People's Acupuncture Tx

CLINIC INFORMATION

Welcome to People's Acupuncture Tx. This is a sliding scale clinic that provides Oriental Medicine; which includes, acupuncture, herbology and Asian bodywork. Other Oriental Medicine techniques that fall in the scope of our practice also include, gua sha, cupping, moxa and Chinese dietary counseling and may occasionally be recommended based on your condition. Treatments are done in a community setting meaning treatments are given in the same room as others. Please be considerate of others. **Cell phones must be turned off in the clinic**. When entering the clinic please speak quietly and keep talking to a minimum. We do not have the space or resources to attend to children while you receive treatment. Please arrange for childcare outside the clinic if you have an appointment scheduled. You can also help us by wearing loose comfortable clothing,

APPOINTMENTS

People's Acupuncture Tx is dedicated to making acupuncture accessible to as many people possible through low cost treatments and high volume and strive to keep the clinic fully booked. Treatments, therefore, are by appointment only**. If you find that you need to cancel an appointment, it is important that you provide 24 hour notice;** this will enable us to fill the time slot. We reserve the right to charge a **$40 fee** for appointments canceled with less than a 24 hour notice or for "no show" appointments.

Because of the tight schedule and the nature of our clinic, **we ask that you arrive to your appointments early or on time**. Should you arrive late, our staff will try to accommodate you, but you may be asked to reschedule for a later date.

PAYMENT FOR SERVICES RENDERED

Payment is due at the time of service and may be paid in cash, check or credit card. You decide where you fall on the sliding scale and pay accordingly, no questions asked.

1st treatment: **$60 – $100**
Follow up treatments: **$40 - $80**

INSURANCE

In order to keep clinic prices affordable, we do not file insurance claims of any kind. Upon request, we will provide you with a printed receipt.

Please sign & date on the line below. Thank you for allowing us to provide you with quality, low cost alternative medicine.

_____ _____

Patient's signature **Date**

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Notification Form Regarding Evaluation Of Patient by Physician

(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 People's Acupuncture Tx 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
___ Smoking Cessation
___ Alcoholism
___ Substance Abuse

_____

Patient signature (required) Date

People's Acupuncture Tx is not responsible for untrue statements made by patients.

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HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that my health care information at People's Acupuncture Tx will be kept private and will not be discussed without my permission. Use and disclosure of my protected health information may be provided to a physician or other healthcare provider providing treatment to if authorized in writing. I understand that my protected health information may be used or disclosed if required by law.

I understand that People's Acupuncture Tx staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and if I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

By signing this form, I am giving People's Acupuncture Tx authorization to contact me by phone, mail, email or text. I acknowledge that all information discussed during the assessment and treatment at People's Acupuncture Tx will be held confidential except in the instance where my safety or the safety of others may be at risk

_____

Patient Name (print)

_____ _____

Patient Signature Date

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize the People's Acupuncture Tx the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____ _____

_____ _____

_____ _____

_____ _____

Patient's Signature Date

People's Acupuncture Tx

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.
People's Acupuncture Tx Tel: (832) 429-7822 E-mail: info@peoplesacupuncturetx.com

Name_____ Gender_____ Date_____
Date of Birth_____ Age_____ Occupation_____ Marital Status_____
Best Phone Number_____
Address: Street_____
City_____State_____Zip_____E-mail_____

Emergency Contact_____ Relationship & Phone_____
Family physician or chiropractor_____
Have you had acupuncture and/or Chinese herbs before? _____
How did you hear about us? _____

Main complaint?_____

How long have you had this problem? _____
What seems to cause this problem? _____
Have you been given a diagnosis? If so, what? _____
To what extent does this problem interfere with your daily activities? _____
What kinds of treatment have you tried? _____
What makes it better?_____Worse? _____
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
Is there anyone in your family with the same/similar problems? _____

Please mark an "x" next to any conditions you have had and a 'check' after conditions you currently have.

Medical History

____ Epilepsy/Seizures	____ Hepatitis A/B/C	____ Tuberculosis
____ Anemia	____ Thyroid disorder	____ Meningitis
____ Bleeding or hemorrhage	____ Arthritis	____ Auto Immune Disease
____ High blood pressure	____ Fibromyalgia	____ IBS / Colitis / Chron's
____ High cholesterol	____ Asthma	____ Cancer
____ Heart disease	____ Emphysema	____ Stroke
____ Diabetes	____ Pneumonia	____ Emotional imbalance
____ HIV	____ Bronchitis	____ Addiction(s)

Other_____
Surgeries/Hospitalization _____
Allergies_____

Medications, vitamins, herbs taken within the last 3 months (Please include reasons and known side effects)

_____
_____
_____
_____

Please mark an "x" next to any conditions you have had and a 'check' after conditions you currently have.

