Kerrville Community Acupuncture: Health History

PATIENT INFORMATION

Name_____

Preferred Name/Nickname _____

Address_____

City, State, Zip_____

Gender _____Age_____ Birthdate _____

Occupation _____

Primary physician _____

Have you had acupuncture before?_____

How did you hear about us?_____

_____

CONTACT INFORMATION

Home phone _____

Other/cell phone _____

Email _____

Best way to reach you? _____

E-mail is used for appointment reminders and occasional updates about schedule changes and specials. You may unsubscribe at any time.

Emergency contact person:

Name _____

Relationship_____

Phone _____

HEALTH HISTORY

What are your primary reasons for coming in for treatment?

1- _____

2 - _____

3 - _____

How is your sleep? _____

_____

How is your digestion? _____

_____

Are you currently taking pain medication or blood thinners (including aspirin)? _____

List medications or food supplements you are taking:

_____

_____

_____

List any known allergies: _____

_____

List serious illnesses, traumatic injuries, major accidents or surgeries:

_____

_____

How long has it been since you've had a complete medical exam? _____

Check symptoms you have or have had in the last year:

- □ Depression or anxiety
- □ Difficulty in focusing
- □ Dizziness/poor balance
- □ Excessive worry or fear
- □ Excessive anger or irritability
- □ Feel sad a lot
- □ Fatigue/tiredness
- □ Headaches
- □ Loss of sleep/poor sleep
- □ Loss or gain of weight
- □ Stress or feeling overwhelmed by life

Check conditions you have or have had in the past:

- □ Allergies
- □ Anemia
- □ Arthritis
- □ Bleeding disorder
- □ Cancer _____
- □ Diabetes
- □ Head trauma
- □ Heart disease
- □ High blood pressure
- □ Hepatitis (type ___)
- □ HIV/AIDS
- □ Migraines
- □ Pacemaker
- □ Seizure
- □ Stroke
- □ Thyroid disease
- □ Local infection (current)

Check illnesses that have occurred in blood relatives:

□ Diabetes □ High blood pressure □ Stroke
□ Cancer □ Heart disease □ Kidney disease

Do you exercise regularly? _____

Anything else you'd like us to know? _____

_____

HEALTH HISTORY…CONTINUED

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

- □ Tremors □ Cramps
- □ Swollen or stiff joints

Pain, weakness, numbness in: (indicate side of body)

- □ Arm □ Leg
- □ Hand □ Foot
- □ Wrist □ Ankle
- □ Elbow □ Knee
- □ Shoulder □ Hip
- □ Neck □ Back

EYES/EAR/NOSE/THROAT/RESPIRATORY

- □ Asthma/wheezing/shortness of breath
- □ Blurred or failing vision
- □ Difficulty breathing
- □ Earache/blocked ears
- □ Eye pain/infections
- □ Eye strain/tearing/dry eyes
- □ Frequent colds
- □ Gum/tooth issues
- □ Jaw pain/TMJ
- □ Nose bleeds
- □ Loss of hearing/ringing in ears
- □ Persistent cough
- □ Seasonal allergies
- □ Sinus congestion/infections
- □ Swollen glands

SKIN

- □ Acne/boils/infection
- □ Bruise easily
- □ Dry skin
- □ Itching/rash
- □ Sensitive skin
- □ Slow wound healing
- □ Sweating: night, spontaneous

GENITO/URINARY

- □ Blood/pus in urine
- □ Burning/pain when urinating
- □ Frequent urination
- □ Frequent urinary tract infections
- □ Inability to control urine
- □ Kidney infection/stones
- □ Urgent urination

CARDIOVASCULAR

- □ Chest pain
- □ Hardening of arteries
- □ High or low blood pressure
- □ High cholesterol
- □ Pain over heart
- □ Poor circulation
- □ Previous heart attack
- □ Rapid/irregular heart beat
- □ Swelling of ankles

GASTROINTESTINAL

- □ Belching, gas or bloating
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ Distention of abdomen
- □ Excessive hunger or thirst
- □ Fatigue after meals
- □ Heartburn/acid reflux
- □ Hemorrhoids (piles)
- □ Indigestion
- □ Nausea
- □ Pain over stomach
- □ Poor appetite
- □ Stomach ulcer
- □ Vomiting

