

# STONINGTON NATURAL HEALTH CENTER

acupuncture • herbal medicine • bodywork

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## Welcome

Welcome to Stonington Natural Health Center. We are so glad you made it here. We provide *Custom Holistic Healthcare for the Whole Family in a Tranquil Waterfront Setting* with Acupuncture & Oriental Medicine, the SNHC Customized Massage which is a combination of Swedish and Deep Tissue Massage to your desired level of pressure, Deep Tissue Massage, Pregnancy Massage, Reconnective Healing, Reflexology, Reiki, and Herbal Consultations.

Our treatments help you to feel better, breathe deeper, rejuvenate, and let go of your worries. Your body, mind, and spirit will thank you. This is your time to relax and heal, initiate and speed up your healing process, so that you can live a longer, healthier, and happier life.

For injuries or health complaints, you will receive the most benefit by creating momentum by grouping treatments close together and coming in for treatments before the effects of the previous treatment disappear. Your practitioner will give you a treatment protocol. It is often recommended to group your treatments close together, which may be daily, twice a week or three times per week. During times of stress, anxiety, or depression, it is helpful to come in for Acupuncture and Massage treatments at least once a week, and in severe cases, daily. Once you are feeling better, we space the treatments apart at a pace that allows the positive effects to hold. Our goal is to shift the pattern of your energy quickly and easily, so that you will have long lasting effects. We focus on bringing you up to your highest healing potential. Once you are at your highest healing potential, regular tune-ups, which can range from once a week to once a month, are important in maintaining good health.

If you have any questions, concerns, or feedback, please talk with us or email us at [info@snhc.com](mailto:info@snhc.com).

We appreciate this opportunity to contribute to you on your path towards optimal health and happiness.

ALL OF US AT STONINGTON NATURAL HEALTH CENTER

The doctor of the future will give no medicine, but will interest her or his patients in the care of the human frame, in a proper diet, and in the cause and prevention of disease.

THOMAS EDISON

All life is an experiment.  
The more experiments you make the better.

RALPH WALDO EMERSON

Enjoy the journey.

DEEPAK CHOPRA

# **INFORMED CONSENT FOR ACUPUNCTURE & ORIENTAL MEDICINE AND MASSAGE TREATMENT AND CARE**

I hereby request and consent to the performance of Acupuncture and Massage Treatments and other complementary medicine procedures on me (or on the patient named below, for whom I whom I am legally responsible) by Megan Marco, Doctor of Acupuncture, Licensed Acupuncturist, and the other Practitioners of Stonington Natural Health Center.

I understand that methods or treatment may include, but are not limited to, Acupuncture, Moxibustion, Cupping, electrical stimulation, Tui Na (Chinese Massage), Shiatsu (Japanese Massage), Swedish Massage, Acutonics (sound therapy), Herbal Medicine, Nutritional Counseling, Applied Kinesiology, Detoxification, Homeopathy, physical examination, Reiki, and Vitamin Therapy.

I will discuss with Megan Marco, DAc, LAc any questions or concerns that I have with my Acupuncture and Oriental Medicine treatments, Massage, or holistic treatments.

The goals of Acupuncture and Oriental Medicine are to normalize physiological functions, to modify the perception of pain, and to treat certain diseases and dysfunctions of the body. I have been informed that Acupuncture is a safe method of treatment. Occasionally there may be some bruising or tingling near the needling sites that lasts a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform Megan Marco, DAc, LAc.

I do not expect the Doctors and Health Practitioners to be able to anticipate and explain all risks and complications. I wish to rely on the Doctors and Health Practitioners to exercise judgment during the course of the procedure which Doctors and Health Practitioners feel at the time, based upon the facts then known, is in my best interest.

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I understand my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. If I have any questions, I will ask. 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.

**To be completed by the patient:**

Patient's Name: \_\_\_\_\_

Signature \_\_\_\_\_

Date: \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

Clinic/Office: Stonington Natural Health Center  
107 Wilcox Road, Suite 103  
Stonington, CT 06378

Name of Acupuncturist: Megan Marco, DAC, LAc

**To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or is physically or legally incapacitated:**

Patient's Name: \_\_\_\_\_

Patient's Representative: \_\_\_\_\_

Relationship to Authority: \_\_\_\_\_

Witness: \_\_\_\_\_

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**PATIENT NOTICE OF PRIVACY POLICY**

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. (Health Insurance Portability and Accountability Act – “HIPAA”)

Patient Rights and Uses and Disclosures of Health Information:

**PERSONAL HEALTH INFORMATION DISCLOSURE:**

In the course of your care as a patient at Stonington Natural Health Center, we may use or disclose personal or health related information about you in the following ways:

1. Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
2. Your health care records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
3. Your name and address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, Stonington Natural Health Center newsletters, or other health related information that may be of interest to you. If you are not home to receive an appointment reminder, a message may be left on your answering machine or voicemail. Further, you have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you, or the reimbursement avenues associated with your care.

