Good Point Acupuncture Patient Health History

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire (FRONT AND BACK)as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Name: ________________________________ Date of Birth: _____/_____/_____ Today's Date: ______/______/______

Age: ________ Phone: ________________________ E-Mail: ____

Address: ___________________________________ City: _______________________ ST:________ Zip: ______________

Occupation: ____________________________ Employer: _________________________

In emergency notify: ______________________________ Phone: ________________________

Have you ever been treated by acupuncture before? Yes No Referred by: ____

Health Concerns: Why are you coming for treatment?

____

____

When did this problem begin? _________________________ What are the precipitating factors? ______________________________

Have you been given a diagnosis for this problem? If so, what? ____

What makes this problem worse? _____________________________ What makes this problem better? ___________________________

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

____

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you have taken within last 2 months:

____

Do you have any reason to believe you may be pregnant? Y N How far along? _________________________________

Do you have any infectious diseases? Y N If yes, please identify: ____

Significant Trauma (auto accident, injuries, surgeries) please also list when:

____

____

On the back of this page, please check mark any of the conditions that you are currently experiencing or that is of major concern

I understand and guarantee this form was completed to the best of my knowledge.

Signature: ____ **Date:** _______________________________

Musculoskeletal System

- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Shoulder pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm Problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Numbness
- ☐ Tingling
- ☐ Broken bones
- ☐ Osteoperosis

Respiratory Cardio-Vascular

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficulty breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Frequent Colds
- ☐ Asthma
- ☐ Rapid heartbeat
- ☐ High blood pressure
- ☐ Low Blood pressure
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

Neuro-psychological

- ☐ Mood swings
- ☐ Nervousness
- ☐ High stress
- ☐ Depression
- ☐ Anxiety
- ☐ Bad temper
- ☐ Poor concentration
- ☐ Insomnia
- ☐ Bi-polar
- ☐ Seizure/Epilepsy
- ☐ Numbness
- ☐ Tingling
- ☐ Paralysis

Head, Eye, Ear, Nose & Throat

- ☐ Dizziness
- ☐ Headaches
- ☐ Migraines
- ☐ Vision problems
- ☐ Eye inflammation
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Ear ringing
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Allergies
- ☐ Dental problems
- ☐ Jaw pain
- ☐ Sore/Bleeding gums
- ☐ Frequent sore throat
- ☐ Difficult speech
- ☐ Cataracts

Gastro-Intestinal System

- ☐ Poor appetite
- ☐ Nausea/Vomiting
- ☐ Abdominal pain
- ☐ Gas
- ☐ Heartburn
- ☐ Ulcers
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Hemorrhoids
- ☐ Liver disease
- ☐ Gallbladder disease
- ☐ Hepatitis B or C
- ☐ Excessive thirst

Genito-Urinary Tract

- ☐ Kidney disease/Stones
- ☐ Painful urination
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Blood in urine
- ☐ Frequent UTI
- ☐ Incontinence

Male Reproductive

- ☐ Sexual difficulties
- ☐ Prostrate problems
- ☐ Testicular pain or swelling
- ☐ Penile discharge

Female Reproductive

- ☐ Irregular cycles
- ☐ PMS
- ☐ Painful periods
- ☐ Bleeding between cycles
- ☐ Breast lumps
- ☐ Breast pain
- ☐ Vaginal pain
- ☐ Frequent vaginal infections
- ☐ Vaginal discharge
- ☐ Fibroids
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Difficulty conceiving
- ☐ Miscarriage
- ☐ Menopausal symptoms

Skin & Hair

- ☐ Rashes
- ☐ Itching
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Dandruff
- ☐ Dry skin
- ☐ Loss of hair

Endocrine

- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Hypoglycemia
- ☐ Diabetes

Habits

- ☐ Alcohol __________per week
- ☐ Cigarettes _________ per day
- ☐ Caffeine _______ cups per day
- ☐ Recreational Drug Use
- ☐ Exercise _________ per week
- ☐ ___________________________
- ☐ ___________________________
- ☐ ___________________________

Good Point Acupuncture Consent to Treatment Form

I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand I have an opportunity to discuss with my professional practitioner the nature and purpose of acupuncture and oriental medical procedures. I understand that no guarantee of cure or improvement in my condition is given or implied and that I am free to stop acupuncture treatment at any time.

By signing below, I do hereby voluntarily request and consent to the performance of the following on myself (or the patient named below for whom I am legally responsible) by a licensed acupuncturist at Good Point Acupuncture: acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, heat/and/or cold therapy and electrical and/or magnetic stimulation, cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendation; exercise advice and healthy lifestyle counseling

I understand and am informed that, as in the practice of allopathic medicine, in the practice of oriental medicine, there are some risks to 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: slight bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, minor burns, scarring, fainting, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioner 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 then known, to be in my best interest.

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.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Good Point Acupuncture as soon as possible.* I understand that herbs and supplements are not returnable or refundable for and reason. Even if they have not been opened.

Liability for Payment: I understand that I am responsible for full payment at the time of service, before the treatment is given. This is because many patients experience such a relaxed feeling after treatment that they often walk out and forget to pay.

Cancellation/No Show Policy: If you have an appointment scheduled with us, we are saving a chair just for you. In order to maintain affordable prices, we ask for 24 hours of advance notice if you must cancel or reschedule an appointment. This gives us time to fill the vacant slot in our schedule, allows us to serve someone else, and helps us keep rates affordable. You may cancel or reschedule an appointment by phone or by using our online appointment scheduler. You may also leave us a voicemail outside of regular business hours. We do not text. Please note that there is a $25 fee for appointments that are cancelled or rescheduled with less than 24 hours' notice, and for missed or "no-show" appointments. There are exceptions for emergencies.

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 Good Point Acupuncture.

______________________________	______________________________	
Patient's Name (please print)	Patient's or Representative's Signature	Date
______________________________	______________________________	
Printed Name of Patient's Representative (if applicable)	Relationship of Authority of Patient's Representative	

Good Point Acupuncture
Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, Acupuncture and Oriental medicine are not considered primary care. As a result, we are required to have you respond to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture 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 (patient's name) ____ am notifying the practitioners at Good Point Acupuncture 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.

OR

___ **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.

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:
___ Chronic pain
___ Smoking addiction
___ Weight loss
___ Alcoholism
___ Substance abuse

____
Patient Signature Required   Date

Good Point Acupuncture is not responsible for untrue statements made by patients.

Good Point Acupuncture
2301 Red Bud Ln., Suite 200 Round Rock, TX 78664
512-731-0642

SUMMARY OF PRIVACY PRACTICES

We don't do anything with your health data without your written consent.

We have a complete NOTICE OF PRIVACY PRACTICES that is available in our office if want to read the complete details.

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 Good Point Acupuncture at any time.

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Signature of Patient or Representative Date