Healing Rivers Acupuncture and Community Center- Patient Intake Form

Thank you for taking the time to fill this out carefully. Though some questions might seem irrelevant to your condition, every piece of information helps to form a complete diagnosis. Oriental medicine treats the whole person, not just disease. All information will be confidential. If you have any questions, please ask.

Name_____ Gender ____ Date_____

Date of Birth _____ Age _____ Occupation_____ Marital Status_____

(H) Phone_____ (W) Phone_____ (M) Phone_____

Address: Street_____

City_____ State_____ Zip_____ Email_____

Emergency Contact_____ Relationship and Phone_____

Family physician or chiropractor_____

Have you had acupuncture and/or Chinese herbs before?_____

How did you hear about Healing Rivers? If a friend, who _____

Main Complaint_____

How long have you had this problem? _____ What seems to cause this problem? _____

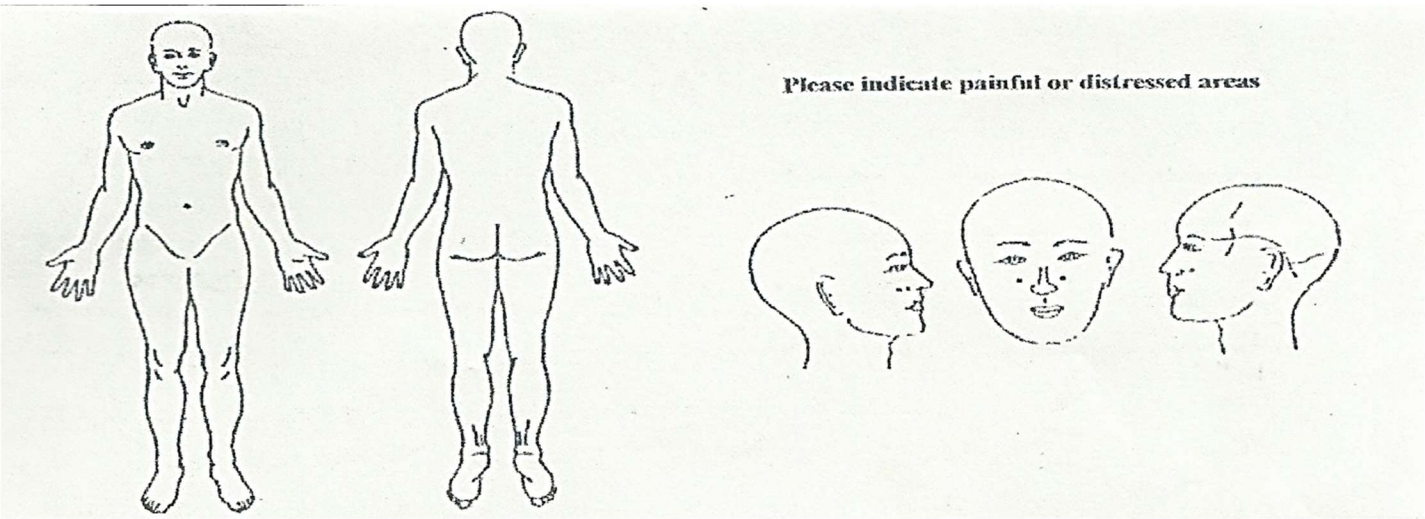
Have you been given a diagnosis? If so, what? _____ To what extent does this problem interfere with your daily activities? _____

What kinds of treatment have you tried? _____

What makes it better? _____ Worse? _____

Please rate your current pain or discomfort on a scale of 1-10: very slight 1 2 3 4 5 6 7 8 9 10 unbearable

Is there anyone in your family with the same/similar problems? _____



Medical History (Please check box if you have had a diagnosis of any of the following and include dates)

□Cancer □Diabetes □Hepatitis □Thyroid Disease □Seizures □Anemia □HIV/AIDS

□Arthritis □Tuberculosis □Hypertension □Emotional Imbalance □Alcohol/drug addiction □Heart Disease

□Digestive Disorder □Fibromyalgia □Venereal Disease □Breathing Problems

Other_____ Surgeries/Hospitalization_____

Allergies_____

Medications, vitamins, herbs taken within last 3 months (Please include reasons and known side effects)

_____
_____
_____
_____
_____
_____
_____
_____

Please describe your childhood health _____

_____

Please describe family medical history_____

_____

Recent Medical Tests

□Physical □Cholesterol □Blood test □Prostate exam □HIV □STD □Pap smear

□Mammogram □Thyroid □Other_____

Test results and date _____

Occupation Do you usually work? □Indoors □Outdoors?

Occupational stress (chemical, physical, psychological, etc.)_____

Personal Height_____ Weight now_____ one year ago_____

Maximum weight_____@ Year_____ __ Blood type_____

Daily Routines Do you smoke? □Yes □No What?_____ How many per day?_____ since when?_____

Recreational drugs?_____

Do you exercise regularly? □ Yes □ No Please describe your exercise program:_____

What are your hobbies/things you most enjoy doing? _____

How many hours do you sleep in general? _____ When do you usually go to bed?_____

Diet How much coffee do you drink? _____cups/day; Sodas _____ / day Tea _____/day

How much water do you drink per day? _____ What kind of alcoholic beverages do you usually drink? _____
average # of drinks per week_____

Are you a vegetarian? □Yes □No □Yes, but not strict Do you eat a lot of spicy food? □ Yes □No

What kind of food cravings do you have? _____

Please describe your average daily diet:

Symptoms Please check any of the following that applies to you now or in the past 3 months :

General □Poor appetite □Poor sleeping □Fatigue □Fever □Chills

□Night Sweats □Sweat easily □Tremors □Cravings □Change in appetite □Poor balance

□Bruise easily □Localized weakness □Weight loss/gain □Peculiar tastes □Desire hot food □ Cold food

□Strong thirst (cold or hot drinks) □Sudden energy drop (What time of day) _____

Favorite time of year _____Worst_____

Are there any other health issues you want to discuss with us?

