Acupuncture Health Clinic

1707 Fort View, Austin, TX 78704
(512)912-8484

9240 Guilbeau Rd., Suite 102, San Antonio, TX 78250
(210)509-8282

Intake Form

Name: *Last* _____*Middle* _____*First* _____

SSN: _____ Date of Birth: _____/_____/_____ Gender ☐F ☐M

Email: _____ Marital Status: _____

Address: _____ City _____ State _____ Zip Code _____

Education (Highest grade or degree achieved) _____

Home (_____) _____-_____ Cell-phone (_____) _____-_____ Occupation: _____

Would you like to receive a text message to remind you of your appointments? ___Yes ___No

Height _____ Weight _____

Emergency Contact Name _____ Relationship to patient _____

Phone (Day) (_____) _____-_____ Evening (_____) _____-_____

How did you hear about our clinic?

_____

Have you ever been treated with Acupuncture or Oriental medicine?

_____

Name of your physician: _____ Tel: (_____) _____-_____

Address: _____ City _____ State _____ Zip Code _____

Chief Complaint and Present Medical History

1. Please describe current health problem(s) for which you are seeking treatment:

_____

2. How long ago did this problem begin?

_____

3. How often are your symptoms present?

Constantly _____ Frequently _____ Intermittently _____ Occasionally _____

4. Have you been given a diagnosis for this problem? If so, what?

_____

Are you currently receiving treatment for your problem? _____If so, please describe:

_____

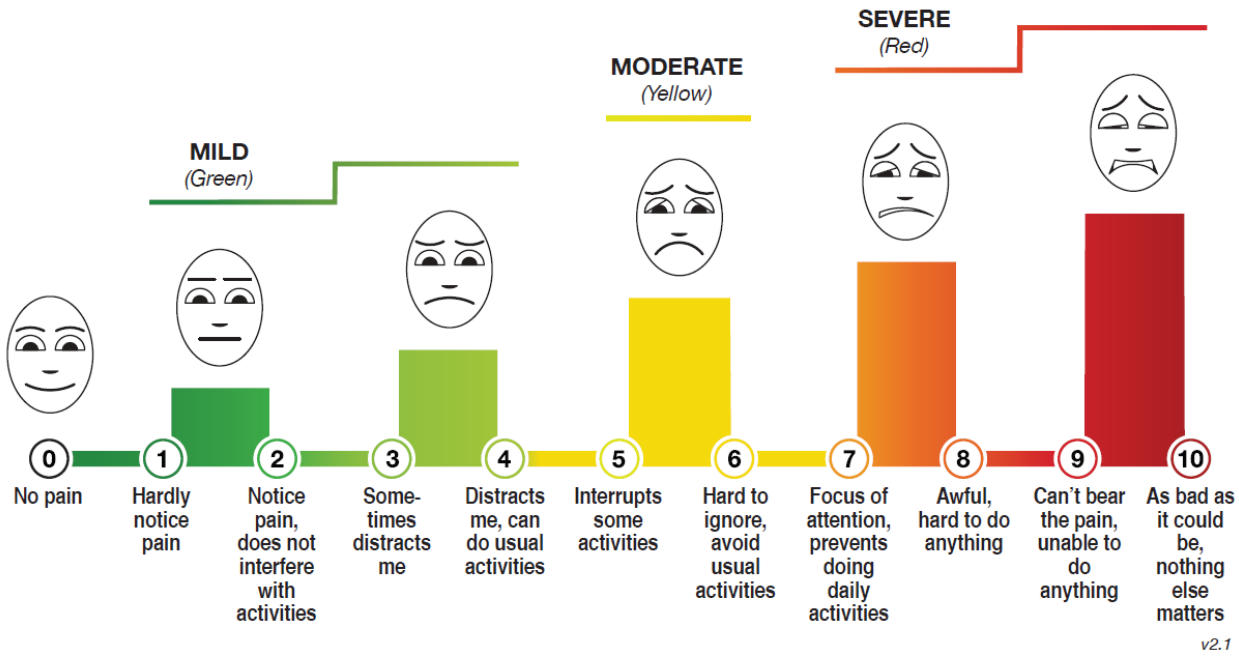
5. What other treatment(s) have you been receiving for the above condition(s)? (Surgery, medicine, chiropractic, massage, etc.)

_____

6. Describe your current overall health condition.

Excellent ___ Good ___ Fair ___ Poor ___ Chronically ill ___

Look at the Pain Rating Scale and read the descriptions under each number. Please rate the severity of your CURRENT PAIN by circling the corresponding number (0 to 10).



Supplemental questions for clinicians to evaluate the biopsychosocial impact of pain.

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual ACTIVITY:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere — *Completely interferes*

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your SLEEP:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere — *Completely interferes*

3. Circle the one number that describes how, during the past 24 hours, pain has affected your MOOD:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not affect — *Completely affects*

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your STRESS:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not contribute — *Contributes a great deal*

**Reference for pain interference: Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore 23(2): 129-138, 1994. v2.1*

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PAST MEDICAL HISTORY

Allergies (Medication/Food/Seasonal):

_____

Illnesses:

_____

Surgeries:

_____

Significant Trauma (Auto accidents, falls, etc.):

_____

Do you have, or have you ever had, any Infectious Disease (HIV, Hep B, Hep C, etc.)?

