun?

How would you describe your mood?

Do you currently use any of the following?

Cigarettes or Tobacco	x _____ packs per	day or week	Marijuana	x _____ times per	day or week
Coffee or Black Tea	x _____ cups per	day or week	Recreational Drugs	x _____ times per	day or week
Alcohol	x _____ per	day or week	*Wine, Beer, or Liquor?*		

Sleep and Energy

How would you describe your sleep?
Rate on a scale from 1 to 10, 10 being the best:

How would you describe your energy?
Rate your energy on a scale from 1-10, 10 being the best:

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Detailed Pain Information

Rate the pain on a scale from 1-10 (10 being the worst):

Where do you have body pain? *RIGHT SIDE or LEFT SIDE*

How long have you had the pain? When was the initial Injury?

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:*

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 the pain on a scale from 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:*

Female Fertility History

- □ 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 concerns
- □ Fertility Concerns or Difficulty conceiving
- □ Working with fertility specialist
- □ 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: Length of cycle:
Last PAP smear: History of Abnormal PAP smear?

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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 me 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: _____

***Please initial each page**: _____date____*

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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 24-hours notice to cancel an appointment. If I do not call within 24 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.

_____

Name and Signature of Responsible Party Date

***Please initial each page**: _____ date____*

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ACUPUNCTURE Fees

Dear Patient:

If you consent to acupuncture treatment in the office, we will be collecting $20.00 in advance for treatment fees. We will bill your carrier; however, some policy plans pay for the procedure and others do not. The standard acupuncture rate is $50.00 for every 15-minute CPT code applied.

- If your insurance pays for the treatment the $20.00 will be applied to the patient portion of the payment from the insurance carrier or if there is "no patient payment" portion, the $20.00 will be a credit on your account and can be used for other services or supplements.

- If your insurance considers the acupuncture treatment as "covered service" and applies the covered portion towards your deductible, you will be responsible to pay the portion that your insurance carrier applied to the deductible until you have met your deductible.

- If your insurance carrier does not cover acupuncture, then the $20.00 will be applied as payment for the service.

Once we find out if your insurance pays for acupuncture, we will note it in the chart and will be able to know whether or not it is paid for by your insurance.

It is very hard to know in advance as to whether your insurance will pay for some of the specialty treatments such as acupuncture.

I, the patient, understand and agree to pay the $20.00 towards the acupuncture treatment. I agree to pay for my deductible if the insurance applied the service to the deductible or coinsurance. I understand I will have a credit of $20.00 if my insurance pays for all the acupuncture treatment.

INSURANCE: _____

Patient Signature: _____ Date: _____

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Hawthorn Healing Spa Financial Disclosure Form

[Infrared Sauna & Constitutional Hydrotherapy]

- Prepaid Hawthorn Healing Spa therapies such as (but not limited to) IR Sauna and Constitutional Hydrotherapy, are deemed non-covered services and will not be submitted to insurance for reimbursement.
- If you have an office visit with one of the doctors scheduled on the same day as one of the Healing Spa treatments, the office visit will be billed to your insurance, but the uncovered healing spa treatments will not be. You will still be responsible to pay for any uncovered services.
- If you do request additional covered services (i.e. Office visit to discuss labs, physical medicine, etc) we will do our best to accommodate this request. Please be aware that additional, covered services will be billed to your insurance. Therefore, you will be responsible for any copays, coinsurance or deductible fees associated with those covered services.
- It may be possible to use funds from an HSA account to pay for these services, but it will be up to you to contact your insurance and determine if your plan's benefits can be applied to these treatments.
- **All Prepaid Hawthorn Healing Spa treatments must be used within six months of purchase otherwise they will be considered void. We will do our very best to make scheduling them for you as convenient as possible. If you schedule a session and do not show up it will still be counted against your prepaid invoice.**

Please print and sign below to indicate that you understand and agree to the above guidelines:

_____

Print

_____

Sign Date

***Please initial each page**: _____date____*

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CONSENT TO TREAT:

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

Please read and sign below to indicate you understand and consent to treatment:

Naturopathic Medicine, Nutritional, Vitamin, Supplement & Lifestyle Counseling

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.

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. All procedures will be discussed and confirmed verbally before starting treatment. 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:**_____

***Please initial each page**: _____date____*

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Please complete the checklist to help us understand your whole health picture. Mark off the symptoms you are currently experiencing on the left or those you struggled with in the past on the right. Please circle the options that best fit you.