Skin & hair ☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema
☐ Pimples ☐ Dandruff ☐ Dry skin ☐ Recent moles ☐ Loss of hair ☐ Purpura
☐ Change in hair or skin textures ☐ Other?

Musculoskeletal ☐ Joint disorders ☐ Weakness muscles ☐ Pain/soreness in the muscles ☐ Tremors
☐ Difficult walking ☐ Cold hands/feet ☐ Swelling of hands/feet ☐ Back pain ☐ Spinal curvature ☐ Hernia
☐ Numbness ☐ Tingling ☐ Paralysis ☐ Neck tightness ☐ Neck pain ☐ Shoulder pain
☐ Hand/wrist pain ☐ Hip pain ☐ Knee pain ☐ Sprain of joint ☐ Other

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Head, eyes, ears, nose, and throat ☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses/lens
☐ Eye strain ☐ Eye pain ☐ Color Blindness ☐ Night blindness ☐ Poor vision ☐ Cataracts
☐ Blurry vision ☐ Earaches ☐ Ringing in ears ☐ Poor hearing ☐ Spots in front of eyes
☐ Sinus problems ☐ Nose bleeding ☐ Sore throat ☐ Grinding teeth ☐ Teeth problems ☐ Facial pain
☐ Jaw clicks ☐ Sores on lips/tongue ☐ Difficulty swallowing ☐ Other

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Cardiovascular ☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Palpitation ☐ Fainting
☐ Phlebitis ☐ Irregular heartbeat ☐ Rapid heartbeat ☐ Varicose veins ☐ Other

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Respiratory ☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty in breathing
☐ Bronchitis ☐ Pneumonia ☐ Chest pain ☐ Production of phlegm – What color? _____

Gastrointestinal ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas
☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath ☐ Rectal pain
☐ Hemorrhoids ☐ Abdominal pain/cramps ☐ Gallbladder problems ☐ Parasites ☐ Chronic laxative use
Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____

Neuro-psychological ☐ Loss of balance ☐ Lack of coordination ☐ Concussion
☐ Depression ☐ Anxiety ☐ Stress ☐ Bad temper ☐ Bi-polar

Genito-urinary ☐ Pain on urination ☐ Frequent urination ☐ Blood in urine ☐ Urgent to urinate
☐ Kidney stones ☐ Unable to hold urine ☐ Dribbling ☐ Pause of flow ☐ Frequent urinary tract infection
☐ Pain in genital ☐ Itching of genital ☐ Other

Female ☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis ☐ Vaginal/genital discharge
☐ Fibroids ☐ Ovarian cysts ☐ Irregular periods ☐ Clots ☐ Pain/cramps prior/during periods
☐ Breast tenderness ☐ Breast Lumps ☐ Fertility Problems ☐ Hot flashes ☐ Moodiness related to periods
_____ number of pregnancies _____ number of births _____ Miscarriages _____ Abortions
_____ Premature births _____ Cesareans _____ Difficult delivery
First date of last period _____ Age of first menses _____ Duration of periods _____days, cycle ____ days
Do you practice birth control ? ☐ Yes ☐ No . If yes, what type and for how long? _____
If you're on birth control pills, what are you taking and for how long? _____

Male ☐ Prostate problems ☐ Discharge ☐ Impotence ☐ Frequent seminal emission
☐ Fertility problems ☐ Ejaculation problems ☐ Painful/swollen testicles ☐ Other

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I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Signature: ☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE AT HEALING RIVERS ACUPUNCTURE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist at Healing Rivers Acupuncture, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that it is not safe for me to remove my own needles. I understand that it is not safe for me to walk while needles are inserted on my body. I have been informed that I can call out or ring the bell if I need to stop the treatment for any reason, such as using the restroom.

I understand that methods of treatment may include, but are not limited to, acupuncture moxibustion, cupping, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last 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 the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while 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) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effect of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's name (please print) Patient's signature

_____

Date signed

_____ _____

Print name & relationship of patient's representative *(if applicable)* Signature of patient's representative

Notification Form Regarding Evaluation of Patient by Physician

(Pursuant to the requirements of 22 TAC §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 Healing Rivers Acupuncture 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.

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.

_____

Patient Signature or Parent/Legal Guardian (required) Date

CANCELLATION POLICY: Healing Rivers Acupuncture & Community Center has a 24-hour cancelation policy. If notification of cancelation *or rescheduling* is not within the 24-hour period there will be a $25.00 fee. Thank You.

_____

Patient Signature or Parent/Legal Guardian (required) Date

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the "Notice of Privacy Practices". I understand that I have the right to review the "Notice of Privacy Practices" prior to signing this document.

I understand that Healing Rivers Acupuncture and Community Center 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 at home, a message will be left on my answering machine, voicemail or with anyone who answers the phone.

By signing this form, I am giving Healing Rivers Acupuncture authorization to contact me with these reminders.

_____

Patient Name (print)

_____

Patient Signature or Parent/Legal Guardian (required) Date