Yes ☐ No ☐

If so, please describe:

_____
_____

Do you use any of the following?

Tobacco _____ Coffee/Tea _____ Alcohol _____ Non-medical drugs _____

If so, please describe the frequency of use

Often _____ Occasionally _____ Seldom _____

List any current medications you are taking (Including over-the-counter medications)

Medication name	Dosage

Please check any of the following symptoms you currently or have previously experienced

General Symptoms

Poor Appetite	☐	Poor Sleep	☐	Body Heaviness	☐	Shortness of Breath	☐
Heavy Appetite	☐	Heavy Sleep	☐	Cold Hands or Feet	☐	Night Sweats	☐
Dream Disturbed Sleep	☐	Poor Circulation	☐	Fatigue	☐	Sweat Easily	☐
Chills	☐	Muscle Cramps	☐	Vertigo/Dizziness	☐		

Head, Eyes, Ears, Nose, Throat

Glasses/Contacts ☐	Night Blindness ☐	Recurrent Sore Throat ☐	Headaches ☐
Eye Strain ☐	Glaucoma ☐	Dry Mouth ☐	Swollen Glands ☐
Eye Pain ☐	Cataracts ☐	Excessive Saliva ☐	Nose Bleeds ☐
Red Eyes ☐	Itchy Eyes ☐	Spots in Eyes ☐	Poor Vision ☐
Teeth Problems ☐	Grinding Teeth ☐	TMJ ☐	Facial Pain ☐
Migraines ☐	Concussions ☐	Sinus Problems ☐	Blurred Vision ☐
Ringing in Ears ☐	Poor Hearing ☐	Earaches ☐	Excessive Phlegm ☐
Gum Problem ☐			

Respiratory

Difficult Breathing ☐	Tight Chest ☐	Asthma/Wheezing ☐	Pneumonia ☐
Cough w/Blood ☐	Cough ☐	Cough w/Phlegm ☐	

Cardiovascular

High Blood Pressure ☐	Chest Pain ☐	Fainting ☐	Blood Clots ☐
Low Blood Pressure ☐	Irregular Heartbeat ☐	Difficult Breathing ☐	Pacemaker ☐
Phlebitis ☐	Palpitations ☐		

Gastrointestinal

Nausea ☐	Vomiting ☐	Diarrhea ☐	Constipation ☐
Intestinal Pain/Cramp ☐	Acid Reflux ☐	Hiccup ☐	Bloating ☐
Hemorrhoids ☐	Bloody Stool ☐	Mucous in Stool ☐	Rectal Pain ☐
Gas ☐	Bad Breath ☐		

Musculoskeletal

Shoulder Pain ☐	Neck Pain ☐	Upper Back Pain ☐	Low Back Pain ☐
Joint Pain ☐	Rib Pain ☐	Limited Use ☐	Limited Range of Motion ☐
Muscle Pain ☐			

Genito-urinary

Painful Urination ☐	Blood in Urine ☐	Frequent Urination ☐	Urgent Urination ☐
Incomplete Urination ☐	Unable to Hold Urine ☐	Wake to Urinate ☐	Kidney Stone ☐
Premature Ejaculation ☐	Nocturnal Emission ☐	Increased Libido ☐	Decrease Libido ☐
Bedwetting ☐	Impotence ☐		

Gynecology

Irregular Periods ☐	Vaginal Discharge ☐	Blood Clots ☐
Menopause ☐	Breast Lumps ☐	PMS ☐
_____ # of Pregnancies	_____ # of Miscarriages	

Neuropsychological

Seizures ☐	Numbness ☐	Poor Memory ☐	Depression ☐	Anxiety ☐
Irritability ☐	Easily Stressed ☐	Tics ☐		

Skin and Hair

Rashes ☐	Psoriasis ☐	Acne ☐	Dandruff ☐	Ulcerations ☐
Hives ☐	Itching ☐	Fungal Infection ☐	Hair Loss ☐	

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FAMILY MEDICAL HISTORY (GENERAL HEALTH)

Please check if you have a family member who has had any of the following:

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

Other Conditions: _____

Please indicate the GENERAL health of your family.

Mother's Side
Good _____ Fair _____ Poor _____ Chronically ill _____

Father's Side
Good _____ Fair _____ Poor _____ Chronically ill _____

Siblings
Good _____ Fair _____ Poor _____ Chronically ill _____

If any of the above is deceased, what was the cause?

