North Austin Acupuncture & Wellness Center

13401 Athens Trail
Austin, Texas 78729
512/968-9908

Notification Form Regarding Evaluation of Patient by Physician

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

(Pursuant to the requirement of section 183.6 (e) of this title and section 6.11, Subsection (d) V.A.C.S. article 4495b, governing the practice of acupuncture)

I (patient name), _____ am notifying North Austin Acupuncture & Wellness Center of the following:

❑ Yes ❑ No I have been evaluated by a physician or dentist for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that a physician should evaluate me for the condition being treated by the acupuncturist.

OR

❑ Yes ❑ No I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of chiropractic treatment prior to acupuncture treatment is _____. After being referred by a chiropractor, if after 60 days 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 to follow this advice.

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:

❑ Chronic Pain
❑ Weight Loss
❑ Smoking Cessation
❑ Alcoholism
❑ Substance Abuse

_____ _____

Patient signature (required) Date

North Austin Acupuncture & Wellness Center is not responsible for untrue statements made by patients.

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Informed Consent to Oriental Medical Health Care at North Austin 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 Marsha Kaye L. Ac. or other licensed acupuncturists who now or in the future treat me at North Austin Acupuncture & Wellness Center.

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, Ionic Foot Detox, 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. I further understand that I need to stay still while the needles are in place to prevent injury or trauma to my body. 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 signature (required) Date

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New Patient Information

Welcome to the North Austin Acupuncture and Wellness Center. We provide Oriental Medicine which includes acupuncture, herbology and Asian bodywork. Other Oriental Medicine techniques that fall in the scope of our practice also include, gua sha, cupping, moxa and Chinese dietary counseling and may occasionally be recommended based on your condition. Additionally we provide Yoga, Pilates, Energy work and Qigong sessions.

Appointments:
Treatments are by appointment only. If you find that you need to cancel an appointment, it is important that we receive twenty-four (24) hours notice. This enables us to fill the time slot. We reserve the right to charge a $50.00 fee for appointments canceled with less than twenty-four (24) hours notice and full treatment price ($85.00) fee for "no show" appointments.

Payment for Services Rendered:
Payment is due at the time of service and may be paid in cash, check,Visa or MC. We are out of network with some insurance companies and can file a claim for you. Alternatively, we can provide you with a printed receipt containing the necessary information enabling you to file an insurance claim.

Time of Service rates are as follows:

Initial and single acupuncture treatments
$120.00 for initial consultation and acupuncture session
$85.00 for follow up acupuncture sessions

Packages (5 and 8 treatment packages expire 6 months from purchase)
$375.00 per package of five acupuncture sessions – ($75.00 per treatment)
$560.00 per package of eight acupuncture sessions – ($70.00 per treatment)
$260.00 monthly (up to 4 treatments) – expires each month

Facial beauty/rejuvenation acupuncture
$1100.00 per package of 10 sessions
$120.00 per session

Other
$40.00 for herbal consult (does not include herbs)
$85.00 - movement/energy work - incl movement, Yoga, Breathwork - 1 hour
$65.00 - movement/energy work - incl movement, Yoga, Breathwork or energy work-45 min
$45.00 - movement/energy work - incl movement, Yoga, Breathwork or energy work - 1/2 hr

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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.

Patient Information

First_____ Last _____Today's Date _____

Address_____ City _____ State____ Zip_____

Phone _____ Birth Date _____

Email Address: _____

Emergency Contact: _____ Phone Number _____

Main problem(s):

_____

_____

What diagnosis, if any, have you received for this problem? _____

_____

When did this problem begin? _____ To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

What kind of treatment(s) have you tried? _____

_____

What makes it worse? _____What makes it better? _____

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 include the mo/yr when the event occurred or when the diagnosis was established)

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type)			Diabetes			High blood pressure		
HIV/AIDS			Seizures			Heart Disease		
Hepatitis (what type)			Thyroid disease			High cholesterol		
Anemia			Tuberculosis			Breathing problems		
Arthritis			Digestive disorders			Alcohol/drug addiction		
Emotional disorders			Depression or anxiety			Other		

Surgeries: _____Hospitalization: _____
_____

Significant trauma: (auto accidents, sports injuries, etc)
_____

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and dosages):
_____
_____
_____

Allergies: (drugs, chemicals, foods, environmental):
_____
_____

Personal Gender _____ Age_____ Height _____ Weight _____

Weight one year ago _____ Maximum weight_____

Occupation: _____ Occupational stress (chemical. physical, psychological, etc.) _____ Do you work indoors or outdoors? _____

Daily Routines

Do you smoke? ❑ Yes ❑ No What?_____ How many per day?_____ Since when? _____

Please describe any use of drugs for non-medical purposes _____

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

Do you exercise regularly? ❑ Yes ❑ No What kind of exercise? _____

Diet

How much coffee do you drink? _____cups/day; soft drinks_____/day; tea_____/day; water_____/day

What kind of alcoholic beverages do you usually drink, if any? _____ Avg number of drinks/wk?