REPRODUCTIVE (as applicable)

- □ Erection difficulties
- □ Discharge
- □ Prostate issues
- □ Lowered libido
- □ Bleeding between periods
- □ Clots in menses
- □ Excessive or scanty menstrual flow
- □ Extreme menstrual pain
- □ Infertility
- □ Irregular cycle, missed periods
- □ Menopausal symptoms
- □ PMS/mood changes with cycle
- □ Previous miscarriage
- □ Pregnancy-related issues

Could you be pregnant?_____

Date last menstrual period began: _____

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature_____ Date _____

Important Notice About Receiving Acupuncture in Texas

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care." As a result, Kerrville Community Acupuncture is required to have you respond to the following statements before you may be treated. ***PLEASE BE ADVISED THAT YOU MUST RESPOND "YES" TO AT LEAST ONE OF THESE STATEMENTS IN ORDER FOR US TO BE ABLE TO TREAT YOU WITH ACUPUNCTURE.***

Pursuant to the requirements of 22 TAC Sec. 183.7 of the Texas State Board of Acupuncture Examiners' Rules and Tex. Occ. Code Ann. Secs. 205.301 and 205.302,

I (patient's name) _____ am notifying the practitioner(s) at Kerrville Community 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 whether to follow this advice.

OR

____ Yes ____ No I am seeking treatment for:

_____ Chronic pain
_____ Smoking cessation
_____ Weight loss
_____ Alcoholism
_____ Substance abuse

Should I return for treatment for any condition other than my original condition treated at this clinic, I understand that it is my responsibility to be evaluated by a physician prior to being treated by acupuncture.

_____

Patient Signature Required Date

Informed Consent to Treatment

I request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of acupuncture. Methods of treatment may include acupuncture, cupping, and herbal medicine. I have been informed that acupuncture, cupping, and herbal medicine are generally safe but that there may be some side effects or risks.

Acupuncture may cause temporary bruising, swelling, bleeding, numbness and tingling, or soreness at the site of needling, as well as dizziness and fainting. Acupuncture may also temporarily aggravate symptoms that existed prior to treatment or cause new symptoms to appear. Rare risks of acupuncture include nerve pain or damage. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Common side effects of cupping include local discoloration of the skin and redness lasting for several days. Rare risks of cupping include blistering.

The herbal medicines (which may be from plant, animal, or mineral sources) recommended to me by my acupuncturist are generally safe in traditionally recommended dosages. Possible side effects of herbal medicine include nausea, gas, stomach ache, diarrhea, and headache. Rare side effects include vomiting, rashes, and hives. I understand that I must stop taking any herbal medicine and notify my acupuncturist if I experience any discomfort or adverse reaction.

I will notify my acupuncturist if I become pregnant or if I am trying to become pregnant, as certain acupuncture points and herbs are contraindicated during pregnancy and could induce miscarriage.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I understand that I can discuss risks and benefits further with my acupuncturist before signing, although I do not expect my acupuncturist to be able to anticipate and explain all the possible risks and complications of treatment. I rely on my acupuncturist to exercise his or her judgment in my best interest during the course of treatment, based on the facts then known.

I understand that there is no implied or stated guarantee of success or effectiveness of a specific course of treatment or series of treatments.

In signing this form, I acknowledge any inherent risks and give my consent for treatment. I intend this consent form to cover the entire course of treatments for my present condition and for any future condition(s) for which I seek treatment at this clinic.

Signature of Patient or Patient's Representative Date

Financial Policy

Payment is due at the time of service. We accept cash, checks, and credit or debit cards. With respect for our intention to offer high quality acupuncture at affordable prices, we ask for 12 hours of advance notice if you must reschedule or cancel your appointment. Please note that no shows and late cancellations will be charged a $10 fee at their next visit. (Exceptions made for emergencies.) Thank you for your understanding.

_____ Please initial to acknowledge that you have read our financial policy.