ACUTOUCH ACUPUNCTURE & HERB CENTER

Patient Information Sheet

CONFIDENTIAL

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Complete this forum as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Last Name	First Name		Preferred Name/Nickname	Date
Gender ☐ M ☐ F	Date of Birth	Age	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Address				
City			State	Zip

Daytime Phone# (home, work, cell – circle one): ( )	Alternate Phone# (home, work, cell – circle one): ( )
Other Phone Number (home, work, cell – circle one): ( )	Email
Occupation	
Emergency Contact & Relation ship	Phone Numbers of Emergency Contact ( )

Insurance ☐ None ☐ PPO ☐ HMO ☐ TWC ☐ Others: _____

Primary	**Secondary**
Ins. Name:_____	Ins. Name:_____
Policy Holder:_____	Policy Holder:_____
Policy Number:_____	Policy Number:_____
Group Number:_____	Group Number:_____
Phone Number:_____	Phone Number:_____

Primary Care Physician (if applicable):	
Other Doctors You See	Specialty
Other Doctors You See	Specialty
Is your injury work related? ☐ Yes ☐ No	Is your injury auto accident related? ☐ Yes ☐ No
How did you hear about us?	Who REFERRED YOU to our clinic?

Under 18 years of age

Last Name First Name

Mother's Name: _____ Contact Number:_____

Medical Information

Please describe current health problem(s) for which you are seeking treatment: _____

Date problem(s) began (mm/dd/yy): _____

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally

Indicate any significant illness(es) you have:

☐ Cancer ☐ Diabetes ☐ Hepatitis ☐ Seizures ☐ Emotional Disorders
☐ High Blood Pressure ☐ Rheumatic Fever ☐ Heart Disease
☐ Infectious Diseases ☐ Others _____
☐ Sexually Transmitted Diseased (Gonorrhea, Syphilis, AIDS, ARC) _____

What treatment have you been taking for the above condition(s)? (Surgery, medications, injections, therapy, chiropractic, etc.) _____

_____

List any other health problems you now have: _____

List any allergies, food sensitivities or food cravings that you have: _____

List any accidents, surgeries, or hospitalizations (include date): _____

LIST MEDICATIONS YOU ARE NOW TAKING _____

DRUG ALLERGIES _____

Please indicate the use and frequency of the following:

☐ Tobacco _____ ☐ Coffee/Black tea _____ ☐ Alcohol _____
☐ Non-Medical Drugs _____ ☐ Exercise _____ ☐ Street Drugs _____

If a family member has had any of the following, please mark the appropriate box and explain:

☐ Arthritis ☐ Cancer ☐ DIABETES ☐ Lupus ☐ Hypertension ☐ Heart disease ☐ Mental disorders
☐STROKE ☐ TUBERCULOSIS ☐ Others _____

MEDICAL HISTORY Mark ☐ for current problems.

☐Decreased Hearing
☐Ringing in ear
☐Ear infections - frequent
☐Dizzy Spells
☐Failing Vision
☐Double or Blurred Vision
☐Eye Pain
☐Eye Infections - frequent
☐Nose Bleeds - recurrent
☐Sinus Trouble
☐Sore Throats - frequent
☐Hay fever/Allergies
☐Hoarseness - prolonged
☐Pneumonia/Pleurisy
☐Bronchitis/Chronic Cough
☐Asthma/Wheezing
☐Shortness of Breath
☐on Exertion
☐Chest Pain
☐High Blood Pressure
☐Heart Murmur
☐Palpitations
☐Irregular Pulse
☐Swollen Ankles
☐Fainting Spells

☐Leg Pain when walking
☐Varicose Veins/Phlebitis
☐Loss of Appetite - recent
☐Difficulty Swallowing
☐Indigestion or Heartburn
☐Persistent Nausea/Vomiting
☐Peptic Ulcers
☐Abdominal Pain - chronic
☐Change in Bowel Habits - recent
☐Diarrhea ☐Constipation
☐Diverticulosis
☐Bloody or Tarry Stools
☐Hemorrhoids
☐Gall Bladder Trouble
☐Jaundice/Hepatitis
☐Hernia
☐Urinary Infections - frequent
☐Lying Flat ☐Painful Urination
☐Blood in Urine
☐Overnight Urination-More Than 2
☐Control in Urination
☐Decrease in Force of Urination
☐Kidney Stones
☐Venereal Disease
☐Urethral Discharge

