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

PATIENT INFORMATION
Full Name (Print):_____
Sex: M / F 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 ____ 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 or No
Is it possible that you are pregnant? Yes or No
Are you currently on birth control? Yes or No
Have you taken birth control in the past? Yes or 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: _____