WELCOME

Thank you for your interest in acupuncture and Oriental medicine. Our goal is to help you achieve your best health and wellness **naturally**.

Before your Visit:

You should eat a light meal or snack before coming for acupuncture and wear loose, comfortable clothes. Please avoid strenuous exercise for at least two hours before and after treatment. Please come in 10 minutes early if you are a new patient.

Fee Schedule

New patient and follow-up patient, per session:	$70
Herbal Medicines (as needed, depend on dosage & condition)	$10 to $40
Anytime 3 treatment package	$190
Anytime 6 treatment package	$360

Payment Policy:

We accept cash, checks, HSA (FSA), Visa, MasterCard, Discover and American Express as forms of payment.

Insurance:
We are an out-of-network provider. If your insurance policy covers acupuncture services, we will provide a Superbill, which you can then submit for reimbursement. Please check with your insurer.

Appointment Cancellation Policy:

Your appointment time is reserved specifically for you. In the event of an appointment to be missed, please give 24 hours notice, either by phone, email, or text messaging.

PATIENT INFORMATION

Date: _____/____/____ Your Phone #: _____

Name: _____Date of Birth:____/____/_____

Address: _____

City:_____State:_____Zip/Postal Code:_____

Email:_____

Sex: _____Male ____Female

Marital Status: ___Single ____ Married ____Divorced ____Separated ___Widowed

Occupation/Job:_____

Emergency Contact Information:_____Their Phone #:_____
Primary Care Physician (PCP)/Doctor:_____ Their Phone #: _____

How did you hear about us?

_____

HEALTH HISTORY

PLEASE CHECK ANY SYMPTOMS YOU HAVE ON A REGULAR BASIS:

General

- ☐ Chills
- ☐ Dizziness
- ☐ Fatigue
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Insomnia
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweating
- ☐ Weight Gain
- ☐ Weight Loss

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Black Stools
- ☐ Bloating
- ☐ Bloody Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult Swallowing
- ☐ Gas
- ☐ Heartburn/GERD
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Vomiting
- ☐ Vomiting Blood

Heart/Cardio-Respiratory

- ☐ Asthma
- ☐ Chest Pain
- ☐ Coughing Blood
- ☐ Blood Pressure (High/Low)
- ☐ Irregular Heart Beat
- ☐ Night Sweating
- ☐ Chronic Cough
- ☐ Phlegm/Sputum
- ☐ Poor Circulation
- ☐ Chronic Bronchitis
- ☐ Short of Breath
- ☐ Swelling of Ankles/Feet
- ☐ Varicose Veins

Eyes/Ears/Mouth/Nose/Throat

- ☐ Blurry Vision
- ☐ Bleeding Gums
- ☐ Cataracts
- ☐ Double Vision
- ☐ Earache
- ☐ Eye Pain
- ☐ Wear Glasses/Contacts
- ☐ Hay Fever/Allergies
- ☐ Hearing Loss
- ☐ Hoarseness/Loss of Voice
- ☐ Nose Bleeds
- ☐ Loss of Smell
- ☐ Chronic Sore Throat
- ☐ Red Eyes
- ☐ Ringing in the Ears
- ☐ Sinus Problems
- ☐ Sores on Lips/Tongue
- ☐ Taste Changes or Loss of Taste
- ☐ Teeth/Gum Problems
- ☐ Vertigo/Spinning Sensation

Genitourinary

- ☐ Abnormal Urine Color
- ☐ Blood or Pus in Urine
- ☐ Burning Urination
- ☐ Frequent Urination
- ☐ Kidney/Bladder Stones
- ☐ Poor Bladder Control
- ☐ Urgency to Urinate

Musculoskeletal

(Pain, Weakness or Numbness)

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Joints
- ☐ Knees
- ☐ Legs
- ☐ Muscles
- ☐ Neck
- ☐ Shoulders

Skin

- ☐ Blood Clotting Problems
- ☐ Bruise Easily
- ☐ Discoloration
- ☐ Lumps

Men Only

- ☐ Breast Lumps/Enlargement/Discharge
- ☐ Genital Pain
- ☐ Testicular Lumps
- ☐ Penile Discharge
- ☐ Genital Sores
- ☐ Impotence

Women Only

- ☐ Abnormal Pap Smear
- ☐ Bleeding/Spotting Between Periods
- ☐ Breast Lumps/Discharge/Skin Chg
- ☐ Birth Control/Contraceptive Use
- ☐ Irregular Periods
- ☐ Menopausal
- ☐ Painful Periods
- ☐ Menstrual Blood Clots
- ☐ Genital Sores
- ☐ Vaginal Discharge