**PERMITTED OR REQUIRED TO USE OR DISCLOSE HEALTH INFORMATION WITHOUT YOUR CONSENT OR AUTHORIZATION:**

UNDER federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. If we are providing health care services to you based on the orders of another health care provider.
2. If we provide health care services to you in an emergency.
3. If there are substantial barriers to communicating with you, but in our professional judgment believe that you intend for us to provide care.
4. If we are ordered by the courts or another appropriate agency.

ANY USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION, OTHER THAN OUTLINED ABOVE WILL ONLY BE MADE WITH YOUR WRITTEN AUTHORIZATION

We normally provide information about your health in person at the time you receive services or care from us. We also may mail information to you regarding your health care, or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing

#### PRACTITIONER LEGAL DUTIES

We are required by state and federal law to maintain the privacy of your patient file and the protected health information herein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

#### COMPLAINTS & QUESTIONS

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your questions to: Megan Marco, DAc, LAc, 860.536.3880.

This notice is effective immediately. This notice, and any alteration or amendments made hereto, will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

\_\_\_\_\_  
Patient Name (printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
DATE

# Patient Health History

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Please indicate the best number to reach you and best number to leave messages:

Home Phone#: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_ Prefer Texting? Y N

Work Phone#: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse or Significant Other: \_\_\_\_\_

Email (to receive newsletters & coupons): \_\_\_\_\_

Hobbies and Interests: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Town, State: \_\_\_\_\_

Specialist: \_\_\_\_\_ Type: \_\_\_\_\_ Town, State: \_\_\_\_\_

Specialist: \_\_\_\_\_ Type: \_\_\_\_\_ Town, State: \_\_\_\_\_

Specialist: \_\_\_\_\_ Type: \_\_\_\_\_ Town, State: \_\_\_\_\_

What are your 3 primary health concerns / health goals in order of importance?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

How long has each concern condition persisted?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What do you think is the cause?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

How does it affect you?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What treatment have you received for this condition?

\_\_\_\_\_  
Diagnosis given?

\_\_\_\_\_  
What were the results of the treatment?

## Patient Health History

What are your hopes and expectations from treatments at Stonington Natural Health Center?

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Blood Type \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Any recent (circle): weight loss or gain?

Do you have any reason to believe you are pregnant?                      Yes                      No

Do you have any chronic infectious diseases?                      Yes                      No

If yes, please explain: \_\_\_\_\_

Are you currently suffering from any chronic illnesses?                      Yes                      No

If yes, please explain: \_\_\_\_\_

Please list any hypersensitivities or allergies that you may have and your reaction:

Allergies to Foods: \_\_\_\_\_

Allergies to Environmental: \_\_\_\_\_

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Allergies to Medications: \_\_\_\_\_

Please list any medications, both prescription and over the counter, you are currently taking -  
- include dosages and duration of use:

Please list any supplements or vitamins you are currently taking -- include dosages and brand names:

Please list any hospitalizations or major surgeries that you have had and the approximate dates they occurred:

Please list any significant traumas (i.e. car accidents, bone fractures, sprains, falls, etc.):

Have you experienced any significant emotional trauma? If so, what and when?



## Patient Health History

Please circle any symptoms that you currently have and underline any symptoms you have had within the past year.

