15901 Central Commerce Drive Suite 102
Pflugerville, Texas 78660
(512) 494-4050

PATIENT INFORMATION

Full Name (Print):____
Sex: __ Date of Birth: (MM/DD/YY) ___/___/___ Age: ______
Street Address: ____
City: ___________________________ State:_________________ Zip Code:___________
Employer:____________________________ Email:____
Phone:_________________________________ Work Phone: __________________________________

EMERGENCY CONTACT

In case of emergency, this office should contact:
Name: _________________________________ Phone: _________________________________
Relation to you: __________________________
REFERRAL
How did you hear about us? ____

Medical Evaluation, Referral, or Recommendation

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care." As a result, Pflugerville Acupuncture is required to have you respond to the following questions before you may be treated. Please be advised that we will not be permitted to treat you if your response is "no" to all of the last three questions.

Have you ever had acupuncture before? __________

Have you seen a physician in the last 12 months for the condition you are seeking treatment for? _________

Have you seen a chiropractor within the last 30 days for the condition you are seeking treatment for? _________

Are you seeking treatment today for one of the following: chronic pain (lasting longer than 6 months), smoking addiction, substance abuse, or weight loss? _________

Patient Signature ____

Date ______________

Pflugerville Acupuncture
Informed Request and Consent

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturist on staff at Pflugerville Acupuncture who now or in the future treat me while employed by, working or associated with, or substituting for Pflugerville Acupuncture, including: acupuncture and other Oriental medical procedures, diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of body areas, observation, range of motion, muscle and orthopedic testing, manipulation of joints and/or viscera, heat/cold therapy, electric/magnetic stimulation therapy, cupping, moxibustion, herbal prescriptions, dietary supplements, dietary recommendations, and exercise and/or lifestyle recommendations.

I understand that I have the opportunity to discuss the nature and purpose of acupuncture and Oriental medical procedures with my student intern, professional practitioners, and/or other clinic personnel. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied. I understand and informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine, there are some risks to treatment. I understand that although these risks are unlikely, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon, but possible, risks include: pneumothorax (punctured lung), punctured organs, sprains, strains, dislocation, fractures, disc injuries, and strokes. I do not expect the practitioner to be able to anticipate and explain all the risks and complications, and I wish to rely on the practitioners to exercise such judgment during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I have read, or have had read to me, this informed consent form. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures and conditions of 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 at Pflugerville Acupuncture clinic.

Patient Name (Print) ____ Date __________
Patient Signature ____ Date __________
Guardian or Representative (Print) ____ Date __________
Guardian or Representative Signature____ Date __________

PRIVACY NOTICE

I acknowledge that I have been provided access to Pflugerville Acupuncture's "Notice of Privacy Practices." I understand that I have the right to review their "Notice of Privacy Practices" prior to signing this document.
I understand that Pflugerville Acupuncture staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not home, a message will be left on my answering machine or with anyone who answers the phone.

Patient Name (Print) ____ Date_____________
Patient Signature ____ Date_____________

Attesting that the Acupuncturist has Referred Him/Her

(Optional Form to be Completed by the Patient)

(*Pursuant to the requirements of 22 T.A.C. 183.7 of the Texas State Board of Acupuncture Examiner's rule, relating to Scope of Practice, and Tex. Occ. Code Ann. 205.315, governing the practice of acupuncture*)

The acupuncturist/student intern has referred me to see a physician. It is my responsibility and choice whether to following his/her advice.

Patient Signature ____
Date ______________

CANCELLATION POLICY

Out of respect for the practitioner's time and in order to maximize availability to patients, a minimum of 24 hours notice for cancellations is required. Not providing 24 hours notice, not showing, or being more than 20 minutes late for a scheduled appointment, may result in a charge of the standard fee to your account. If your appointment slot is filled after you cancel, this fee is waived. Compliance with this policy enables better service to you and other patients. Thank you for understanding.

