ROUND ROCK
HEALTH & WELLNESS

Health History

Thank you for taking the time to complete this Health History carefully and completely.

Name:		Date:
SSN:	Birth date:	Gender:
Email:		Preferred name:
Address / City / State / Zip:		
Home Phone:	Cell Phone:	Work Phone:
Employer:	Occupation:	
Employer's Address / City / State / Zip:		
Name of Spouse / Domestic Partner (or parent, if a minor):		
Home Phone:	Cell Phone:	Work Phone:
Emergency Contact / Relationship:		
Home Phone:	Cell Phone:	Work Phone:
Responsible Party (for billing):		
Billing Address / City / State / Zip (if different than above):		
Name of Primary Care Physician:		Phone:
Have you had acupuncture before today? If so, for what condition? Was it a pleasant experience?		

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Health History

Please list the reasons for your visit today, in order of importance and include date of onset and severity:
Have your complaints been diagnosed? Please explain.
Are you currently taking any prescription medications / vitamins / supplements / herbs? Please list them (or attach the necessary documentation).
Do you have any known medication allergies?

PAST MEDICAL HISTORY

Childhood Illnesses:
Major Illnesses:
Surgeries:

PAST FAMILY MEDICAL HISTORY

Please include incidence of TB, cancers, skin disease, hypertension, nervous disorders, diabetes, arthritis, heart disease, stroke, seizures, asthma, allergies, alcoholism/substance abuse, etc.

Father:	Mother:
Siblings:	Grandparents

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Health History

DAILY HABITS / NUTRITION

Do you smoke or use another form of tobacco? What type and how often?

Please indicate if you consume the following and with what frequency:

❑ Alcohol ❑ Drugs ❑ Coffee ❑ Tea ❑ Soda

Do you exercise? What type and how often?

Are there foods you are sensitive or allergic to?

Do you subscribe to a particular diet? If so, which of the following?

❑ Vegan ❑ Ovo/Lacto/Pesca-terian ❑ Atkins Diet ❑ Dairy Free
❑ Vegetarian ❑ Paleo Diet ❑ Gluten Free ❑ Sugar Free

Please describe what you eat in an average day:

WOMEN

Age when periods began:

Date of last period:

Date and results of last PAP:

Number of cycle days (28, 30 etc):

Number of days of flow:

Is your cycle regular? Explain.

Spotting / Vaginal Discharge
❑ Yes ❑ No
When?

❑ Yes ❑ No
When?
Color:

Pain / Cramping
❑ Mild ❑ Moderate ❑ Extreme

❑ Before ❑ During or ❑ After Periods

PMS
❑ Breast Swelling/Tenderness ❑ Irritability ❑ Anxiety

Color / Consistency of Blood
❑ Bright ❑ Rust ❑ Pale ❑ Purple
❑ Sticky ❑ Thick ❑ Thin

Any menstrual difficulties during your teens? (pain, flow, regularity, cramps, etc.)

Birth control history (method and duration of use)

Date of Menopause:

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Health History

Obstetric history (pregnancies, births, miscarriages)	Are you pregnant?	Trying to become pregnant?*
STD history (herpes, genital warts, etc.)		***I must immediately notify my acupuncturist should I become pregnant (_____)** Initials

MEN

History of impotence, premature ejaculation, fertility difficulties, prostate health, discharge from penis, vasectomy, etc.:
STD history (herpes, genital warts, etc.)

Please indicate which of the following symptoms you have now or have had in the past:

LIVER/GALLBLADDER

- ❑ Irritability / Anger
- ❑ Depression
- ❑ Stress
- ❑ Visual problems
- ❑ Red / Dry / Itchy Eyes
- ❑ Watery eyes
- ❑ Ear Ringing / Tinnitus: high pitched
- ❑ Migraines
- ❑ Headache
- ❑ Spots or Floaters in Vision
- ❑ Gallstones
- ❑ Dizziness
- ❑ Blurry Vision
- ❑ Feeling of a Lump in Throat
- ❑ GERD
- ❑ Dry Skin
- ❑ Itchy Skin
- ❑ Acne
- ❑ Genital Pain
- ❑ Itching Genitals
- ❑ Eczema
- ❑ Nighttime Teeth Clenching
- ❑ Muscle Cramping / Twitching
- ❑ Tension
- ❑ Joint Pain
- ❑ Tremors / Convulsions
- ❑ Indecisiveness
- ❑ Neck / Shoulder Pain
- ❑ Poor Circulation
- ❑ Cold Hands and Feet
- ❑ Soft / Brittle Nails
- ❑ Sighing
- ❑ Hernia
- ❑ Breast Distension
- ❑ Waking Too Early in AM
- ❑ Emotional Eating
- ❑ Bad Taste
- ❑ Bad Breath
- ❑ Vertigo
- ❑ Scanty Periods
- ❑ Amenorrhea
- ❑ Painful Periods
- ❑ Heavy Periods
- ❑ Craving Sour

