

Form Instructions:

- Please use only BLACK INK to fill out form.
- Do not email form back to us.
- Please bring this form, completed and signed, with you to your appointment.

PATIENT INFORMATION CONFIDENTIAL

Legal Name:

Last	First	Middle	<input type="checkbox"/> Male <input type="checkbox"/> Female
Physical address only – P.O. Box is not accepted.		Birth date:	Age:
Address:		City, State	Zip
Phone:		Email:	
Emergency contact:		Relationship:	Phone:

HEALTH HISTORY:

<ul style="list-style-type: none"> • Have you had acupuncture before? <input type="checkbox"/> No <input type="checkbox"/> Yes • Have you taken Chinese herbs before? <input type="checkbox"/> No <input type="checkbox"/> Yes 	<ul style="list-style-type: none"> • Are you wearing a pacemaker? <input type="checkbox"/> No <input type="checkbox"/> Yes Other device implant: _____
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Major surgeries:	Date:
_____ / _____	_____
_____ / _____	_____
_____ / _____	_____

Current medications:	For purpose:	How long?
_____ / _____	_____ / _____	_____
_____ / _____	_____ / _____	_____
_____ / _____	_____ / _____	_____
_____ / _____	_____ / _____	_____
_____ / _____	_____ / _____	_____

Supplements:	Allergic to: _____
_____	_____
_____	Health/diet restrictions:
_____	_____
_____	_____

- Energy level: Very low Low – Moderate High
- Stress level: Low Medium High Very high
- Urination: Normal Too little Frequent Often at night
- Bowel movement: Daily Constipated: _____ X per week
- Sleep: Feel rested upon waking Tired upon waking Wake often during night Disturbing dreams
- Body temperature:

Day	<input type="checkbox"/> Normal	<input type="checkbox"/> Mostly cold	<input type="checkbox"/> Warm – Hot: __hands __feet __chest/abdomen __back __neck __face/head
Night	<input type="checkbox"/> Normal	<input type="checkbox"/> Mostly cold	<input type="checkbox"/> Warm – Hot: __hands __feet __chest/abdomen __back __neck __face/head

PATIENT'S NAME: (Last) (First) (Middle)

HEALTH HISTORY:

Please (✓) all that applies currently or within the past year:

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> cough chronic | <input type="checkbox"/> Liver disorders | <input type="checkbox"/> Kidney stone |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Eye disorders | <input type="checkbox"/> Prostate disorders |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> A B C D E | <input type="checkbox"/> Migraines/headaches | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Impotence (men) |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Gallstone | <input type="checkbox"/> Sleep disorder | <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Groin pain |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> HIV+ | <input type="checkbox"/> Arthritis-rheumatoid | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Genital pain/sores |
| <input type="checkbox"/> Hyperglycemia | <input type="checkbox"/> AIDS | <input type="checkbox"/> Arthritis-osteo | <input type="checkbox"/> Burning urination | <input type="checkbox"/> Penile discharge |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> STD | <input type="checkbox"/> Gout | <input type="checkbox"/> Difficulty to urinate | <input type="checkbox"/> Nocturnal emission |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heartburn/reflux | <input type="checkbox"/> Scanty urine | <input type="checkbox"/> Intercourse pain |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Cold/Flu | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Allergy | <input type="checkbox"/> Bloating/gas | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Bowel incontinence |
| <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Prolapsed organ |
| <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Sinus | <input type="checkbox"/> Constipation | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Hernia hiatal |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Diarrhea chronic | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Hernia inguinal |

Other condition(s): _____

Pain (location):

How long?

Severity of Pain:

- | | | | | | | | | | | | | | |
|-------|-------|--------|---|---|---|---|---|---|---|---|---|----|---------|
| _____ | _____ | Lowest | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Highest |
| _____ | _____ | Lowest | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Highest |
| _____ | _____ | Lowest | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Highest |

- | | | | | |
|--|--|------------------------------------|---------------------------------------|-----------|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Acute stress | Other mood/mental disorders: _____ | Addictions: | How long? |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Post-traumatic stress | | <input type="checkbox"/> Cigarettes | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anger/irritability | | <input type="checkbox"/> Alcohol | _____ |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> Phobias | | <input type="checkbox"/> Other drugs: | _____ |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> OCD | | | |

Women Only:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> PMS (severe) | <input type="checkbox"/> Mastitis/lumps | <input type="checkbox"/> Vaginal infections recurring | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Painful period | <input type="checkbox"/> Ovarian cysts/PCOS | <input type="checkbox"/> Pelvic Inflammatory Disease | <input type="checkbox"/> Menopause disorders |
| <input type="checkbox"/> Heavy period | <input type="checkbox"/> Fibroids uterine | <input type="checkbox"/> Habitual miscarriage | <input type="checkbox"/> Pregnancy disorders |
| <input type="checkbox"/> Irregular period | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Infertile | <input type="checkbox"/> Postpartum disorders |
| <input type="checkbox"/> Absence of period | <input type="checkbox"/> Abnormal discharge | <input type="checkbox"/> Prolapsed uterus | other _____ |

- Contraceptives: _____
- Hysterectomy: Complete Partial date: _____
- How many: ___ C-sections ___ Vaginal births ___ Miscarriages ___ Abortions

MENSTRUATION:

- Date of last period: _____ Total days: _____
- Volume: Normal Light Heavy _____ days
- Regular Irregular
- Consistency: Normal Thick/sticky Thin Watery
- Breast tenderness: No Yes
- Clots: None Few A lot Big Small
- Water retention: No Yes
- Color: Pale red Red-bright red Dark red Br/Blk
- Cramps/pain: Abdomen Low back Head
- Strong odor: No Yes
- Low Medium Severe Before During After
- Mood: Irritable/angry Depressed Crying spells

Are you currently pregnant? No Yes _____ months _____ weeks • Breastfeeding? No Yes

Cancer history:

- Type of cancer: _____ from _____ to _____, Active Remission date _____
- Treatment method(s):
 Chemo / from _____ to _____ Radiation / from _____ to _____ Surgery Other _____

PATIENT'S NAME: (Last) _____ (First) _____ (Middle) _____

NOTIFICATION OF PRIOR EVALUATION BY A PHYSICIAN

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

I (Patient's name) _____ am notifying St. Teresa Acupuncture Wellness Clinic, 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 understand that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist. Patient's Initial 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 2 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. Patient's Initial 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.

PATIENT'S ACKNOWLEDGMENT:

- Patient acknowledges that all information provided in this form is truthful and correct.
- Patient, or representative of patient, is at least 18 years of age on the date of signing this form.
- If patient becomes pregnant or believes that she may be pregnant while undergoing treatment at St. Teresa clinic, it is patient's responsibility to immediately inform acupuncturist.
- While being present for treatment at St. Teresa clinic, patient is not permitted to handle needles or any treatment implements. Patient shall not attempt to perform on oneself, or on any person, any treatment procedure including but not limited to inserting needles, withdrawing needles, manipulating needles, cupping, moxibustion, bloodletting, or electric stimulation. Violation will result in the denial of all services to patient permanently. St. Teresa clinic policy applies to the patient as well as any person accompanying patient in the treatment room.
- Patient understands that if patient falsifies any information in this form, refuses to provide the requested information, or refuses to sign any parts of this form, St. Teresa Acupuncture Wellness Clinic reserves the right to deny all services to patient.

Signature of Patient (or Representative) _____ Date _____

Representative's Name: _____ / _____
PRINT Relationship