Beachside Community Acupuncture PLLC

Personal Information

Name: _____ Age: _____ Birth Date: _____

Full Address: _____

Cell Phone Number: _____ Occupation: _____

E-mail address: _____

If under 18, person responsible for your account: _____

Gender: □ Male □ Female □ Non-binary Height: _____ Weight: _____

Relationship status: □ Single □ Partnered □ Married □ Divorced □ Separated □ Widowed

Emergency Contact Name: _____ Contact Phone: _____

Primary Care Physician: _____ Phone: _____

May we contact him/her? □ Yes □ No How did you hear about us? _____

Have you had acupuncture therapy before? □ Yes □ No Are you a veteran? □ Yes □ No

Please indicate if any of the following pertain to you:

□ Hepatitis □ HIV □ High Blood Pressure □ Seizures □ Pacemaker □ Blood-Thinning Medication

Please indicate how much you consume of the following and how frequently:

Coffee: _____ Soda: _____ Water: _____

Alcohol: _____ Tobacco: _____ Other drugs: _____

Dietary restrictions: _____

Please list any prescription or over-the-counter medications, vitamins, and supplements you are presently taking and the reason for taking them:

_____

_____

_____

_____

_____

_____

What would you like to accomplish with acupuncture? This is NOT your chief complaint but rather your health goal (i.e. to run a 5k without pain, to have the energy to keep up with your nephew, etc.)

_____

Health History

Please indicate your top three health concerns for which you are seeking treatment, how they started, and how long you have been experiencing them:

1. _____

2._____

3._____

What other forms of treatment have you sought?

_____

Does anything make your condition better or worse?

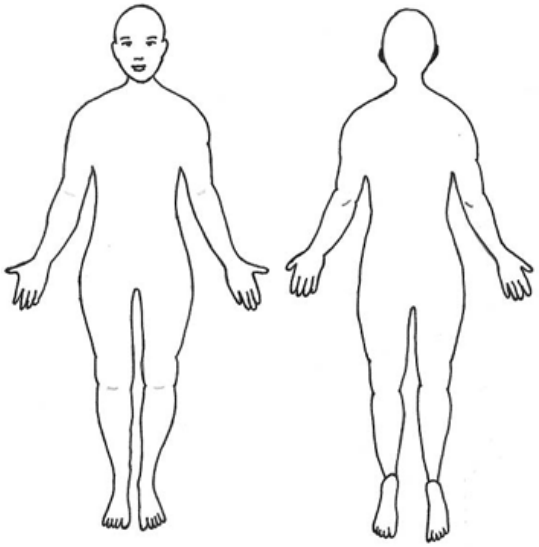
_____

Please list any surgeries or major health incidents (injuries, trauma, accidents, hospitalizations, etc.) in your life and the date of occurrence:

_____

_____

Please indicate where you experience physical pain or discomfort:



How would you characterize your physical pain?

□ dull/achy □ sharp/stabbing □ burning □ tingling □ numb □ electrical □ throbbing □ stiff

□ tight □ continuous □ comes and goes □ fixed location □ moves around □ shooting/radiating

How would you rank your pain on a scale of 1-10? (10 = “I need to go to the Emergency Room now.”)

Day to day: _____ At its lowest: _____ At its highest: _____

Symptoms Survey

Please indicate the symptoms or conditions you currently experience at least a few times per month:

Digestion	Head	Body
Excessive appetite	Dry mouth	Cough
Poor appetite	Hearing issues	Shortness of breath
Low energy after eating	Ringing in the ears	Palpitations
Bloating	Dizziness	Chest pain / tightness
Acid reflux / heart burn	Difficulty focusing	Gallstones
Belching	Poor memory	Kidney stones
Gas	Vision issues	Urinary issues
Hemorrhoids	Hair loss	Edema / swelling
Prolapse	Headaches	Restless leg / leg cramps

Emotions	Allergies	Sweating
Depression	Congestion / runny nose	Heat / sweating at night
Irritability	Itchy / watery eyes	Spontaneous sweating
Anxiety	Sneezing	Too much sweating
Panic attacks	Skin issues	Too little sweating

Do you tend to feel: □ Hot □ Cold Are any parts of your body hotter or colder? _____

Do you experience any hot or cold flashes? How often? _____

Lifestyle

How many hours of sleep do you get? _____ How many times do you wake? _____

For how long? _____ What wakes you? _____

Do you have: □ Difficulty falling asleep □ Nightmares □ Vivid dreams □ Grogginess on waking

How many bowel movements do you have in a day or week? _____

Are your bowel movements: □ Well-formed □ Loose □ Small pebbles □ Easy to pass □ Difficult to pass

How would you rate your energy level on a scale of 1-10, with 10 being the highest: _____