KIDNEY/URINARY BLADDER

- ❑ Urgency to Urinate
- ❑ Painful Urination
- ❑ Frequent UTIs
- ❑ Dropped Bladder
- ❑ Deafness
- ❑ Tinnitus: low pitched
- ❑ Incontinence (circle one or both: urine / stool)
- ❑ Lack of Bladder Control
- ❑ Weakness / Pain in Low back
- ❑ Hearing Problems
- ❑ Weak / Painful Knees
- ❑ Decrease in Bone Density
- ❑ Feel Cold Easily
- ❑ Early graying
- ❑ Kidney Stones
- ❑ Low Sex-drive / Libido
- ❑ Excess Sex-drive
- ❑ Fearful Feelings
- ❑ Hair Loss
- ❑ Poor Short-term Memory
- ❑ Hot Flashes / Night Sweats
- ❑ Tooth Problems
- ❑ Loose Teeth
- ❑ Sore throat
- ❑ Difficulty Inhaling
- ❑ Craving Salty

HEART/SMALL INTESTINE

- ❑ Heart Palpitations
- ❑ Insomnia / Sleep Problems
- ❑ Chest Pain
- ❑ Startle Easily
- ❑ Flushed Face
- ❑ Restlessness / Agitation
- ❑ Vivid Dreams
- ❑ Painful Urination
- ❑ Dream Disturbed Sleep
- ❑ Mouth Sores
- ❑ Tongue Ulcers
- ❑ Shoulder Pain
- ❑ Poor Long-term Memory
- ❑ Craving Bitter

LUNG/LARGE INTESTINE

- ❑ Bloody Cough
- ❑ Dry Cough
- ❑ Cough with Sputum
- ❑ Nasal Discharge Color:
- ❑ Post Nasal Drip Color:
- ❑ Sinus Congestion
- ❑ Itchy, Red, Painful Throat
- ❑ Skin Rashes / Hives
- ❑ Snoring
- ❑ Spontaneous Sweating
- ❑ Excessive Sweating
- ❑ Grief / Sadness
- ❑ Sinus Infection
- ❑ Shortness of Breath
- ❑ Allergies
- ❑ Freq. Colds / Flu
- ❑ Mild Fever
- ❑ Brittle or Dry Hair
- ❑ Difficulty Exhaling
- ❑ Emphysema
- ❑ Sneezing
- ❑ Bronchitis
- ❑ Black/Bloody Stools
- ❑ Bloody Noses
- ❑ Constipation
- ❑ IBS
- ❑ Diarrhea
- ❑ Craving Pungent/Spicy

SPLEEN/STOMACH

- ❑ Heaviness in Body
- ❑ Fatigue
- ❑ Difficulty Rising in AM
- ❑ Weak Muscles
- ❑ Edema (circle one or both: <u>hands</u> / <u>feet</u>)
- ❑ Bruise Easily
- ❑ Bleed Easily
- ❑ Bad Breath
- ❑ Heavy Periods
- ❑ Varicose Veins
- ❑ Nausea / Vomiting
- ❑ Swollen or Bleeding Gums
- ❑ Abdominal Pain
- ❑ Poor Appetite
- ❑ Gas
- ❑ Belching
- ❑ Hemorrhoids
- ❑ Constipation
- ❑ Diarrhea
- ❑ Dry Lips
- ❑ Pale Lips
- ❑ Abdominal Pain
- ❑ Indigestion
- ❑ Heartburn
- ❑ Overthinking
- ❑ Tendency to Gain Weight
- ❑ Foggy Brain
- ❑ Craving Sweets

ROUND ROCK HEALTH & WELLNESS CENTER

Informed Consent to Treat

I, the undersigned "Patient", agree to receive acupuncture treatments and related therapies by a licensed acupuncturist at Round Rock Health & Wellness Center. Treatment methods may include, but are not limited to, acupuncture, tui-na massage, cupping therapy, herbal medicine, nutritional supplements, heat and moxibustion therapy, electro-stimulation, physiotherapy exercises, as well as lifestyle and nutritional counseling.

