HONEYSUCKLE **A**CUPUNCTURE **C**LINIC

INFORMED CONSENT TO CHINESE MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturists on staff at the Honeysuckle Acupuncture Clinic (HAC) who now or in the future treat me while employed by, working or associated with or serving as back-up for HAC, including those working at this clinic: acupuncture and other Chinese Medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle, etc.; modes of manual or physical therapy such as Asian body work, acupressure, insertion and manipulation of acupuncture needles, administration of thermal or electrical treatments, moxibustion; energy flow exercise; the prescription of herbal as well as dietary supplements; dietary recommendation; exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with my professional practitioner, and/or with other clinic personnel the nature and purpose of acupuncture and Chinese Medicine procedures. Although I am aware that acupuncture and the other procedures used in Chinese Medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Chinese Medicine there are some risks of treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, puncture of organs, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, blisters, aggravation of current symptoms, appearance of new symptoms, general aches, fatigue, dark red or purple marks from cupping, skin itching, redness, discomforts from taking herbs, sprains, strains, dislocation, miscarriage, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner, to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts known, to be in my interest. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. 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 at the Honeysuckle Acupuncture Clinic.

_____	_____
Patient's name (please print)	Patient's signature
_____	_____
Date signed	Witness
_____	_____
Print name of patient's representative (if applicable)	Relationship or authority of patient's representative
_____	_____
Signature of patient's representative (if applicable)	Date Signed

HONEYSUCKLE **A**CUPUNCTURE **C**LINIC

Notification Form Regarding Evaluation of Patient by Physician

(Pursuant to the requirement of 22 T.A.C section 183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ Code Ann., section 205.351, governing the practice of acupuncture)

I (patient's name), _____ am notifying the Honeysuckle Acupuncture Clinic 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 I should be evaluated by a physician or dentist 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 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 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 symptoms related to one or more of the following conditions:

OR

___ Chronic Pain ___ Smoking addiction
___ Weight loss ___ Alcoholism
___ Substance abuse

Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

_____

Patient Signature (required) **Date**

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

_____

Patient Signature (required) Date

_____

Acupuncturist's Signature Date

The Honeysuckle Acupuncture Clinic is not responsible for untrue statements made by patients.

Honeysuckle **A**cupuncture **C**linic

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the Honeysuckle Acupuncture Clinic (HAC) "Notice of Privacy Practices". I understand that I have the right to review HAC's "Notice of Privacy Practices" prior to signing this document.

I understand that HAC 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 I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

Information stripped of any personal identifiers may also be used for research and educational purposes by individual practitioners or HAC. By signing this form, I am giving Honeysuckle Acupuncture Clinic authorization to contact me with these reminders and to utilize my information for research and educational purposes.

_____ _____

Patient Name (print) Date

_____ _____

Patient Signature HAC Privacy Rep/Date

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize the Honeysuckle Acupuncture Clinic the use or disclosure of my individually 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

Honeysuckle Chinese Acupuncture Clinic

8711 Burnet Road, A20, Austin, TX 78757 TEL: 512-374-4988 www.HoneysuckleAcupuncture.com

Client Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name		Gender: □ F □ M	Martial Status:	#of Children Date
Date of birth	Age	Occupation		Employer
Main phone #	Other phone #		Emergency contact name & phone	
E-mail address			Allow email contact by HCA	□ Yes □ No
Address: Street		City	State	Zip
Family physician	Tel:	Chiropractor		Tel:
Name of insurance company			Does your insurance cover acupuncture?	□ Yes □ No □ ?
Have you ever been treated by acupuncture before? □ Yes □ No Have you ever taken Chinese Herbs? □ pills / tablet □ powder □ raw / bulk				
How did you find out about our clinic?				