General
____ Low energy
____ Spontaneous sweating
____ Excessive thirst or hunger
____ Chills/Fever
____ Heat or cold intolerance
____ Cold hands and feet
____ Sweaty palms and feet
____ Hot flashes
____ Night sweats
____ Lack of sweating
____ Weight loss
____ Weight gain
____ Sudden energy drop

Musculoskeletal
___Pain/Weakness/Numbness
__ Arms
__ Feet
__ Hands
__ Joints
__ Legs
__ Hips
__ Neck
__ Shoulders
__ Back
__ Pain all over
____ Muscle spasm
____ Tremors
____ Swelling of hands or feet
____ Arthritis
____ Osteoporosis
____ Broken bones

Mental/Emotional
____ Stress
____ Mood swings/depression
____ Anxiety or nervousness
____ Irritability
____ Anger
____ Worry
____ Sadness
____ Fear
____ Over thinking
____ Poor memory
____ Difficulty concentrating
____ Eating disorder

Neurologic
____ Seizures
____ Vertigo or dizziness
____ Paralysis
____ Muscle weakness
____ Numbness or tingling
____ Loss of balance
____ Lack of coordination
____ Loss of memory

Skin and Hair
____ Rashes
____ Color change
____ Eczema
____ Fungus
____ Itching
____ Hives
____ Acne or boils
____ Bruise easily
____ Loss of hair

Respiratory
____ Frequent colds
____ Cough
____ Pain or difficulty breathing
____ Wheezing or asthma
____ Shortness of breath
____ Production of phlegm
____ Bronchitis
____ Chronic infections
____ Coughing blood
____ Seasonal allergies

Head
____ Headaches
____ Migraines
____ Jaw/TMJ problems
____ Facial pain

Nose and Sinuses
____ Stuffiness
____ Runny nose
____ Sneezing
____ Nose bleeds
____ Hay fever
____ Sinus problems
____ Loss of smell
____ Sinus headaches

Ears
____ Impaired hearing
____ Earaches
____ Ringing
____ Dizziness

Mouth and Throat
____ Teeth grinding
____ Hoarseness
____ Copious saliva
____ Dry mouth
____ Bleeding gums
____ Mouth, tongue or lip sores
____ Frequent sore throat
____ Bad breath
____ Chronically swollen glands
____ Difficulty swallowing

Eyes
____ Impaired vision
____ Floaters or 'spots'
____ Cataracts
____ Blurriness
____ Glaucoma
____ Near/Far sightedness
____ Tearing or dryness
____ Eye pain/strain
____ Itchy eyes
____ Red or inflamed eyes
____ Poor night vision

Cardiovascular
____ Murmurs
____ Chest pain
____ Poor circulation
____ Blood clots
____ Deep leg pain
____ Irregular heartbeat
____ Heart palpitations
____ Varicose veins
____ Fainting
____ Swelling in ankle

Digestive
____ Nausea
____ Vomiting
____ Diarrhea
____ Constipation
____ Belching
____ Passing gas
____ Heartburn or acid reflux
____ Ulcer
____ Hemorrhoids
____ Pain or cramps
____ Black stool
____ Blood in stool
____ Parasites

Urinary Tract
____ Pain on urination
____ Increased frequency
____ Urgency
____ Urine leakage
____ Dark urine
____ Cloudy urine
____ Scanty urine
____ Blood in urine
____ Infections
____ Kidney stones

Reproductive
____ Pain in genitals
____ Itching in genitals
____ Pain with intercourse
____ Chlamydia
____ Herpes
____ Genital warts
____ Discharge or sores

Female
____ May be pregnant
____ Peri-Menopausal
____ Completed menopause
____ Partial/Total hysterectomy
____ PMS
____ Bleeding between cycles
____ Painful ovulation
____ Painful menses
____ Clotting
____ Heavy cycles
____ Scanty cycles
____ Irregular cycles
____ Abnormal paps
____ Ovarian cysts
____ Endometriosis
____ Uterine fibroids
____ Vaginal discharge
____ Frequent vaginal infections
____ Trouble conceiving
____ Menopause symptoms
____ Breast lumps or pain
____ Nipple discharge

____ How many days of bleeding per cycle?
____ Are cycles regular? ____ On birth control?
____ Age of first menses
____ # of pregnancies
____ # of miscarriages
____ # of live births
____ # of abortions
____ # of cesarean

Male
____ Testicular pain or swelling
____ Discharge
____ Testicular mass
____ Prostate problems
____ Erectile dysfunction
____ Premature ejaculation
____ Low sperm count or motility

Lifestyle
____ Vegetarian
____ Healthy diet
____ Eat lots of fried food
____ Eat lots of meat
____ Eat lots of sweets
____ Eat lots of salty
____ Eat lots of sour
____ Eat lots of spicy
____ Smoke cigarettes
____ Drink alcohol
____ Drink coffee
____ Drink cola
____ Recreational drugs
____ Regular exercise
____ Sleep well
____ # hours of sleep
____ Wake up tired
____ Trouble falling asleep
____ Trouble staying asleep