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
❑ Alcoholism
❑ Substance Abuse
❑ Smoking Cessation

_____ _____
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, micro-current, 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. 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, cosmetic acupuncture, herbal treatment and Asian bodywork. Other Oriental Medicine techniques that fall in the scope of our practice also include, gua sha, cupping, moxa, and more. Additionally we provide Yoga, 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 $90.00 fee for appointments canceled with less than twenty-four (24) hours notice or "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 can provide you with a printed receipt (super bill) containing the necessary information enabling you to file an insurance claim directly.

Services offered:

Initial Consultation
Acupuncture session
Cosmetic Acupuncture
Energy session
Yoga session
Breathwork
Herbal Consult

North Austin Acupuncture &Wellness Center

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 _____

How did you hear about us? _____

Health Concerns: Please list your top health concerns in order of priority

1._____

2._____

3._____

What diagnosis, if any, have you received for these concerns?

_____

_____

When did this problem begin? _____ To what extent does this problem interfere with your daily activities?

_____

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

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		
Depression			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):
Prescriptions:_____
_____
Vitamins: _____
_____
Herbs: _____

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

Personal Gender _____ Age_____ Height _____ Weight _____

Weight one year ago _____ Maximum weight_____

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

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

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

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 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
_____

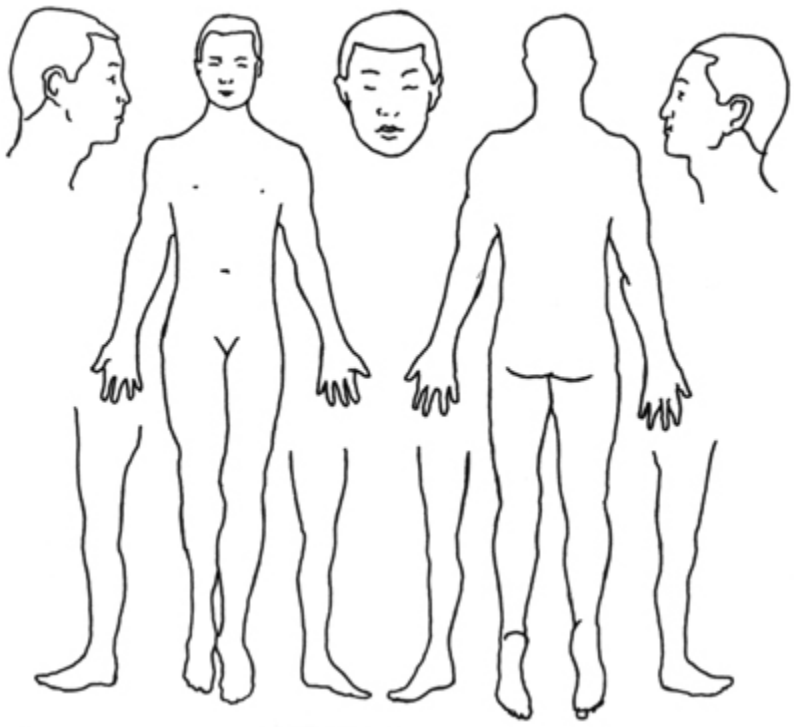
Snacks

_____

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

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_____

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

❑Fainting ❑Phlebitis ❑Irregular heartbeat ❑Rapid heartbeat ❑Varicose veins

❑Other_____

Respiratory ❑Cough ❑Coughing blood ❑Wheezing ❑Difficulty in breathing

❑Bronchitis ❑Pneumonia ❑Chest pain ❑Production of phlegm

❑Other_____

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

Other:_____

Neuro-psychological ❑Loss of balance ❑Lack of coordination ❑Concussion

❑Depression ❑Anxiety ❑Stress ❑Bad temper ❑Bi-polar

Other:_____

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_____ (Bright red, deep red, light red, pink, brown, black)

Length of period_____ Date of last period_____ Days in cycle_____

Days between cycles _____ First date of last period _____ Age of first period _____

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 _____

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_____

Other health concerns:

_____

_____

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

Signature: _____

Print Name: _____ Date: _____