☐Chronic Fatigue
☐Weight Loss - recent
☐Anemia ☐Bruise easily
☐Mumps
☐Thyroid Disease
☐Convulsions/Seizures
☐Stroke
☐Tremor/Hands Shaking
☐Muscle Weakness
☐Numbness/Tingling Sensations
☐Headaches - frequent
☐Arthritis/Rheumatism
☐Back Pain - recurrent
☐Bone Fracture/Joint Injury
☐Gout
☐Foot Pain ☐Cold Numb Feet
☐Rashes ☐Hives
☐Psoriasis ☐Eczema
☐Sleeping Difficulty
☐Nervousness ☐Depression
☐Memory Loss
☐Moodiness - excessive
☐Phobias
☐Mental Illness

☐Chicken Pox ☐Polio
☐Measles ☐Germ. Measles
☐Rheumatic ☐Scarlet Fever

FEMALES - Menstrual History
Age at Onset_____☐Reg ☐Irreg
Flow ☐Heavy ☐Mod ☐Light
☐Pain/Cramps with Mens. Flow
_____ Days of Flow
_____ Length of Cycle
☐Pain/Bleeding After Sex
No. of Pregnancies_____
No. of Live Births_____
No. of Miscarriages_____
Birth Control Method_____
B.C. Pill (name)_____
☐Flushing/Menopause
☐H.I.V.
Other Symptoms of Diseases
☐_____
☐_____
☐_____

REQUEST AND CONSENT FOR TREATMENT

I hereby request the Acupuncturist to treat me. I also authorize him/her to perform on me the treatment known as Acupuncture as his/her judgment may indicate and authorize him/her to use whatever therapeutic methods he/she may see fit, whether or not such methods are commonly and generally accepted and practiced in this community.

The Acupuncturist has frankly and fully explained to me the nature and purpose of the treatment, the risks involved, the collateral hazards and possibilities of complications during or as a result of the treatment. I understand what the term "complication" means, and in giving my consent to the treatment, I have in mind his/her frank and full explanation. If any unforeseen condition arises in the course of the treatment and in the judgment of the Acupuncturist it is advisable to use procedures in addition to or different form those now contemplated, I also request and authorize him/her to do whatever he/she deems advisable.

The Acupuncturist has made no guarantee as to the results that may be obtained.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read, reviewed, understand and agree to the Notice of Privacy Policies for healthcare services in this office. This practice has attempted to provide each patient with a Notice of Privacy Policies.

PATIENT'S CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I give consent to Austin Acupuncture Clinic for the use and disclosure of my individual identifiable health information or Protected Health Information for the following specific purposes:

A. Providing treatment to me;
B. Relating to the payment of the services this office has rendered to me;
C. The general healthcare operations of this practice.

The Purpose of This Consent: Protected Health Information is any information which includes:

A. Demographic information;
B. Information gathered by this practice as it relates to my past, present and future physical or mental health or condition;
C. Information gathered by this office for past, present or future payments for providing the healthcare services;
D. Healthcare operations purposes will include quality assessment activities, credentialing, business management and other general operations procedures or activities.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Clinic, but the Clinic is not required to agree to these restrictions. However, if the Clinic agrees to a restriction that I request, the restriction is binding on the Clinic.

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures from this Clinic before I sign this consent form regarding the use and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the Clinic has acted in reliance on this consent.

If you are suffering from any of the following diseases/ conditions, please notify the acupuncturist at this time:

1. Heart condition _____
2. Stroke _____
3. Water retention from diabetes _____
4. Fainting from needles _____
5. Bruise easily _____
6. Please confirm that the acupuncturist has shown you the disposable needles. Yes _____ No _____

In the event that my condition is such that treatment is beyond the normal capabilities of the clinic, I understand that I may be referred to other competent practitioners including, but not necessarily limited to, medical physicians or other acupuncturists. **I also agree to give 24 hours notice if I am going to be unable to make my scheduled appointment. I fully understand I may be charged the regular treatment fee if I miss an appointment without giving 24 hours notice.**

I have been given no guarantee as to the results that may be obtained.

_____ _____

Signature of Patient Date

Form to be Completed by Patient, Notifying the Acupuncturist of Whether He/She Has Been Evaluated by a Physician, and Other Information.

(Pursuant to the requirements of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) _____ am notifying the acupuncturist John Su, of the following:

___ Yes ___ No I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

Signature _____ Date _____

OR

___ Yes ___ No I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

Signature _____ Date _____

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for one of the following conditions:

____ Weight Loss ____Chronic Pain ____ Smoking Cessation

Signature _____ Date _____

Form to be Completed by Patient, Attesting that the Acupuncturist Has Referred Him/Her

(Pursuant to the requirement of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ. Code Ann. §205.351, governing the practice of acupuncture.)

The acupuncturist has referred me to see a physician. It is my responsibility and choice whether to follow his or her advice.

Patient's signature _____ Date _____

Acupuncturist's signature _____ Date _____