Reason for Visit (What diagnosis, if any, have you received for this problem):

_____

When did this problem begin? _____ What are the causes of this problem? _____

What kind of treatment have you tried? _____

What makes this problem worse? _____What makes this problem better? _____

Is there anybody in your family with the same/similar problems? _____

Medical History (Please indicate with a '**P**' (past) '**C**' (current) '**F**' (family) if any of the conditions below apply):

	Heart conditions		High blood pressure		Stroke		Respiratory conditions
	Diabetes		Depression or anxiety		Neurological		Spinal or head injury
	HIV/AIDS		Dizziness/fainting		Cancer		Headaches/migraines
	Hepatitis		Sprain/Strain/Fracture		Venereal disease		Epilepsy
	Thyroid disease		Deep vein thrombosis		Haemophiliac		Wear a pacemaker
	Lung condition		Digestive problems		Osteoarthritis		Possibility of pregnant
	Kidney disorder				Rheumatoid Arthritis		Upcoming Surgeries

Do you use the following? If so how often? Cigarettes: _____ Alcohol: _____ Drugs: _____ Coffee: _____ Pop: ____

Do you exercise regularly □ Yes □ No Please describes your exercise program: _____

Hours sleep in general _____Times go to bed _____Do you feel refreshed in the morning? □ Yes □ No

Are you a vegetarian? □ Yes □ No □ Yes, but not so strict Do you eat a lot of spicy food? □ Yes □ No

Please indicate the proportions of the following food you eat most: Proteins_____ Vegetable _____ Carbes _____

Significant trauma: (auto accidents, sports injuries, etc) _____

Allergies: (drugs, chemicals, foods, environmental):_____

Have you been hospitalized and/or treated for any infectious/serious conditions or surgeries? If yes, briefly explain for what condition or reasons and the year (below).

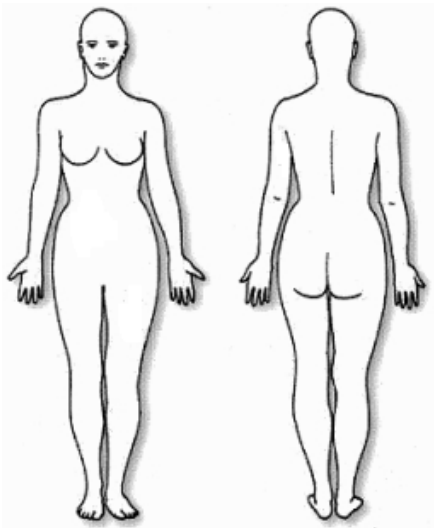
Please list herbal medicine and other supplements currently taking:

Herbs/supplements	Reason to take	Herbs/supplements	Reason to take
1.		3.	
2.		4.	

Please list any prescription medication or over the counter drugs currently taking:

Prescription medication	Reason to take	Prescription medication	Reason to take
1.		4.	
2.		5.	
3.		6.	

On the figures right, please circle the areas of concern/pain:



Sensations/pain characteristics (circle):

Sharp __ Burning __ Moving __ Tingling __ Dull __ Severe__

Stabbing __ Shooting __ Throbbing __ Numbness __

Muscle pain ____ Joint pain ____

Pain level (please scale your pain level from 1-10):

Constant _____

At certain position or movement _____

What relieves the pain? (circle) ice, rest, activity, massage, heat

What aggravates the pain? (circle) weather, heat, cold, rest, activity

For each symptom below that you currently have, rate its severity from 1-5 (5 being worst). Leave blank if N / A.

Gan
___ Irritability / frustration / impatient
___ Depression / Stress
___ Emotional eating
___ Unfulfilled desires
___ Visual problems / floaters
___ Blurred vision / poor night vision
___ Red / Dry / Itchy eyes
___ Headaches / Migraines
___ Dizziness
___ Feeling of lump in throat
___ Muscle twitching / spasm
___ Neck / shoulder tension
___ Brittle nails
___ Sighing
___ Sensation or pain under rib cage
___ PMS
___ Genital itching / pain / lesions

Xin
___ Palpitations
___ Chest pain / tightness
___ Insomnia / Sleep problems
___ Restless / easily agitated
___ Vivid dreams
___ Lack of joy in life
___ Forgetful
___ Aversion to heat
___ Bitter taste in mouth
___ Tongue / mouth ulcers / cankers

Shen
___ Frequent urination
___ Bladder infection
___ Lack of Bladder control
___ Wake to urinate
___ Feel cold easily
___ Cold hands / feet
___ Night sweats / hot flushing
___ Low sex drive
___ High sex drive
___ Loss of head hair
___ Hearing problems
___ Crave salty food
___ Fear
___ Poor long term memory
___ Ankle swelling
___ Tinnitus

Fei
___ Dry cough
___ Cough with Phlegm
___ Nasal discharge / drip
___ Sinus infection / congestion
___ Itchy / painful throat
___ Dry mouth / throat / nose
___ Skin rashes / hives
___ Snoring
___ Grief / sadness
___ Shortness of breath
___ Allergies / asthma
___ Weak immune system
___ Alternate fever / chills