How would you rate your stress level on a scale of 1-10, with 10 being the highest: _____

Please list your primary sources of stress: _____

Have you experienced any form of abuse? _____

For Men

Date of your last prostate exam: _____ Are you sexually active? □ Yes □ No

Any concerns with: □ High libido □ Low libido □ Starting an erection □ Maintaining an erection

□ Other men's health issues: _____

Please list any STDs you have had: _____

For Women

Number of pregnancies: _____ Number of births: _____

Are you sexually active? □ Yes □ No Is there any chance you might be pregnant now? □ Yes □ No

Any concerns with: □ High libido □ Low libido □ Painful intercourse

Date of last period: _____ Cycle length: _____ Number of days of flow: _____

Is your menses: □ Heavy □ Light □ Very dark □ Very bright □ Clotted □ Spotting

Please indicate if you experience the any of these symptoms before or during your menses:

□ Lower back pain □ Diarrhea □ Constipation □ Moodiness □ Breast pain / soreness □ Bloating

□ Increased appetite □ Decreased appetite □ Headache □ Nausea □ Insomnia □ Fatigue □ Heaviness

□ Cramping, please describe timing and severity: _____

Please indicate if you experience any of these other urogenital symptoms:

□ Vaginal dryness □ Profuse vaginal discharge □ Yeast infections □ Urinary tract infections

Please indicate if you have been diagnosed with any of the following:

□ Fibroids □ Fibrocystic breasts □ Endometriosis □ Ovarian Cysts □ Polycystic Ovary Syndrome

Please list any STDs you have had: _____

Fertility

How do you track your cycles? □ BBT □ Ovulation kits □ Cervical fluid □ Counting days □ None

Please briefly share your fertility journey, including the testing you have had done and the medical interventions you've tried:

_____

_____

_____

Did we miss anything? Anything else you'd like us to know?

_____

_____

Beachside Community Acupuncture PLLC

Notification Regarding Evaluation of Patient by Physician

According to Texas law (pursuant to the requirements of Section 183.10(a)(11) and Section 205.302, Article 4495b governing the practice of acupuncture) we are required to inform you that in the State of Texas, acupuncture and Oriental Medicine is not considered primary health care. As a result, you must respond in the affirmative to *at least one* of the following three statements. Please be advised that per the law, we will not be permitted to treat you unless *at least one* of the 3 statements below is answered in the affirmative.

I, _____, am notifying the acupuncturist of *at least one of the following*:

Yes_____ No_____I have been evaluated by a physician, dentist, or nurse practitioner for the condition which I am requesting treatment within the six months prior to being treated by Beachside Community Acupuncture PLLC.

-OR-

Yes_____No_____I have received a referral from my chiropractor within the last 30 days for acupuncture. The date of this referral is _____. After being referred by a chiropractor if no substantial improvement occurs within 30 days or 20 treatments (whichever comes first), I understand that the acupuncturist is required by Texas law to refer me to a physician. It is my responsibility and choice as to whether 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 am seeking treatment for symptoms related to one of more of the following conditions:

_____Weight loss _____Smoking Addiction/Cessation ____Chronic Pain _____Substance Abuse

Patient signature:_____ Date:_____
Patient's printed name:_____

CANCELLATION POLICY

We understand that there are times when a patient must miss an appointment due to emergencies or obligations with work or family. However, when a patient does not cancel an appointment in advance they are preventing another patient from utilizing that time. To ensure that our schedule remains accurate so that we may help as many patients as possible, appointments must be canceled at least 24 hours in advance. Your credit card on file will be charged $40 for a missed follow-up or $47.50 for a missed new patient appointment if you fail to give adequate notice.

Patient signature:_____ Date:_____

If you are signing on behalf of someone else, please indicate your relationship to the patient next to your signatures. If you are signing on behalf of a minor, you must be his or her legal guardian.

Beachside Community Acupuncture PLLC

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 licensed acupuncturists within Beachside Community Acupuncture, PLLC, who now or in the future treat me while employed by, working or associated with or serving as back-up for the clinic, including those working at the clinic at which I am signing this form 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, acupressure/Tui Na, Chinese herbal medicine, nutritional supplementation, micro-current, and nutritional counseling.

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. 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.

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

PATIENT SIGNATURE _____ Date_____

HIPAA ACKNOWLEDGEMENT

I acknowledge that Beachside Community Acupuncture PLLC has provided me with a Notice of Privacy Practices, and I agree to the terms indicated in them. By signing below, I also give my permission to be contacted by phone, email, or mail and that messages regarding appointments may be left for me on my voicemail.

PATIENT SIGNATURE _____ Date_____

If you are signing on behalf of someone else, please indicate your relationship to the patient next to your signatures. If you are signing on behalf of a minor, you must be his or her legal guardian.