_____

Do you have any additional medical/health concerns that we should know? Yes ☐ No☐

Please describe:

_____

_____

Patient Signature _____ Date _____

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REQUEST AND CONSENT FOR ACUPUNCTURE

I hereby request and authorize licensed acupuncturist(s) of the Acupuncture Health Clinic to perform on me the treatment known as "Acupuncture" as his/her judgment may indicate, and further authorize him/her to use whatever therapeutic methods he/she see fit, regardless of whether these methods are commonly and generally accepted and practiced in this community. I understand that acupuncture may include:

1) The non-surgical, non-incisive insertion of disposable needles in specific locations on the body;

2) The recommendation of herbal dietary supplements;

3) The recommendation of energy-flow exercises or other prescribed forms of movement;

4) The collection of data and information regarding the functioning of various physical processes, by interrogation, observation, palpation, and other methods specific to the practice of acupuncture; and

5) The use of localized heat and/or electrical stimulation, whether alone or in combination with the other procedures described above

In the event that any unforeseen condition arises in the course of treatment, and in the judgment of the Acupuncturist it is advisable to use procedures in addition to or different than this now contemplated, I also request and authorize him/her to perform such treatments, use such procedures, or otherwise act in accordance with his/her professional opinion.

I understand acupuncture treatment to involve the use of needles, acupressure, moxibustion and electrical stimulation, etc. The risks, although limited, include: puncturing organs in the abdomen or chest cavities. Acupuncture may affect people on all levels: physical, emotional, mental and spiritual, because it works with the whole body to create balance. The duration of treatment varies from person to person depending on the specific illness and their constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.

Patient Signature _____ **Date** _____

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PATIENT FINANCIAL RESPONSIBILITY FORM

PRIMARY INSURANCE INFORMATION

☐Triwest ☐AETNA ☐UHC ☐BCBS ☐Humana
☐Medicare ☐Medicaid ☐Tricare ☐Tricare Prime

Address: _____

Policyholder's Name: _____ Date of Birth: _____

Relationship to patient: _____ Social Security #: _____

Phone: _____ Identification #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION

☐Triwest ☐AETNA ☐UHC ☐BCBS ☐Humana
☐Medicare ☐Medicaid ☐Tricare ☐Tricare Prime

Address: _____

Policyholder's Name: _____ Date of Birth: _____

Relationship to patient: _____ Social Security #: _____

Phone: _____ Identification #:_____Group #: _____

I, _____ understand that I am fully liable for payment of expenses associated with the Acupuncturist's provision of acupuncture in accordance with my request and consent to receive treatment, and agree to pay or cause to be paid, in full, the amount billed for these services. In the event that my condition is such that treatment is beyond the normal capabilities of the Acupuncturist, I understand that I may be referred to other competent practitioners including, but not necessarily limited to, medical physicians or other practitioners. I also agree to give 24 hours' notice if I am unable to make my scheduled appointment. I fully understand I may be charged the regular treatment fee ($30.00) if I miss an appointment without giving 24 hours' notice.

Patient signature: _____ Date: _____

Notice of Privacy Policies for Healthcare services (See Laminated Sheets at the back)

I, _____, have read, reviewed, understand and agree to the Notice of Privacy Policies for healthcare services of this office, if I so choose I can ask the front desk for a copy of these policies.

Patient signature: _____ Date: _____

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MEDICAL EVALUATION, REFERRAL, OR RECOMMENDATION

(Pursuant to the requirements of 22 T.A.C. 183.7 of the Texas State Board of Acupuncture Examiners' rule (relating to Scope of Practice) and Tex. Occ. Code Ann. 205.351, governing the practice of acupuncture)

I, _____, am notifying the Acupuncturist 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.

_____ Yes _____ No I have received a referral from my chiropractor within the last 30 days for acupuncture.

Note: In the case of patients seeking treatment for smoking addiction, weight loss, alcoholism, chronic pain (***defined as pain lasting longer than 6 months***), or substance abuse, referral by a physician, dentist, or chiropractor is not required.

After being referred by a chiropractor, if after 2 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: _____ **Date: _____**

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Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your service
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address worker's compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agency for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all the information we have about you. The new notice will be available upon request, in our office, and on our website.

Other Instructions for Notice

- Effective Date of this Notice: July 5, 2019.
- Privacy Official

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- In compliance with Texas law, mandatory privacy training is provided to Acupuncture Health Clinic employees at least annually.

PATIENT'S CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, give consent to Acupuncture Health Clinic the use and disclosure of my individual identifiable health information or Protected Health Information for the following specific purposes:

A. Providing treatment to me;
B. Relating to the payment of the services this office has rendered to me;
C. The general administrative operations this practice provides to me.

The Purpose of This Consent: Protected Health Information is any information which includes:

A. Demographic information;
B. Information gathered by this practice as it relates to my past, present and future physical or mental health or condition;
C. Information gathered by this office for past, present or future payments for providing the healthcare services;
D. Healthcare operations purposes will include quality assessment activities, credentialing, business management and other general operations procedures or activities.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Clinic, but the Clinic is not required to agree to these restrictions. However, if the Clinic agrees to a restriction that I request, the restriction is binding on the Clinic. **I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures from this Clinic before I sign this consent form regarding the use and disclosures of my Protected Health Information.**

I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the Clinic has acted in reliance on this consent.

Patient signature: _____ **Date: _____**