Healing Acupoints, PLLC

Information provided on this form is confidential. It is very important the information given is complete and accurate to assist you properly in your healing process.

Today's Date ___/___/___

Name _____ Date of Birth ___/___/___ Age:_____ Sex:

Address_____

City/ State/ Zip _____ email _____

Telephone: (home)_____ (work)_____ (cel) _____

Emergency Contact Person/Relationship_____

Phone #_____

Who is your Primary Care Physician ? _____

Referrals are the best compliments. Whom may we thank for your referral ?

What are the concerns for which you are seeking care ? (symptoms, diagnosis and date of onset)

1. _____
2. _____
3. _____

What other treatments have you received for any of these conditions? _____

What makes your condition better ? (movement, rest, heat, cold, eating, sleeping, crying, screaming, etc)_____

What makes your condition worse ? (fatigue, stress, certain foods or times of day, heat, cold, hunger, etc)

_____

Significant Trauma, Hospitalizations, Surgery, X-Rays, Special Studies

Please include accidents, falls, illness as well as emotional along with month/year

_____

_____

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Allergies

Are you hypersensitive or allergic to any food, drugs, chemical or environmental substances?

_____

Medications and Supplements

What medications (prescribed or over the counter) herbs, vitamins, supplements, etc. are you currently taking ?

_____

_____

_____

Check each that you currently use :

Laxatives	Pain Relievers	Antacids	Cortisone
Antibiotics	Heart/Blood medication	Allergy Medication	Thyroid medication
Sleeping Pills	Anti-Depressants	Birth Control Pills	Hormones

Exercise, Energy and Dietary:

How much exercise per week_____Length of workout _____ Activities _____

How is your energy level ?_____When is it lowest ?_____Highest?_____

Typical Diet

Meals per day # of Snacks Caffeinated Drinks Alcohol per week

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

What foods are your weakness?_____

Water intake per day _____Prefer warm or cold drinks _____

Excessively thirsty ?_____

Special Diet :_____

Personal History Please check any symptoms you have now or ever have had.

Cancer _____	Diabetes_____	Seizures_____
Heart Disease _____	High/Low Blood Pressure_____	Stroke _____
Anemia _____	Kidney Disease _____	Hepatitis _____
Thyroid Imbalance_____	Asthma _____	Eating Disorder_____
Arthritis _____	Ulcer _____	Alzheimers _____
Auto Immune _____	Alcohol/Drug Addiction_____	Chronic Fatigue_____
Blood Clotting Disorder_____	Prolapsed Organ _____	Chronic Pain _____

Do you smoke ? (Tobacco or Marijuana) For how long ? _____ How much a day ?_____

Other serious Health Condition _____

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Family Medical History Please check any condition that applies to your immediate family : (M) Mother, (F) Father, (S) Sister, (B) Brother, (GM) Grandmother, (GF) Grandfather

High Blood Pressure _____ Diabetes_____ Heart Disease_____

Cancer _____ Stroke_____ Asthma _____

Seizures _____ Genetic Disorder _____ Infertility_____

Other Serious Condition _____

Have you had any of the following Childhood Illnesses (check if yes)

Scarlet Fever ___ Diptheria ____ Rheumatic Fever ____ Mumps _____ Measles ____ German Measles _____

Have you had negative reactions to immunizations ? Yes No _____

General

Height _____ Weight _____ lbs.

Weight one year ago _____ lbs. Maximum Weight _____ lbs. When _____

Blood Type _____ Most recent blood pressure reading? _____/_____ Taken when?_____

Check any symptoms you currently experience and star ones you have had in the past

GENERAL
____ Poor or Change in Appetite
____ Poor Sleep
____ Fatigue / Low Energy
____ Fevers
____ Chills
____ Cravings
____ Bleed/Bruise Easily
____ Night Sweats or Hot Flashes
____ Sweat Easily
____ Colder than those around you
____ Warmer than those around you
____ Weight loss or gain
____ Libido Low, Med or High
____ High Stress

NOSE AND SINUSES
____ Frequent Colds
____ Nose Bleeds
____ Sinus Congestion
____ Frequent Runny Nose
____ Hay Fever
____ Sinus Problems
____ Loss of Smell

IMMUNE
____ Chronic Fatigue Syndrome
____ Chronic Infections
____ Chronically Swollen Glands
____ Slow Wound Healing

HEAD / NECK
____ Headaches
____ Migraines
____ Jaw Pain
____ Teeth Grinding
____ Swollen Glands
____ Goiter
____ Recurrent Sore Throats/Colds