( ) Pregnancies
( ) Abortions
( ) Miscarriages
( ) Children Born

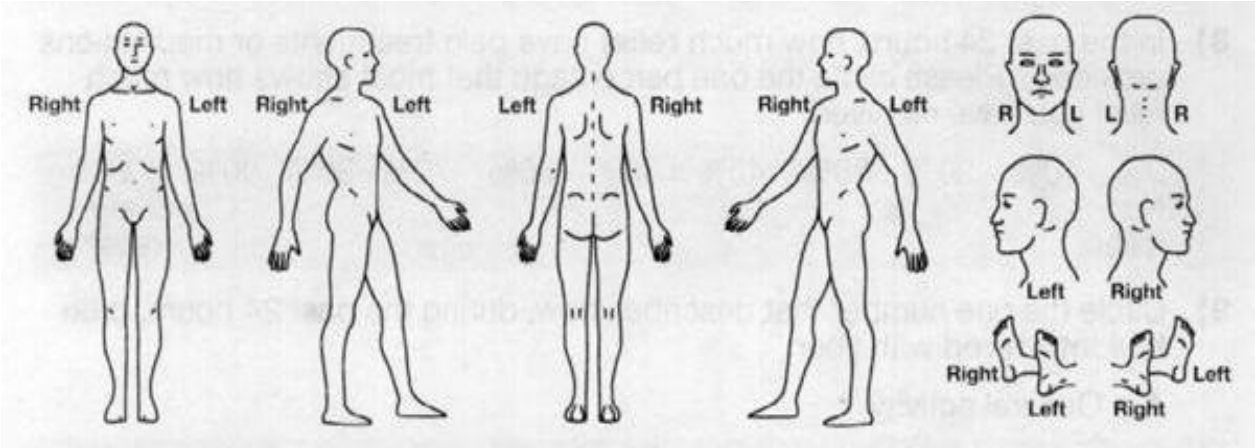
Last Menses: ___/___/____
Last Pap: ___/___/____
Last Mammogram: ___/___/____
Are You Pregnant? _____

Significant Past or Current Illnesses

☐ Cancer	☐ STD
☐ Heart Disease	☐ Hepatitis
☐ Diabetes	☐ HIV/AIDS
☐ High Blood Pressure	☐ Rheumatic Fever
☐ High Cholesterol	☐ Blood Clotting
☐ Thyroid Disease	☐ Stroke
☐ Tuberculosis (TB)	☐ Seizures
	Others_____
	_____

PAIN EVALUATION

Pain Scale:												
no pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**severe pain**



Mark each area where you are having pain according to the pain scale above.

1. Have you ever received treatment for this condition? Yes___No___
   What was their diagnosis? _____
   What treatments were performed? _____
   _____

2. Please list all medications, vitamins, supplements and/or herbs you are currently taking.

Medication Name	Dose	How many per day?	For how long?

3. Please list any allergies: _____
   _____

4. Major Surgeries / Hospitalizations

Date	Procedure / Reason

5. Health Habits (tobacco, alcohol, drugs, special diet, exercise, exposure to chemicals, toxins, etc.)

   _____
   _____
   _____

INFORMED CONSENT TO TREATMENT AND DISCLOSURES

By signing below, I voluntarily consent to be treated with one or all of the modalities listed below by a Texas licensed acupuncturist at The Woodlands Acupuncture & Herbal Clinic. I understand that acupuncturists practicing in the state of Texas **are not** primary care providers and that regular primary care by a licensed physician (M.D. or D.O.) is very important.

Acupuncture/Moxibustion: 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, modify or prevent pain perception, and normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, infection, burns, scars, fainting, pain, discomfort, numbness or tingling at the needling site that may last a up to a few days. More unusual and very rare risks include spontaneous miscarriage, nerve damage and organ puncture.

Chinese/Western Herbs and Nutritional Supplements: I understand that substances from the Oriental Materia Medica and German Commission E Monographs may be recommended to treat bodily dysfunction or diseases, modify or prevent pain perception, and 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 herbs may be inappropriate during pregnancy and that I will notify a clinical staff member who is caring for me if I am or become pregnant. I am aware that adverse side effects may result from taking these substances, including changes in bowel/bladder function, nausea/vomiting, abdominal pain/discomfort, gas, belching, rashes, hives and tingling of the tongue. Should I experience any problems which I associate with these substances, I will stop taking them and call 832-797-7343 as soon as possible.