Pi
___ Heaviness in the head / body
___ Fatigue / after eating
___ Difficult getting up in morning
___ Water retention
___ Muscular tired / weak
___ Bruise easily
___ Unusual bleeding (stool, nose, etc)
___ Bad breath
___ Poor appetite
___ Increased appetite
___ Crave sweets
___ Poor digestion
___ Nausea / vomiting
___ Bloating / gas
___ Hemorrhoids
___ Constipation
___ Loose stool
___ Alternate constipation / loose
___ Abdominal pain
___ Intestinal pain / cramping
___ Heartburn
___ Pensive / over-thinking
___ Overweight
___ Foggy mind
___ Yeast infection
___ Aversion to cold
___ Cold nose
___ Increased Thirst
___ Prefer Warm / Cold drinks
___ Sweat easily

Date last menses began	Is your menstrual cycle: Regular ___ Irregular ___
Menstrual cycle length (i.e. 26-30 days)? How old were you when you had your first menstruation?	
How many days do you bleed in total? Describe your flow: Heavy ___ Light ___ Average ___ Consistency of blood: Watery ___ Thick ___ Average ___ Does your blood contain clots? Yes __ No __ ...and... At which point during the cycle? Start __ Mid __ End __ Describe the color of your blood: (red, dark red, brown, purple, brownish red, bright red, pink, etc)	
Do you experience menstrual pain? Yes __ No __ What relieves the pain?	Before menses ____ During_____ After ____ Stabbing ___Cramping __ Dull __ Heavy ___ On/off __
Do you experience Pre-menstrual symptoms (PMS)? Please check all that apply. Breast tenderness ___ Cramps ___ Acne ___ Change in Bowel ___ Bloating ___ Headaches ___ Nausea ___ Moodiness ___ Fatigue ___ Night sweats ___ Sleep disturbances ___ Please list any other pre-menstrual symptoms:	
Do you ovulate on your own? Yes ___ No ___ What Day? _____ Do you chart your cycle? (circle) BBT / Ovulation sticks Do you experience pain around ovulation? Yes ___ No ___ Do your breasts get tender around ovulation? Yes ___ No ___ Do you notice stretchy clear egg white slippery cervical mucous around ovulation? Yes ___ No ___	
How many times have you been pregnant? _____ How many times have you given birth? _____ Ages of children _____ Sex of Children _____ Have you had any miscarriages? Yes ___ No ___ If yes, how many, at how many weeks pregnant, and in what year(s)?	
How many times have you had a D&C preformed? _____ How many abortions have you had? _____ In what year(s)? _____ Were there any problems that occurred during these pregnancies? _____	
Have you ever been diagnosed with STD? ……. Yes__ No__ If answered yes, list STD's: _____ Pelvic inflammatory disease? ……. …… …… Yes__ No__ Uterine fibroids? ……. …… …… Yes__ No__ Polyps? ……. …… …… Yes__ No__ Pelvic adhesions? ……. …… …… Yes__ No__ Prolapsed uterus? ……. …… …… Yes__ No__ Unique shape of uterus? ..... ……..... Yes__ No__ Endometriosis? ……. …… …… …… Yes__ No__ PCOS (polycystic ovarian syndrome)? ……. ….. Yes__ No__	
Date of last pap smear: _____/_____/_____ (dd/mm/yyyy) Have you ever had an abnormal pap smear? Yes ___ No ___ Have you ever had a cervical biopsy or operation? Yes ___ No ___ Do you get yeast infections regularly? Yes ___ No ___ Do you get bladder infections regularly? Yes ___ No ___	
Do you experience vaginal discharge? Yes ___ No ___ If yes, what colour? White ___ Yellow ___ Green ___ Pinkish ___ Red ___ If yes, what consistency? Watery / thin ___ Thick ___ Sticky ___ If yes, does it have foul odour? Yes ___ No ___	
Have you taken oral contraceptives? Yes ___ No ___If yes, for how long? _____When did you stop? _____ Have you ever had an IUD? Yes ___ No ___ Have you ever taken Depo-Provera? Yes ___ No ___	

I have completed this form correctly to the best of my knowledge.

Signature:

□ Adult Patient □ Parent or Guardian □ Spouse