NOW	PAST		NOW	PAST	
☐	☐	Tired, Weak, Low Energy	☐	☐	Acne, Pimples, Cysts
☐	☐	Anxiety, Worry, Nervous, Overthinking	☐	☐	Rashes
☐	☐	Depression, Melancholy, Moodiness	☐	☐	Ulcers or sores
☐	☐	Anger, "Road rage", Frustration	☐	☐	Dry, Rough, Cracking, Scaling
☐	☐	Apathy, Hopelessness, Selfharm	☐	☐	Ulcers or sores
☐	☐	Insomnia or Waking frequently	☐	☐	Brown spots or bronzing
☐	☐	Vivid Dreaming or Nightmares	☐	☐	Facial rash or rosacea
☐	☐	Frequent Infections	☐	☐	Flushing, Hives
☐	☐	Headaches	☐	☐	Moles, Warts, Skintags, Growths
☐	☐	Inability to sweat	☐	☐	Slow healing cuts
☐	☐	Excessive sweating, Night sweats	☐	☐	Scaring, Keloid
☐	☐	Hot flashes	☐	☐	Runny Nose, Hayfever, Sinusitis
☐	☐	Dizziness or loss of balance	☐	☐	Nosebleeds
☐	☐	Seizures or convulsions	☐	☐	Dry or chapped lips
☐	☐	Concussion or Head Trauma	☐	☐	Sore throat or tonsillitis
☐	☐	Weight Gain	☐	☐	Clearing throat often
☐	☐	Weight Loss	☐	☐	Red, Sore, Cracked tongue
☐	☐	Hands tingling, Feet tingling	☐	☐	Cold sores, Herpes or Shingles
☐	☐	Thyroid disorder	☐	☐	Diminished smell or taste
☐	☐	Glasses or Contacts	☐	☐	Frequent Cavities or dental work
☐	☐	Blurred or Poor Vision	☐	☐	Bleeding gums
☐	☐	Dry, Itchy, Burning Eyes	☐	☐	Horse or raspy voice
☐	☐	Runny or Watery Eyes	☐	☐	Frequent Coughing
☐	☐	Light sensitivity	☐	☐	Spitting up mucus or blood
☐	☐	Night Blindness or Halos	☐	☐	Difficulty breathing
☐	☐	Red or Puffy Eyes	☐	☐	Chest pain
☐	☐	Ear aches & infections	☐	☐	Loss of appetite
☐	☐	Ringing in the ears	☐	☐	Difficulty swallowing or gagging
☐	☐	Diminished hearing	☐	☐	Nausea, Vomiting
☐	☐	Wax buildup	☐	☐	Bad breath, thick tongue coat
☐	☐	Hair Loss, breaking, thinning	☐	☐	Excessive appetite, food cravings, binge
☐	☐	Easy bruising	☐	☐	Heart burn, reflex, regurgitation

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NOW	PAST		NOW		
☐	☐	Digestive Pain after eating	☐	☐	Hernia
☐	☐	Indigestion, Heaviness after eating	☐	☐	Leg pains, Leg cramps
☐	☐	Digestive Pain on an empty stomach,	☐	☐	Hands or feet turn white or blue
☐	☐	Difficulty digesting fats	☐	☐	Varicose veins
☐	☐	Stool dark colored	☐	☐	Tendency to Anemia
☐	☐	Light colored stool	☐	☐	High blood pressure
☐	☐	Undigested food in stool, Blood in stool	☐	☐	Low blood pressure
☐	☐	Constipation, Incomplete elimination	☐	☐	Shortness of breath walking upstairs
☐	☐	Loose stool, diarrhea	☐	☐	Changes in Urination
☐	☐	Foul odors	☐	☐	Frequent urination, Nighttime urination
☐	☐	Hemorrhoids	☐	☐	Pain with urination
☐	☐	Cramping Pains	☐	☐	Blood in urine
☐	☐	Bloating	☐	☐	Cloudy urine
☐	☐	Belching, Gas	☐	☐	Foamy urine
☐	☐	Headache, Dizzy, Irritable if skips a meal	☐	☐	Frequent Urinary Tract Infections
☐	☐	Palpitations, Racing heart, Irregular	☐	☐	Bladder infection, Kidney Infection
☐	☐	Dizziness upon standing	☐	☐	Kidney stones
☐	☐	Altitude sickness	☐	☐	Low Back Pain
☐	☐	Chest Tightness	☐	☐	Enlarged Prostate
☐	☐	Swollen feet or ankles	☐	☐	Low libido
☐	☐	Cold hands or feet	☐	☐	High libido
☐	☐	Muscle Pain or tightness	☐	☐	Pain with intercourse
☐	☐	Joint Pain or stiffness	☐	☐	Genital pain or discomfort
☐	☐	Bone Pains	☐	☐	Difficulty completing intercourse
☐	☐	Tremors, twitches or loss of strength			

Anything else you think is important for us to know before starting:

_____

_____

_____

_____

***Please initial each page**: _____date____*