South Austin Community Acupuncture

2041 SOUTH LAMAR ▪ AUSTIN, TEXAS 78704 ▪ (512)707-8330

Welcome. Please take a minute to read this introduction to our clinic.

▪ We treat in a community setting

This means receiving treatment in the same room as others, or in a common area.

Treating patients in a community setting has many benefits: it's easy for friends and family members to come in for treatment together; many patients find it comforting; plus a collective energetic field becomes established which actually makes individual treatments more powerful – the Chinese call this 'group benefit'. Also, it is by virtue of the fact that we treat in a group setting that allows us to charge what we charge.

▪ We have a sliding scale

We charge $20-$40 per treatment for acupuncture, plus an additional $10 first appointment fee. Please see our sliding scale guidelines and select the amount you choose to pay. We do not verify income, so please pay fairly.

Any cost of herbs is over and above the cost of acupuncture.

▪ Consideration for others

Cell phones must be turned of in the clinic.

When entering the community treatment room, please speak quietly and keep talking to a minimum. Others may be relaxing quietly. Please be considerate.

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.

▪ Flexibility

The community setting requires some flexibility from you. For instance, if you are particularly sensitive to sounds, please bring earplugs. Some people snore.

We have blankets and throw pillows available inside the treatment room if you think you'll get cold or if your arms need some support. Help yourself to them.

You can also help us by wearing loose comfortable clothing, and having your shoes and socks off and pants rolled up to just above the knee when we come in. Basically, we need you to participate in making yourself comfortable in the community room before we arrive to treat you.

If you need to leave by a certain time, please let us know ahead of time.

▪ Commitment

We will provide a safe environment with skilled practitioners.

Acupuncture is a process. Our intention is to help you make a commitment to this process. Often more than one treatment is required to resolve a problem, and so we strive to make it possible for you to receive acupuncture regularly enough and long enough to get better and stay better.

▪ Enjoy

Most of all, enjoy your time here. We do!

Please initial to indicate you have read and understood the above _____

Our Sliding Scale

We offer acupuncture in a group setting on a sliding scale.

Please take a look at our guidelines below and check the payment option that best works for you:

Check one	Annual household income:	Acupuncture treatment	Additional treatments within a week
□	< $20,000	$20	$20
□	$20,000 - $25,000	$25	$20
□	$25,000 - $30,000	$30	$25
□	$30,000 - $40,000	$35	$30
□	> $40,000	$40	$35
□	I want to pay more	$__	

There is also a first appointment fee of $10.

Cancellation policy / $20 no-show charge

We value our time. If you need to cancel or change an appointment, please call us and we will accommodate you. If you have an appointment scheduled and you don't show up and don't call us prior to the appointment to let us know you won't be coming, you will be charged a missed appointment fee of $20.

Please pay fairly. We are only able to offer our services at these prices with the support of the community.

Please initial to indicate you have read and understood the above _____

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HEALTH QUESTIONNAIRE

PLEASE COMPLETE THIS QUESTIONNAIRE AS THOUROUGHLY AS POSSIBLE. The information on this form will help us give you the best and most comprehensive care possible. Even though some of the questions may seem unrelated to your condition, they may play a contributing or underlying role in diagnosis and treatment of your problem.

All information provided is strictly confidential

GENERAL INFORMATION

Name: _____Today's Date ____ / _____ / _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____Work Phone: (___) _____ Cell Phone :(___) _____

Occupation: _____ Employer: _____

D.O.B. ____ / _____ / _____ Age: _____ Gender: M F Height: ____' _____" | Weight: _____

Relationship Status: Live w/other(s) Live alone Single Married Separated Divorced Widowed

In case of emergency notify: _____Relation: _____ Phone: _____

Patients Representative:_____ Relation: _____
(if under 18 or otherwise requiring guardianship)

Name of your primary health care provider: _____

Have you tried acupuncture before? Yes No

How did you hear about us? _____

YOUR HEALTH CONCERNS

WHY ARE YOU COMING FOR TREATMENT? Please include: location of complaint, time of onset, and cause or diagnosis (if known). Also tell us what treatments you have tried and anything that helps or aggravates the problem.

1)

2)

3)

FAMILY HISTORY: Indicate any which affected your parents, grandparents, siblings, or children.