SKIN
____ Rashes
____ Eczema or Psoriasis
____ Acne, Boils
____ Redness of Skin
____ Itching
____ Fungal Infections
____ Skin Discoloration
____ Hair Loss
____ Dry Skin/Scalp
____ Greasy Hair
____ Change in Hair texture
____ Night Sweats
____ Slow healing ulcerations
____ Weak or ridged nails
____ Recent Moles

MOUTH AND THROAT
____ Sore Throat
____ Copious Saliva
____ Teeth Grinding
____ Sore Tongue/Lips
____ Gum Problems
____ Hoarseness

RESPIRATORY
____ Chest Congestion
____ Chest Tightness
____ Asthma
____ Difficulty inhale/exhale
____ Phlegm...what color ?
____ Cough ___ Wet or ___ Dry
____ Coughing Blood
____ Bronchitis
____ Pneumonia

NEUROLOGIC
____ Seizures or Tremors
____ Paralysis
____ Muscle Weakness
____ Numbness or tingling
____ Easily Stressed
____ Vertigo or Dizziness
____ Loss of Balance

CARDIOVASCULAR
____ Chest Pain or Pressure
____ Shortness of Breath
____ Irregular Heart Beat
____ Palpitations at Rest
____ Blood Clots
____ Irregular Heart Beat
____ Palpitations/ Fluttering
____ Swelling of Hands or Feet

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EYES AND EARS
____ Itchy Eyes
____ Watery Eyes
____ Dry Eyes
____ Swollen/painful eyes
____ Red Eyes
____ Blurred Vision
____ Spots in Front of Eyes
____ Cataracts
____ Color Blindness
____ Double Vision
____ Glaucoma
____ Hearing Difficulty
____ Ringing
____ Earaches/ Infection

DIGESTION
____ Abdominal Pain/Cramps
____ Trouble Swallowing
____ Heartburn/Acid Reflux
____ Change in Appetite/Thirst
____ Nausea
____ Vomiting
____ Gas/Bloating
____ Belching or Passing Gas
____ Diarrhea
____ Constipation
____ Pain or Cramps
____ Mucous in Stools
____ Black/Bloody Stool
____ Hemorrhoids
____ Itchy/Burning Anus
____ Bad Breath
____ Strong Smelling Stools
____ Food in Stools
____ IBS
____ Crohns
Bowel Movements : How Often ? ___
Stools ___ Hard ___ Firm
___ Soft ___ Loose (> 2 / day)

CIRCULATION
____ Faintness
____ Dizziness
____ Easy Bleeding or Bruising
____ Anemia
____ Deep Leg Pain
____ Varicose Veins
____ Cold hands/feet
____ Spontaneous Sweating

ENDOCRINE
____ Hypothyroid
____ Heat or Cold Intolerance
____ Hypoglycemia
____ Diabetes
____ Excessive Thirst
____ Excessive Hunger
____ Seasonal Depression

MUSCLE / JOINT / BONES
____ Neck Pain
____ Jaw Pain
____ Shoulder Pain
____ Arm/Wrist Pain
____ Knee Pain
____ Back Pain: Low Middle Upper
____ Sciatica
____ Heaviness of Limbs
____ Muscle Pain/Tension
____ Muscle spasms / cramps
____ Restless Leg Syndrome
____ Weak/Sore Lower Body
____ Areas of Numbness
____ Loss of Strength
____ Tingling Sensations

GENITO-URINARY
____ Pain/Burning when urinating
____ Frequent Urination
____ Dark or Pale Yellow
____ Cloudy Urine
____ Night Urination
____ Copious or Scanty Urination
____ Inability to hold Urine
____ Urinary Tract Infections
____ Kidney Stones
____ Blood in Urine

MENTAL / EMOTIONAL
____ Mood Swings
____ Anxiety or Nervousness
____ Depression
____ Poor Concentration
____ Poor Memory
____ Angry Outbursts
____ Weepy
____ Sadness

FEMALE ONLY
____ Irregular Cycles
____ Bleeding between Cycles
____ Pain during Intercourse
____ Clotting
____ Heavy or Excessive Flow
____ PMS
____ Painful Menses
____ Vaginal Discharge ? Color ?
____ Vaginal Itching/Burning
____ Vaginal Odor
____ Menopausal Symptoms
____ Vaginal Dryness
____ Sexually Transmitted Disease
____ Breast Pain / Tenderness
____ Nipple Discharge
____ Breast Lumps

Are you sexually active? Yes No
Do you practice Birth Control ? Type ?
_____
Have you ever taken the Pill ?
Used an IUD ?

Number of Pregnancies _____
Number of Live Births _____
Number of Miscarriages _____
Number of Abortions _____
Number of Ectopic Pregnancies ____

Difficulty Conceiving _____
Difficult or Premature Births _____
Do you do Breast Self Exams ?
Date of last PAP/Pelvic _____
Abnormal PAP ? When ?