Patient Signature ____
Date ______________

RELEASE OF HEALTH INFORMATION

I, ____, hereby authorize Pflugerville Acupuncture the use or disclosure of my individually identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorize to receive my information is/are not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

Pflugerville Acupuncture Medical History Questionnaire

Name: ____ Date:_____________
Height: __________________ Weight: ___________ Age: _______
Please describe the reason for your visit today.
____
____
How long have you had this condition?____
What treatment(s) have you been receiving for your condition(s)?
____
____
____

Lifestyle

Please indicate the use and frequency of the following:
Tobacco: ________________________ Coffee: ________________________
Tea: (hot or cold)__________________ Alcohol: ________________________
Recreational drugs: ________________ Exercise: ________________________
________________________________ ________________________

Have you ever been hospitalized? If so, what were the reasons and when did it occur (surgeries, accidents, etc)?
____
____
What prescription medications, over the counter medication, herbal supplements, or dietary supplements (vitamin, minerals, etc) are you currently taking?
Prescription Medication: ____
____
Over the counter: ____
Other: ____
What allergies, if any, do you have?
____
When was your last physical exam? ___________________
Were there any abnormalities? ____

Family History

Please check if a family member has had any of the following conditions:

Arthritis: _____ Cancer: _____ Heart Disease: _____ Hypertension: _____ Mental Disorder: _____

If checked, what is your relation to this family member?
____

Please check if you have experienced any of the following symptoms or diseases <u>in the past 3 months</u>.

General

Fatigue___	Fibromyalgia ____	Nights sweats ____
Poor Balance ____	Sciatica ____	Tremors ____
Weight gain ____	Weight loss ____	

Head, Eyes, Ears, Nose, Throat

Acne ____	Blurred Vision ____	Cataracts ____
Chronic swollen glands ____	Cold sores ____	Dry mouth ____
Dry throat ____	Earaches ____	Eye pain ____
Glasses/contacts ____	Glaucoma ____	Gum problems ____
Headaches ____	Itchy eyes ____	Night blindness ____
Nosebleeds ____	Poor hearing ____	Recurrent sore throat ____
Red eyes ____	Sinus problems ____	Teeth grinding ____
Tinnitus ____	TMJ ____	Vertigo/Dizziness ____

Respiratory

Asthma____	Blood-streaked sputum____	Chills____
Cough ____	Difficulty breathing ____	Phlegm ____
Pneumonia ____	Shortness of breath ____	Sneezing ____
Spontaneous sweating ____	Tightness in chest ____	

Cardiovascular

Chest Pain ____	Dream-disturbed sleep ____	
High blood pressure ____	Pacemaker ____	
Irregular heartbeat ____	Low blood pressure ____	
Palpitations ____	Phlebitis ____	Poor circulation ____
Poor sleep ____	Vivid dreams ____	

Gastrointestinal

Acid reflux ____	Bad breath ____	Bloody stool ____
Body heaviness ____	Constipation ____	Diarrhea ____
Fatigue____	Gas ____	Heavy appetite ____
Hemorrhoids ____	Hiccup ____	IBS ____
Intestinal pain/cramp ____	Mucus in stool ____	Muscle cramps ____
Nausea ____	Vomiting ____	Poor appetite ____
Rectal pain ____	Thyroid issues ____	

Musculoskeletal

Joint pain ____	Limited range of motion ____	Limited use ____
Lower back pain ____	Muscle pain ____	Muscle weakness ____
Neck pain ____	Rib pain ____	Shoulder pain ____
Upper back pain ____	Knee pain____	Fibromyalgia____

Genito-urinary

Bedwetting ____	Bloody urination ____	Decreased libido ____
Frequent urination ____	Painful urination ____	
Incomplete urination ____	Night urination ____	
Stones ____	Urinary Tract Infection ____	

Women's Health

# of pregnancies ____	# of miscarriages ____	Abortion ____
Blood clots ____	Breast lumps ____	Change in BM due to period ____
Cancer ____	Cysts ____	Vaginal Dryness ____
Hair loss ____	Hot flashes ____	Increase in libido ____
Infertility ____	Irregular periods ____	Menopause ____
Painful periods ____	PMS ____	Vaginal Discharge ____

Women's Menstrual History

Age of first period: ______________ Avg. length of flow: _________________
Date of last period: ______________ Date of last check up: ________________
Length of cycle (day 1 of period to day 1 of next period): __________________
Any abnormal discharge? Yes No
Is it possible that you are pregnant? Yes No
Are you currently on birth control? Yes No
Have you taken birth control in the past? Yes No

Men's Health

Cancer ____	Decrease in libido ____	Erectile dysfunction ____
Hair loss ____	Increased libido ____	Infertility ____
Nocturnal emission ____	Premature ejaculation ____	Prostate issues ____

I have completed this health questionnaire to the best of my knowledge.

Name (Print): ____

Signature: ____