

Kerrville Community Acupuncture: Health History

PATIENT INFORMATION	CONTACT INFORMATION																		
<p>Name _____</p> <p>Preferred Name/Nickname _____</p> <p>Address _____</p> <p>City, State, Zip _____</p> <p>Gender _____ Age _____ Birthdate _____</p> <p>Occupation _____</p> <p>Primary physician _____</p> <p>Have you had acupuncture before? _____</p> <p>How did you hear about us? _____</p> <p>_____</p>	<p>Home phone _____</p> <p>Other/cell phone _____</p> <p>Email _____</p> <p>Best way to reach you? _____</p> <p>Do you prefer email or text for appointment reminders? _____</p> <p>Emergency contact person: Name _____</p> <p>Relationship _____</p> <p>Phone _____</p>																		
HEALTH HISTORY																			
<p>What are your primary reasons for coming in for treatment?</p> <p>1- _____</p> <p>2 - _____</p> <p>3 - _____</p> <p>How is your sleep? _____</p> <p>_____</p> <p>How is your digestion? _____</p> <p>_____</p> <p>Are you currently taking pain medication or blood thinners (including aspirin)? _____</p> <p>List medications or food supplements you are taking: _____ _____ _____</p> <p>List any known allergies: _____</p> <p>_____</p> <p>List serious illnesses, traumatic injuries, major accidents or surgeries: _____ _____</p> <p>How long has it been since you've had a complete medical exam? _____</p>	<p>Check symptoms you have or have had in the last year:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Depression or anxiety <input type="checkbox"/> Difficulty in focusing <input type="checkbox"/> Dizziness/poor balance <input type="checkbox"/> Excessive worry or fear <input type="checkbox"/> Excessive anger or irritability <input type="checkbox"/> Feel sad a lot <input type="checkbox"/> Fatigue/tiredness <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of sleep/poor sleep <input type="checkbox"/> Loss or gain of weight <input type="checkbox"/> Stress or feeling overwhelmed by life <p>Check conditions you have or have had in the past:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Allergies</td> <td><input type="checkbox"/> Hepatitis (type ____)</td> </tr> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> HIV/AIDS</td> </tr> <tr> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Migraines</td> </tr> <tr> <td><input type="checkbox"/> Bleeding disorder</td> <td><input type="checkbox"/> Pacemaker</td> </tr> <tr> <td><input type="checkbox"/> Cancer _____</td> <td><input type="checkbox"/> Seizure</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td><input type="checkbox"/> Head trauma</td> <td><input type="checkbox"/> Thyroid disease</td> </tr> <tr> <td><input type="checkbox"/> Heart disease</td> <td><input type="checkbox"/> Local infection (current)</td> </tr> <tr> <td><input type="checkbox"/> High blood pressure</td> <td></td> </tr> </table> <p>Check illnesses that have occurred in blood relatives:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease <input type="checkbox"/> Kidney disease <p>Do you exercise regularly? _____</p> <p>Anything else you'd like us to know? _____</p> <p>_____</p>	<input type="checkbox"/> Allergies	<input type="checkbox"/> Hepatitis (type ____)	<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Migraines	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Seizure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Head trauma	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Local infection (current)	<input type="checkbox"/> High blood pressure	
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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, nurse practitioner or dentist for the condition being treated within the past 12 months. I recognize that I should be evaluated by a physician, nurse practitioner 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, nurse practitioner or dentist 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. There is a \$25 fee for returned checks. With respect for our intention to offer high quality acupuncture at affordable prices, we ask for 24 hours of advance notice if you must reschedule or cancel your appointment. Please note that no shows and late cancellations will be charged a \$40 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.