____ Ovarian Cysts
____ Endometriosis
____ Uterine Fibroids/Polyps
____ Polycystic Ovarian Syndrome
____ Pelvic/Tubal Infection
____ Pelvic Inflammatory Disease
____ Pelvic Adhesions/Scarring
____ Chlamydia
____ Herpes
____ Bacterial Vaginosis
____ Genital Warts

MALES ONLY
____ Hernias
____ Testicular Masses
____ Testicular Pain
____ Varicoceles
____ STD
____ Premature Ejaculation
____ Prostate Disease
____ Sexually Transmitted Disease
____ Discharge or Sores
____ Sexual Dysfunction

Are you sexually active ? Yes No
Birth Control ? Type?

____ Infertility
____ Semen Analysis Results ?

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Muscles, Joints & Bones Continued :

Do you have pain or tightness? Where?_____

Recent injuries? _____ Was this from an auto accident or work related?_____

The pain is (check all that apply): Sharp Dull Aching Numb

Superficial Pain Deep Pain Burning Tingling Shooting

Pain worse/better with heat Pain worse/better with cold Pain worse/better with pressure

Pain worse in am/pm Pain worse/better with movement

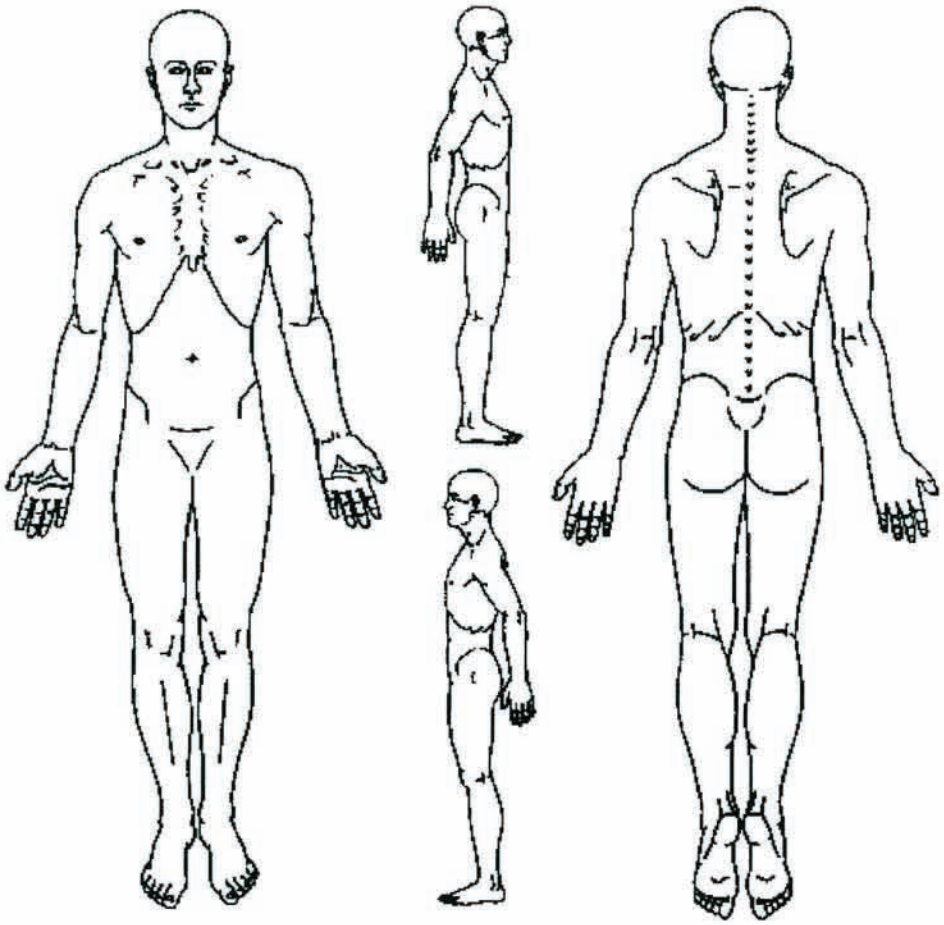
I have (check all that apply): Swollen joints Arthritis/joint pain Tendonitis

Bone pain Muscle cramping Muscle pain Repetitive Strain Injury

Fractured Bone(s) -- Where?_____

Other_____

Pain Diagram (please mark all areas of pain on diagram below) A= aching B= burning N=numbness P= pins and needles S= stabbing pain O= other type of sensation



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Gynecological/Reproductive, continued