Acupressure/Tui-Na/Cupping: I understand that I may also be treated with acupressure, tui-na and/or cupping as a way to modify or prevent pain perception and normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, bleeding, sore muscles or aches.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort.

With all modalities listed above I may experience an aggravation of symptoms existing prior to treatment. I understand that I may refuse any or all treatments at anytime and do not expect the staff to be able to anticipate all possible risks or complications of the treatments. I wish to rely on the staff to exercise judgment during the course of treatment which the staff thinks at the time, based upon the facts then known, is in my best interest. I understand that acupuncture, herbs and related treatments, as in any medical therapy, make no guarantee as to the results.

By voluntarily signing below, I acknowledge that I have read, or had read to me, all of the above information and am fully aware of what I am signing. I understand that I may ask the staff for a more detailed explanation. I give my permission and consent to treatment for the entire course of treatment for my current condition and for any future condition(s) for which I seek treatment.

Signature of Patient/Representative: _____ Date: _____

Print Patient/Representative Name: _____

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 T.A.C. §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 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.

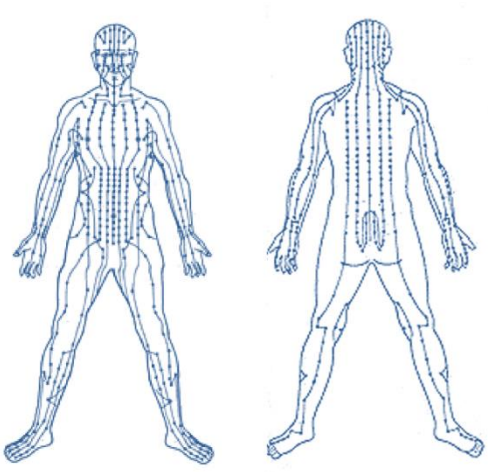
Signature_____ Date_____

Exemption according to 22 T.A.C. §183.7c of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice).

(c) Notwithstanding subsections (a) and (b) of this section, 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.

Date:_____

NEW PATIENT INITIAL ASSESSMENT



Patient Name:_____

Age:_____ Gender:_____
Date of Birth:_____
BP:____/_____ Pulse:_____
RR:_____ Temp:_____
Weight:_____ Height: _____
O2 sat: _____

Office Use Only:

1. **Chief Complaint**

2. Pain Numerical Rating (1 to 10): Current_____Worst_____Least_____

Temporal Parameters (better, worse, same): AM_____ PM_____

Positional Parameters (better, worse, same): Standing_____ Sitting_____

Lying: Prone (Face Down)_____Supine (Face Up)_____Lateral

(R or L)_____

Factors Affecting Pain: Makes Worse_____
Makes Better_____

Work Activities: Extramural_____
Housework_____
ADL_____

3. Mood: _____Normal _____Depressed _____Anxious

Affect: _____Normal _____Depressed _____Elevated _____Flat
_____Reactive _____Agitated

4.General Questions

Energy: _____High _____Med _____ Low
___Fever___Chills Fever___Chills (=,<,>) _____

___Spontaneous Sweating ___Night Sweating _____

5. Appetite: ___Normal ___Increased ___Decreased ___Special Cravings:_____
_____

6. Digestion:_____
_____

7. Bowel Movement:_____
8. Thirst:___No___Yes Preference for: ___Cold___Warm___Room Temperature drink ___ No Preference
_____

9. Urination:___Normal ___Abnormal:_____
_____

10. Body Thermal Feeling: ___Normal ___Abnormal:_____
_____

11. Weight:_____Normal _____Loss___Gain How much?(kg/lbs)_____ In how long?_____

12. Sleep:_____
_____
13. (Women Only) Menstruation:___Regular___Irregular___PMS___Clots_____
_____
_____
_____
_____

14. Physical Examination

General:_____
_____

Tongue:_____

Pulse:_____

Other:_____

15. TCM Diagnosis:_____
_____

16. Treatment Plan: _____
_____
_____
_____
_____

17. Acupuncture Treatment:

Points	PP	Side	TC	Gauge	Depth	Angle	Time	Other

18. Herbal Prescription: _____

19. Referral/Advice: _____

Acupuncturist's Signature:_____ Date:_____