<p><b><u>General:</u></b>            Low energy or fatigue            Allergies            Insomnia            Spontaneous sweating            Night sweats            Aversion to heat            Aversion to cold            Chronic infections</p>	<p><b><u>Head and Neck:</u></b>            Headaches            Red/swollen eyes            Dry/itchy eyes            Watery eyes            Mucus or discharge from eyes            Eye pain            Blurry vision            Night blindness            Glasses or contacts            Glaucoma or cataracts            Dizziness/vertigo            Recurrent phlegm            Sinus problems            Nosebleeds            Frequent sore throats            TMJ (jaw problems)            Earaches            Difficulty hearing            Hearing loss            Noises or Ringing in ears            Ear discharge            Excess earwax            Fever blisters            Sores on tongue or in mouth            Loss of smell            Change of taste            Dry throat/mouth            Excessive thirst            Bad Breath</p>	<p><b><u>Respiratory:</u></b>            Pain in lungs            Asthma            Wheezing            Pneumonia            Chronic bronchitis            Persistent cough            Shortness of breath            Difficulty breathing            Frequent colds            Hay fever            Spitting or coughing up blood</p>
<p><b><u>Gastrointestinal:</u></b>            Nausea/vomiting            Low appetite            Abdominal pain            Gas            Burping            Bloating            Indigestion            Acid reflux/heartburn            Heavy feeling after eating            Ulcers            Loose stools            Constipation            Blood in the stools            Black/tarry stools            Undigested food in stools            Hemorrhoids            Rectal pain/itching</p>	<p><b><u>Neurologic:</u></b>            Paralysis            Numbness/tingling            Seizures            Loss of balance            Epilepsy            Tics            Lyme Disease            Bell's Palsy</p>	<p><b><u>Musculoskeletal:</u></b> (<i>pain, numbness or weakness</i>)            Neck/shoulder Arms            Legs                      Feet            Joints                      Knees/elbows            Hands                      Whole body            Lower back            Mid/upper back            Muscle spasms/cramps (where?)            _____            Broken bones (where?)            _____            Sprains/strains (where?)            _____            Tendonitis (where?)            _____</p>
<p><b><u>Cardiovascular:</u></b>            Heart disease            High blood pressure            Chest pain            Heart Attack            Heart palpitations/fluttering            Heart murmurs            Varicose veins            Swelling of legs/ankles            Stroke            Aneurism</p>	<p><b><u>Emotions:</u></b>            Mood swings              Stress            Nervousness              Sad            Mental tension            Angry            Irritability                  Frustrated            Anxiety                      Worried            Depression                Afraid</p>	

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## Patient Health History

Please circle any symptoms that you currently have and underline any symptoms you have had within the past year.

<p><b><u>Skin:</u></b>          Acne or pimples          Hives          Stretch marks          Skin ulcers or sores          Cracks in corners of mouth          Dryness, roughness or scaling of skin          Dry or chapped lips          Hair loss or thinning          Dry course hair          Bruise easily          Cold sores or herpes          Nails weak, ridged or split easily          Brown spots or bronzing          Warts, moles, or skin tags          Sunburn easily          Cuts heal slowly or scar badly          Flush easily          Athlete's foot          Jock itch          Any other itchy areas            _____</p>	<p><b><u>Female Reproductive:</u></b>          Breast lumps/tenderness          Nipple discharge          Irregular periods          Painful periods          PMS          Short cycle (less than 24 days)          Long cycle (more than 35 days)          Heavy periods          Bleeding between periods          Difficulty conceiving          Miscarriages          Endometriosis          Fibroids          Abnormal PAP smear: _____          Vaginal discharge          Vaginal itching          Vaginal pain          Pelvic Pain          Pain with intercourse          Hot flashes          Diminished or excessive sex drive          Difficulty reaching orgasm          Perimenopause          Menopause, age at last menses: _____</p>	<p><b><u>Genitourinary Tract:</u></b>          Painful urination          Urinary urgency          Urinary frequency          Difficult urination          Incontinence          Kidney stones          Urinary tract infections          Frequent urination at night          Sexually Transmitted Disease          Blood in the urine          Dark urine</p> <hr/> <p><b><u>Male Reproductive:</u></b>          Genital pain          Low sex drive          Difficulty conceiving          Low sperm count          Sexual difficulty / impotence          Enlarged prostate          Testicular pain or swelling          Genital discharge          Rashes or sores</p>
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## Patient Health History

### Family History:

	Mother	Father	Brothers	Sisters	Spouse	Child	Child	Child
Age (if living)								
Names								
Health (G=good P=poor)								
Age at death (if deceased)								
<i>Check any of the following conditions that apply to members of your family</i>								
Cancer—where?								
Diabetes								
Heart Disease								
Heart Attack								
High Blood Pressure								
Stroke								
Mental Illness								
Other								

**Nutrition:** Please describe what you generally eat at each meal.

<b>Breakfast</b>	
<b>Lunch</b>	
<b>Dinner</b>	
<b>Snacks</b>	

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## Patient Health History

Do you smoke cigarettes? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how much? \_\_\_\_\_

Do you consume caffeine? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what and how much? \_\_\_\_\_

Do you drink soda? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what and how much? \_\_\_\_\_

Do you consume artificial sweeteners (aspartame, nutrasweet, splenda, saccharin)?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how much? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how much and how often? \_\_\_\_\_

What do you do for exercise and how often?

\_\_\_\_\_

Is there anything else about you or your condition that you would like me to know or address?

\_\_\_\_\_

\_\_\_\_\_

How did you hear about Stonington Natural Health Center (so we can offer our SNHC Rewards)?

\_\_\_\_\_

As a part of the SNHC Rewards Program,  
for every person that you refer,  
receive a **complimentary 10 minute massage**  
added onto your Acupuncture Treatment  
(\$15 value!)  
**OR**  
save up five of your Referrals and receive a  
**Full One-Hour Acupuncture Treatment**  
(\$100 Value!)

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