Attempting Pregnancy currently? If so, for how long? _____
Currently Pregnant If so, how far along _____ Currently breastfeeding If so, how long?_____ Difficult scanty or painful lactation _____
Post-partum difficulties_____
Describe_____
Premature deliveries _____ Difficult deliveries_____
Describe_____
Difficulties in Pregnancy
Describe_____

_____

_____
Age of first menses_____ What was it like for you?_____
Date of last menses_____ Recent menstrual changes If so, what ?_____
How many days do you normally bleed? _____ How many days between periods? _____
How heavy is the bleeding? Heavy Average Light How many pads/tampons per day?_____
What color is the blood? Pale red, pink Red Dark red Purple Brown Black
Is the blood Watery Clotted Mucousy Thick Strong odor

Painful periods If so, how many days does pain last? _____ What makes the pain better?_____ Heaviness or pressure in pelvis with periods
Have you ever gone more than 2 months without getting your period? When?_____
PMS What symptoms_____ When do they start?_____
Bleeding/Spotting between periods When in cycle _____
Do you ovulate regularly?_____ If so, on what day of your cycle?_____ Is ovulation painful?____ Do you observe cervical mucus changes with ovulation?_____ Bleeding with ovulation?_____
Do any of your symptoms seem to change or worsen around you period?
How?_____ Menopausal Symptoms
Describe_____

_____

_____

Sleep

How long do you normally sleep? _____ hours per night
I have difficulties with (check all that apply): ____Falling asleep ____ Staying asleep
____Dream-disturbed sleep _____Waking up at about _____am/pm and not being able to fall back asleep

Emotional Health

Have you ever been treated for a psychological concern? Yes No
Have you experienced sexual or physical abuse? Yes No
Have you ever considered or attempted suicide? Yes No
Have you ever been treated for substance abuse? Yes No
Please rate your overall stress level. Low Medium High

Are you currently working with a counselor? If so, who?_____ If possible, please describe the most challenging emotion you experience_____
When do you most often feel this emotion?_____
What experiences or activities bring you the most joy and nourishment?_____

_____
What goals do you have for your acupuncture treatments?_____

_____

Comments: Please describe anything else you would like to discuss. _____

_____

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Form to be completed by Patient, notifying the Acupuncturist of Whether He/She has been evaluated by a Physician, and other Information

(Pursuant to the requirements of '183.6(e)' of this title (relating to Denial of License; Discipline of Licensee) and Tex. Occ. Code Ann., '205.351, governing the practice of acupuncture.)

I (patient's name) _____, an notifying the acupuncturist (practitioner's name) _____ 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 recognized that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

_____ (initials of patient) Date: _____

_____ 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 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me t a physician. It is my responsibility and choice whether to follow this advice.

Signature _____ Date _____

Note:

Exemptions according to **Rule 183.6 (e) Scope of Practice**

3) …an acupuncturist holding a current and valid license may without an evaluation or a referral from a physician, dentist, or chiropractor perform acupuncture on a person for **smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse.**

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HIPPA Notice
Privacy Disclosure and Policies

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

Safeguards in place include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Public Interaction

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc.. It is our preference to discuss your health in the office setting only to protect you privacy and ensure that important information is kept in your chart.

Consultations

We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, we may gather and maintain information that may include these examples of non-public personal information

- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information)

Records Release

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have Seema Sharma, Licensed Acupuncturist maintain my records confidentially in accordance with the law. I agree to inform Seema Sharma, Licensed Acupuncturist if I need any special arrangements pertaining to this issue.

signature	date
print name	

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COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could including receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:	_____	Parent / Guardian Signature	_____	Witness Signature	_____
Name	_____	Name	_____	Name:	_____
Date	_____	Date	_____	Date:	_____

FINANCIAL POLICIES

Healing Acupoints, PLLC request payment for your treatment at the time of service.

Cash or check payments are preferred but we also take VISA, MasterCard and American Express.

I authorize the release of medical information necessary to process my claims. Initial _____

Returned Checks. If your check is returned for insufficient funds, there will be a $25.00 Returned Check fee added to your account, in addition to the amount the check was for. Initial _____

Nonpayment. If your account is over 90 days past due from our first billing sent to you, it will be referred to a collection agency for payment. By signing this agreement you will also authorize the office to release information needed to secure payment. Initial _____

Missed Appointments. If you miss your appointment or cancel with less than 24 hours notice, you will be charged for the appointment. Initial _____

I have read and understand the policies and agree to abide by the guidelines.

_____ _____

Signature of patient or responsible party Date

Thank you for understanding our policies. Please let us know if you have any questions.

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ACUPUNCTURE INFORMED CONSENT TO TREAT

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 the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese 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 have 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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 Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects 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.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

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