I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture. Infection is also a rare but possible risk. I understand that the acupuncturist uses only sterile disposable, single-use needles, and maintains a clean and safe environment. Massage is very safe but may lead to temporary muscle soreness, redness, or bruising. Burns and scarring are a potential risk of heat and moxibustion therapy. Bruising is a common side-effect of cupping.

I agree to immediately notify the acupuncturist should I become pregnant as some of the aforementioned treatment modalities are inappropriate during pregnancy.

The herbs and nutritional supplements used in Chinese Medicine are considered safe, but may have potential side-effects. I understand that some herbs may be toxic at high doses, and some are incompatible with some medications. **I will therefore disclose ALL current medications before starting herbal therapy.** Some herbs are also inappropriate during pregnancy, so **I will immediately notify the acupuncturist should I become pregnant.** If I notice an unpleasant side-effects associated with herbal treatments, I will immediately notify the acupuncturist at the number below.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her to exercise judgment during the course of treatment to make decisions that are in my best interest, based on the facts known. I understand that clinical and medical staff may review my files but all my records will be kept confidential an can only be released under my personal written consent, or when required by law.

If I am unable to attend a prescheduled appointment, I agree to cancel at least 24-hours in advance. Failure to do so will result in my being charged the full amount of the treatment price. If I am more than 15 minutes late to my appointment, I understand that I will forfeit the appointment and will be charged the full amount of the treatment price.

By voluntarily signing below, I show that I have read (or have had read to me) and understand this Informed Consent to Treat. I have been told about the risks and benefits of acupuncture and related therapies and have had the opportunity to ask questions. This consent form shall cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Printed Name of Patient (and Representative) Printed Name of Licensed Acupuncturist

Signature of Patient (or Representative) Date Signature of Licensed Acupuncturist Date

ROUND ROCK HEALTH & WELLNESS CENTER

Patient Evaluation

In the State of Texas, acupuncture and Traditional Chinese Medicine are not considered "primary health care". As a result, we are required to have you respond affirmatively to the following statement before you are treated. Please be advised that we cannot treat you with acupuncture or herbal medicine **if your response to all of these statements is no.** (Pursuant to the requirements of 22 TAC §183.7 of the Texas State Board of Acupuncture Examiners' rules, relating to Scope of Practice, and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I, _____ am attesting to the following:

___ YES ___ NO I have been evaluated by a physician, dentist, or nurse practitioner for the condition being treated within 12 months of the date on this form. I recognize that I should be evaluated for this condition by a physician, dentist, or nurse practitioner prior to seeking treatment at this clinic.

OR

___ YES ___ NO I have received a referral for acupuncture from a chiropractor within the last 30 days. The date of the referral is ____ / ____ / ____ and the most recent date of treatment prior to the acupuncture treatment was ____ / ____ / ____. After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvements 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 heed this referral.

OR

___ YES ___ NO I have not been evaluated by a physician, dentist, or nurse practitioner, nor have I received a referral for acupuncture from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

___ Chronic pain ___ Alcoholism ___ Weight loss
___ Smoking addiction ___ Substance Abuse

Should I return for treatment for any condition other than my original condition(s), I understand it is my responsibility to be evaluated by a physician, dentist, or nurse practitioner prior to receiving acupuncture at this clinic:

Printed Name of Patient | Signature of Patient (or Representative)

Date | (Printed Name of Representative and Relationship)

The LAc has referred me to a MD, dentist, or NP and it is my responsibility and choice to take that advice.

Signature of Patient (or Representative) | Date

Signature of Licensed Acupuncturist | Date

**(Round Rock Health and Wellness Center and the licensed acupuncturist are not responsible for errors or false statements on this form)*

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Receipt of Privacy Practices

By signing my name below, I acknowledge I have read and have been offered a copy of a Notification of Privacy Practices of Round Rock Health and Wellness, which highlights my privacy rights according to the Health Insurance Portability and Accountability Act (HIPAA).

Printed Name of Patient	Signature of Patient (or Representative)
Date	(Printed Name of Representative and Relationship)