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 (Please be as specific as possible):

Morning _____

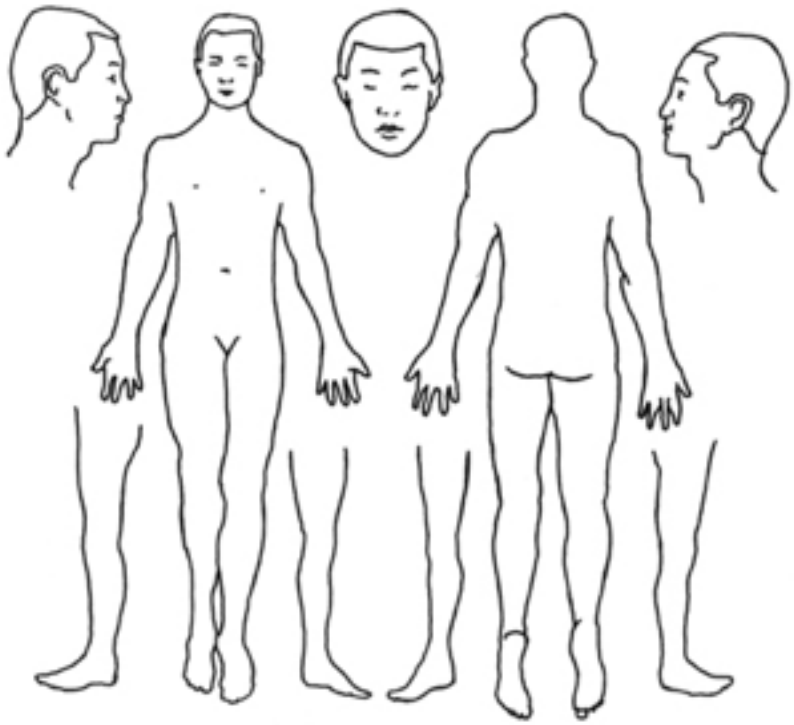
Afternoon _____

Evening _____

Snacks _____

Remarks and additional information regarding diet _____

Indicate painful or distressed areas:



Signs & Symptoms: Please check any of the following that applies to you now or in the past 6 months.

General

❑Poor appetite ❑Poor sleeping ❑Fatigue ❑Fever ❑Chills

❑Night Sweats ❑Sweat easily ❑Tremors ❑Cravings ❑Change in appetite

❑Poor balance ❑Bleed easily ❑Bruise easily ❑Localized weakness ❑Weight loss/gain

❑Peculiar tastes ❑Desire hot food ❑Desire cold food ❑Strong thirst (cold or hot drinks)

❑Sudden energy drop (What time of day) _____ Favorite time of year_____ Worst time of year_____

Skin & Hair ❑Rashes ❑Ulcerations ❑Hives ❑Itching ❑Eczema

❑Pimples ❑Dandruff ❑Dry skin ❑Recent moles ❑Loss of hair ❑Purpura

❑Change in hair or skin texture ❑Other?

Musculoskeletal ❑Joint disorders ❑Muscle weakness ❑Muscle pain/soreness ❑Tremors

❑Difficult walking ❑Cold hands/feet ❑Swelling of hands/feet ❑Back pain ❑Scoliosis

❑Hernia ❑Numbness ❑Tingling ❑Paralysis ❑Neck tightness/pain

❑Shoulder pain ❑Hand/wrist pain ❑Hip pain ❑Knee pain ❑Joint sprain ❑Other _____

Head, Eyes, Ears, Nose, Throat ❑Dizziness ❑Migraines ❑Concussion

❑Eye strain ❑Eye pain ❑Color blindness ❑Night blindness ❑Poor vision ❑Cataracts

❑Blurry vision ❑Earaches ❑Ringing in ears ❑ Poor hearing ❑Spots/floater in vision

❑Sinus problems ❑Nose bleeding ❑ Sore throat ❑Grinding teeth ❑Teeth problems ❑Facial pain

❑Jaw clicks/TMJ ❑Sores on lips/tongue ❑Difficulty swallowing ❑Other

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Cardiovascular ❑High Blood Pressure ❑Low Blood Pressure ❑Chest pain ❑Palpitations

❑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 ❑Other

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Gastrointestinal ❑Nausea ❑Vomiting ❑Diarrhea ❑Constipation ❑Gas

❑Belching ❑Black stools ❑Blood in stools ❑Indigestion ❑Bad breath ❑Rectal pain

❑Hemorrhoids ❑Abdominal pain/cramps ❑Parasites ❑Chronic laxative use

❑Gallbladder problems

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 ❑Urgency to urinate

❑Kidney stones ❑Unable to hold urine ❑Dribbling ❑Pause of flow ❑Frequent urinary tract infection

❑Pain in genitals ❑Itching in genitals ❑Other

Female ❑Frequent vaginal infections ❑Pelvic infection ❑Endometriosis ❑Vaginal discharge

❑Fibroids ❑Ovarian cysts ❑Irregular periods ❑Clots ❑Pain/cramps prior/during periods

❑Breast tenderness ❑Breast lumps ❑Fertility problems ❑Hot flashes ❑Moodiness related to periods

_____# pregnancies _____# births _____ # miscarriages _____ # abortions

_____ # premature births _____ # cesareans _____ # difficult delivery

Menstrual flow: ❑Heavy ❑Light ❑Clots ❑Painful ❑spotting between periods Color of menses_____

Length of period_____ Date of last period_____ Days in cycle_____

First date of last period _____ Age of first period _____ 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? _____

PMS symptoms _____

Female (continued)

Is there any possibility that you are pregnant? ❑ Yes ❑ No

Menopause: Age_____ Hysterectomy/age and reason _____
HRT_____

Male ❑Prostate problems ❑Discharge ❑Impotence ❑Frequent seminal emission

❑Fertility problems ❑Ejaculation problems ❑Painful/swollen testicles ❑Other

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Other health concerns:

_____

_____

I have completed this form correctly to the best of my knowledge.

Signature: _____ ❑Adult Patient ❑Parent or Guardian ❑Spouse

Print Name: _____ **Date:** _____