"I Can Make a Difference in Your Life"
Justin Mandel, Dipl.O.M.L.Ac
Board Certified Oriental Mediciine

80 East 11th Street #641
New York, NY 10014
914-646-4545

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Rockville Centre, NY 11570
914-646-4545

Dear Brand New Rapid Health Response Patient,

Before anything else, I wanted to take the time to welcome you to my practice ☺

Before you come in to see me for your first visit please do these 2 things to make your experience as best as possible:

1) ***Fill out all forms as completely as possible*** - This will save both of us time. If you have any questions, leave what you are working on blank and skip to the next part. Be sure not to forget filling out the very last page where your name, date, and signature is required.

2) ***Please eat a light snack or piece of fruit BEFORE you come in*** – that is if you are have not eaten anything in the past 5 hours prior to your scheduled visit. I have found that this nearly completely eliminates any feelings of nausea that a very small percentage of people might experience. Food needs to be in the stomach so it will help ground you since we tend to move a lot of energy in the body during acupuncture.

I'm honored to be your choice of alternative medicine specialist and I look forward to meeting you for the first time! I will do everything possible to produce the "Rapid Health Response" in you by delving deeply into my complete repertoire of expertise based on all of my knowledge, years of training, and post-graduate training I've received!

Best in Health,

Justin Mandel Dipl.O.M.L.Ac

Justin Mandel, Dipl.O.M. L.Ac
Board Certified in Oriental Medicine
Inventor of the Bladder RE-EXPANSION Technique®

Rapid Health Response+
Alternative Medicine

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have any questions, please ask. Thank you.

Personal Information

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Occupation _____ Person responsible for your account _____

Medical Doctor's Name, address, phone _____

_____

Date of last MD visit and diagnosis _____

How did you hear about us? _____

Sex: ☐ Male ☐ Female Height _____ Weight _____ Birth date _____ Age _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Number of children _____

Have you received Acupuncture before? ☐ Yes ☐ No

When? _____ With whom? _____

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	Relative	Date	Illness	You	Relative	Date
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐	☐	_____	Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____	Seizures	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Emotional Disorders	☐	☐	_____
Infectious Diseases	☐	☐	_____	Tuberculosis	☐	☐	_____
Allergies	☐	☐	_____	Drug, Alcohol abuse	☐	☐	_____

Sexually Transmitted Diseases: ☐ AIDS ☐ HPV ☐ Herpes ☐ Syphilis ☐ Other Date _____

List any medications and supplements you are currently taking:

Medicine	Dosage	Reason	How Long	Prescribed by

Please indicate the use and frequency of the following:

	Yes	No	How much		Yes	No	How much		Yes	No	How much
Coffee/tea	☐	☐	_____	Tobacco	☐	☐	_____	Water intake	☐	☐	_____
Non-medical drugs	☐	☐	_____	Alcohol	☐	☐	_____	Soda pop	☐	☐	_____

Personal Information (continued)

What is the main health problem for which you are seeking treatment?

What other forms of treatment have you sought?

Serious Illnesses/ Injuries (please list date and outcome):

Hospitalizations/ Surgeries (please list reason and outcome):

Allergies (Food, Medications, etc…):

Please state any concerns that you would like to discuss…

Thank you for taking the time to fill in this information as completely as possible.
The reason that RapidHealthResponse uses such comprehensive forms is to help us provide you with the best health care possible.

For Women

Age of 1st period (menarche) _____ Are you pregnant? ☐ Yes ☐ No # of pregnancies _____

Age of Last period (menopause) _____ # of live births ____ # of Abortions ____ # of Miscarriages _____

Date of last: Gynecologic exam _____ Pap Smear _____ Mammogram _____ Bone Density Scan _____

Results _____

Number of days between periods _____ Number of days of flow _____ Color of flow _____

Clots? ☐ Yes ☐ No Color _____

Average number of pads used per day: 1st day____ 2nd day ____3rd day ____4th day ____+ days _____

Have you been diagnosed with: ☐ Fibroids ☐ Endometriosis ☐ Ovarian Cysts ☐ PID ☐ Fibrocystic Breasts ☐ Other _____

Location of Pain: ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other _____

Nature of Pain (please indicate Before, During or After menses)

Cramping _____ Stabbing _____ Burning _____ Aching _____ Dull _____ Bloating _____

Consistent _____ Intermittent _____ Bearing down sensation _____

Other Symptoms related to menses: ☐ Headache ☐ Mood swings ☐ Hot flashes ☐ Night sweats ☐ Insomnia ☐ Nausea ☐ Poor appetite ☐ Ravenous appetite ☐ Swollen breasts ☐ Constipation ☐ Diarrhea ☐ Vaginal dryness ☐ Discharge ☐ Increased libido ☐ Decreased libido

For Men

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____

Frequency of Urination: daytime____ nighttime____ Color of urine: ☐ clear ☐ murky odor: _____

Symptoms: ☐ Prostate problems ☐ Delayed stream ☐ Dribbling ☐ Incontinence ☐ Retention of urine ☐ Rectal dysfunction ☐ Increased libido ☐ Decreased libido ☐ Premature ejaculation ☐ Impotence ☐ Back pain ☐ Groin pain ☐ Testicular pain ☐ Other _____

Symptom Survey (For everyone)

Please indicate any of the following symptoms experienced in the last 3 months (+) Frequently (√) Sometimes