☐ Addiction(s)	☐ Blood disorders	☐ Genetic Disease	☐ Overweight
☐ Allergies	☐ Cancer	☐ Heart Disease	☐ Stroke
☐ Arthritis	☐ Depression	☐ Hypertension	☐ Suicide
☐ Asthma	☐ Diabetes	☐ Mental Illness	☐ Thyroid disorder
☐ Other			

YOUR MEDICAL HISTORY: Check any conditions you that apply to you, past or present. Indicate when, if past:

☐ Heart Disease	☐ High Fever	☐ Hepatitis	☐ Thyroid disorder
☐ Kidney disease	☐ Asthma	☐ Venereal disease	☐ Cancer
☐ Liver disease	☐ Pneumonia	☐ HIV	☐ Diabetes
☐ Lung disease	☐ Bronchitis	☐ Measles	☐ Bleeding or hemorrhage
☐ Emotional imbalance	☐ Emphysema	☐ Mumps	☐ Stroke
☐ Auto Immune Disease	☐ Tuberculosis	☐ Chicken Pox	☐ Epilepsy/Seizures
☐ Arthritis	☐ Hemophilia	☐ Polio	☐ Paralysis
☐ Fibromyalgia	☐ Anemia	☐ Meningitis	☐ IBS / Colitis / Chron's
☐ Eczema	☐Glaucoma	☐ Rheumatic fever	☐ Nervous system disorder
☐ Psoriasis	☐Cataracts		
☐ Other			

Major injuries or traumas: What and When?

_____

Hospitalization and surgeries: What and When?

_____

CURRENT MEDICATIONS: PLEASE LIST ANY PRESCRIPTION MEDICATIONS, OVER-THE-COUNTER MEDICATIONS, VITAMINS OR OTHER SUPPLEMENTS YOU ARE CURRENTLY TAKING.

_____

_____

_____

_____

LIFESTYLE:

Do you sleep well? ☐ Yes ☐ No | 6-8 hours average per night? ☐ Yes ☐ No | Do you awaken rested? ☐ Yes ☐ No

What do you do to handle stress?

What are 3 things that you know you could do to improve your health?

(1) _____ (2) _____(3) _____

On a scale of 1-10, how committed are you to optimal health? (circle one) 1 2 3 4 5 6 7 8 9 10

SYMPTOM PROFILE: PLEASE CHECK EACH THAT APPLIES TO YOU

GENERAL:

- ☐ LOW ENERGY
- ☐ SPONTANEOUS SWEATING
- ☐ HOT/COLD BODY TEMP
- ☐ EXCESSIVE THIRST
- ☐ CHILLS/FEVER
- ☐ AVERSION TO HEAT OR COLD
- ☐ COLD HANDS/FEET
- ☐ SWEATY PALMS/FEETS
- ☐ HOT FLASHES
- ☐ NIGHT SWEATS
- ☐ LACK OF SWEATING
- ☐ WEIGHT LOS
- ☐ WEIGHT GAIN

SKIN:

- ☐ RASH
- ☐ ITCHING
- ☐ COLOR CHANGE
- ☐ BRUISE EASILY
- ☐ SLOW WOUND HEALING
- ☐ ACNE, BOILS
- ☐ HIVES
- ☐ HAIR FALLING OUT
- ☐ WEAK/BRITTLE NAILS

RESPIRATORY:

- ☐ COUGH
- ☐ PRODUCTION OF PHLEGM
- ☐ WHEEZING
- ☐ SHORTNES OF BREATH
- ☐ DIFFICULT BREATHING
- ☐ COUGHING BLOOD
- ☐ FREQUENT COLDS/$_{FLU}$/SINUS INFECTIONS
- ☐ CHRONIC ALLERGIES

ALLERGIC TO:

- ☐ MOLD
- ☐ CEDAR
- ☐ PET FUR
- ☐ DUST
- ☐ POLLEN
- ☐ OAK
- ☐ HAY FEVER
- ☐ ENVIRONMENTAL SENSITIVITY

HEAD, EAR, EYES, NOSE, THROAT:

- ☐ HEADACHES
- ☐ MIGRAINES
- ☐ JAW PAIN / TMJ

-- -

- ☐ IMPAIRED HEARING/HEARING LOS
- ☐ EARACHES
- ☐ RINGING IN EARS
- ☐ DIZZINES

-- -

- ☐ SPOTS IN FRONT OF EYES
- ☐ POOR NIGHT VISION
- ☐ DOUBLE OR BLURRED VISION
- ☐ EYE PAIN/STRAIN
- ☐ CONTACTS/GLASSES
- ☐ TEARING OR DRYNES
- ☐ ITCHY EYES
- ☐ RED/INFLAMED EYE

-- -

- ☐ SINUS PROBLEMS
- ☐ NASAL OBSTRUCTION
- ☐ RUNNY NOSE
- ☐ SNEEZING
- ☐ NOSE BLEEDS
- ☐ LOSS OF SMELL

- -

- ☐ TEETH PROBLEMS
- ☐ MOUTH ULCERS
- ☐ SORES ON TONGUE
- ☐ BAD BREATH
- ☐ BLEEDING GUMS
- ☐ DRY MOUTH
- ☐ ORAL THRUSH
- ☐ RECURRENT SORE THROAT
- ☐ HOARSENES
- ☐ DIFFICULTY SWALLOWING

EMOTIONAL/MENTAL/PSYCHOLOGICAL:

- ☐ INSOMNIA
- ☐ NERVOUSNES
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ MOOD SWINGS
- ☐ IRRITABILITY
- ☐ OFTEN FEEL ANGRY
- ☐ POOR MEMORY
- ☐ DIFFICULTY CONCENTRATING
- ☐ MENTAL RESTLESSNES
- ☐ WORRY
- ☐ FEEL SAD A LOT
- ☐ CRY UNCONTROLLABLY
- ☐ TERRORS
- ☐ MUCH FEAR
- ☐ HISTORY OF ABUSE
- ☐ CONSIDERED OR ATTEMPTED SUICIDE

DIGESTIVE:

- ☐ NAUSEA
- ☐ VOMITING
- ☐ LOW APPETITE
- ☐ EXCESSIVE HUNGER
- ☐ HYPOGLYCEMIA
- ☐ FATIGUE AFTER MEAL
- ☐ STOMACH ULCER
- ☐ REFLUX/ HEARTBURN
- ☐ DIARRHEA /LOOSE STOOL
- ☐ GAS
- ☐ BLOATING
- ☐ INDIGESTION
- ☐ STOMACH ACHE
- ☐ ABDOMINAL PAIN
- ☐ CONSTIPATION
- ☐ HEMORRHOIDS
- ☐ GALLSTONES
- ☐ JAUNDICE
- ☐ BLOOD IN STOOL
- ☐ EATING DISORDER
- ☐ LESS THAN 1 BM A DAY

LIFESTYLE:

- ☐ VEGETARIAN
- ☐ HEALTHY DIET
- ☐ EAT MUCH FRIED FOODS
- ☐ EAT MUCH MEAT
- ☐ SMOKE CIGARETTES
- ☐ DRINK ALCOHOL
- ☐ DRINK COF FEE
- ☐ USE DRUGS
- ☐ EAT A LOT OF SWEETS
- ☐ EXERCISE REGULARLY

CARDIOVASCULAR:

- ☐ CHEST PAIN
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ PALPITATIONS
- ☐ POOR CIRCULATION
- ☐ IRREGULAR HEARTBEAT
- ☐ FAINTING
- ☐ BLOOD CLOTS
- ☐ SWELLING OF ANKLES
- ☐ VARICOSE VEINS

URINARY TRACT:

- ☐ FREQUENT URINATION
- ☐ FREQUENT NIGHT URINATION
- ☐ POOR BLADDER CONTROL
- ☐ BURNING/PAIN ON URINATION
- ☐ DILUTE URINE
- ☐ DARK URINE
- ☐ CLOUDY URINE
- ☐ SCANTY URINE
- ☐ PROFUSE URINE
- ☐ FREQUENT INFECTION
- ☐ BLOOD IN URINE
- ☐ KIDNEY STONES

MUSCULOSKELETAL:

- ☐ PAIN / WEAKNESS / NUMBNESS
  - ☐ ARMS
  - ☐ FEET
  - ☐ HANDS
  - ☐ JOINTS
  - ☐ LEGS
  - ☐ HIPS
  - ☐ NECK
  - ☐ SHOULDERS
  - ☐ BACK
  - ☐ PAIN AL OVER
- ☐ MUSCLE SPASMS/CRAMPS
- ☐ JOINT STIFFNES
- ☐ BROKEN BONES

MALE:

- ☐ PROSTATE PROBLEMS
- ☐ TESTICULAR PAIN/SWELLING
- ☐ DISCHARGE
- ☐ ERECTILE DYSFUNCTION
- ☐ NOCTURNAL EMISSION
- ☐ FERTILITY PROBLEMS
- ☐ EJACULATION PROBLEMS

FEMALE:

- ☐ MAY BE PREGNANT
- ☐ PERI-MENOPAUSAL
- ☐ COMPLETED MENOPAUSE
- ☐ PARTIAL / TOTAL HYSTERECTOMY
- ☐ CHRONIC VAGINAL INFECTIONS
- ☐ ABNORMAL PAP
- ☐ ENDOMETRIOSIS
- ☐ OVARIAN CYST
- ☐ UTERINE FIBROIDS
- ☐ UTERINE PROLAPSE
- ☐ IRREGULAR CYCLE
- ☐ PMS
- ☐ LONG TIME SPANS W/ NO PERIOD
- ☐ BLEEDING BETWEEN PERIODS
- ☐ MENSTRURAL CRAMPS
- ☐ PAINFUL OVULATION
- ☐ PAINFUL PERIODS
- ☐ HEAVY PERIODS
- ☐ SCANTY PERIODS
- ☐ CLOTS
- ☐ BREAST LUMPS

PERIOD LASTS_____DAYS

_____DAYS BETWEEN PERIODS

Number of:

PREGNANCIES

ABORTIONS

MISCARRIAGES

BIRTHS

Anything else you want to tell us about?

SUMMARY OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For complete details, please read the NOTICE OF PRIVACY PRACTICES that is available in our office.

I. How we may use and share health data about you:

a) Treatment - To give you medical treatment or other types of health services.
b) Payment - To bill you or a third party for payment for services provided to you.
c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have read this SUMMARY OF PRIVACY PRACTICES and understand that I may request the full NOTICE OF PRIVACY PRACTICES document from South Austin Community Acupuncture at any time.

_____

Signature of Patient or Representative Date

INFORMED CONSENT TO TREATMENT

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of acupuncture. Methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, bodywork, and nutritional counseling.

I am hereby informed that the aforementioned treatment methods are al generally safe but that there may be some side effects or risks, as follows:

Acupuncture may potentially cause temporary bruising, swelling, bleeding, numbness and tingling, or soreness at the site of needling. Unlikely risks of acupuncture include lung puncture (pneumothorax), nerve damage, organ puncture, and infection - although South Austin Community Acupuncture uses only sterile, disposable needles and maintains a clean and safe environment.

Potential risks of moxibustion include blistering, burns, and scarring. Common side effect of cupping and gua sha are temporary bruising and redness lasting a few days.

The herbal and nutritional supplements (which may be from plant, animal, or mineral sources) recommended to me by my practitioner are generally safe in the traditionally recommended doses. Possible side effects of herbs include nausea, gas, stomache ache, diarrhea, and headache. Unusual side effects of herbs include vomiting, rashes, hives, and tingling of the tongue.
I understand I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reaction.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy and could induce miscarriage.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose, although I do not expect my practitioner to be able to anticipate and explain al possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand that my acupuncturist may review my medical records and lab reports, but al my records will be kept confidential. My health information will be handled in accordance with the Summary of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment; payment and healthcare operations received, incurred or carried out at this practice.

_____

Signature of Patient or Representative Date

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 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 (patient's name) _____, am 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 recognize 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 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 and choice whether to follow this advice.

Signature _____ Date _____

Optional Form to be Completed by Patient, Attesting that the Acupuncturist Has Referred Him/Her

(Pursuant to the requirement 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.)

The acupuncturist has referred me to see a physician. It is my responsibility and choice whether to follow his or her advice.

Patient's signature _____ Date _____

Acupuncturist's signature _____ Date _____