<u>General</u>
__ Depression
__ Dizziness
__ Fainting
__ Fatigue
__ Forgetfulness
__ Headache
__ Irritability
__ Loss of sleep
__ Loss of weight
__ Migraines
__ Nervousness

<u>Gastrointestinal</u>
__ Poor Appetite
__ Bloating
__ Constipation
__ Diarrhea
__ Excessive hunger
__ Excessive thirst
__ Hemorrhoids
__ Indigestion
__ Nausea, Vomiting
__ Rectal bleeding
__ Stomach pain

<u>Eyes, Ears, Nose, Throat</u>
__ Bleeding gums
__ Blurred vision
__ Dry mouth, throat
__ Earaches
__ Frequent colds
__ Hay fever
__ Loss of hearing
__ Nosebleeds
__ Persistent cough
__ Ringing in ears
__ Shortness of breath
__ Sinus problems

<u>Muscles, Joints, Bones</u>
(Pain, weakness, numbness)
__ Arms __ Legs
__ Shoulders __ Hips
__ Elbows __ Knees
__ Wrists __ Ankles
__ Hands __ Feet
__ Fingers __ Toes
__ Back __ Neck
__ TMJ __ Carpal Tunnel Syndrome

<u>Skin, Nails</u>
__ Bruises easily
__ Eczema
__ Hives
__ Psoriasis
__ Dry Skin
__ Brittle Nails

<u>Cardiovascular</u>
__ Chest pain
__ High cholesterol
__ Palpitations
__ Poor circulation
__ Swelling of the ankles
__ High Blood Pressure
__ Low Blood Pressure

INSURANCE

Should we agree to bill your insurance for you, please understand that this is done as a courtesy and it is not our responsibility to pursue payment of your account. YOU SHOULD CONTRACT WITH YOUR INSURANCE COMPANY AND IT IS YOUR RESPONSIBILITY TO COLLECT AND/OR NEGOTIATE SETTLEMENT OF YOUR CLAIMS. We will be happy to furnish information and answer all inquiries directed to us from your insurance company.

INSURANCE ACCEPTANCE

We will be happy assist you in billing you insurance and will accept payment directly to the doctor. IT IS THE PATIENT'S RESPONSIBILITY TO UNDERSTAND THEIR POLICY AND THE BENEFITS PERTAINING TO THEIR ACUPUNCTURE TREATMENT. Please provide us with an original completed claim form. If for any reason the claims are denied, the patient or responsible party will satisfy the account in full. If there is a deductible or co-payment, that portion will be due at the time of each service. IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY US WITH ANY CHANGES IN COVERAGE.

CANCELLATION OR NO-SHOW APOINTMENT

Regarding cancellations or no-show appointments, our policy states that there must be a 24-hour notice between when you cancel an appointment and the actual time of your appointment. If you have cancelled treatment without 24-hours notice, you will be given a verbal warning. On your second cancellation, you will be charged the full fee you normally pay before you may be treated again.

Please try to be on time for your appointment, because it affects every single patient after you if you are late. We respect your time as well, and will do our utmost to stay on schedule.

In order to render a high standard of care, this policy was developed to insure each patient's treatment time.

I understandand accept the above policy.

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

Wu-Wei Healing Arts is committed to your health and well being. JustinMandel,Dipl.O.M.L.Ac has a great deal to offer as an Acupuncturist , but he cannot totally replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.
To comply with Article 160, Section 812 1.1 (b) of NYS Education Law we request that you read a sign the following statement:

WE, THE UNDERSIGNED, DO AFFIRM THAT _____

HAS BEEN ADVSIED BY **JustinMandel,Dipl.O.M.L.Ac**

TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH A PATIENT SEEKS ACUPUNCTURE TREATMENT.

_____ _____
Patient Signature Date

_____ _____
Licensed Acupuncturist Signature Date

II. INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with Chinese Medicine by Justin Mandel Licensed Acupuncturist. I have discussed the nature and purpose of my treatment with Justin Mandel, L.Ac Dipl. C.H.

I understand that methods of treatment may include but are not limited to: Acupuncture, Moxibustion, Cupping, Electrical Stimulation, and Tui Na (Chinese Massage).

I have been informed that Acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last for a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of Acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although JustinMandel,Dipl.O.M.L.Ac uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) which may be recommended are traditionally considered safe, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachaches, vomiting, diarrhea, rashes, hives, and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify any member of RapidHealthResponse of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify RapidHealthResponse if I become pregnant.

I do not expect JustinMandel,Dipl.O.M.L.Ac to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on his judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts known to them, is in my best interests.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent from to cover the entire course of treatment and for any future conditions) for which I seek treatment.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated)

_____
Date Consent Completed

_____
Print Name of Patient

_____
Signature of Patient or Representative

_____
Print Name of Patient Representative

To be completed by JustinMandel,Dipl.O.M.L.Ac providing information and obtaining consent

_____

JustinMandel,Dipl.O.M.L.Ac

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24 Hour Cancellation Policy

I understand that there is 24 hour cancellation policy to see JustinMandel,Dipl.O.M.L.Ac for Acupuncture treatment. In the event that I miss an appointment without 24 hours notice given, I will be charged the full amount for my scheduled visit through my credit card.

_____
(Name)

_____
(Signature)

_____
(Date)

Credit Card (Please Check):
[ ]Visa [ ] Mastercard [ ] Discover

Card Number:_____

Expiration Date:_____

3 Digit number on back of card:_____