SALADO ACUPUNCTURE
418 N. MAIN ST. SUITE 4
SALADO, TX 76571
TEL.: (254) 421-2491
WWW.SALADOACUPUNCTURE.COM

HIPAA Acknowledgement and Appointment Reminder Form

I acknowledge that I have been provided access to Salado Acupuncture's "Notice of Privacy Policies". I understand that I have the right to review Salado Acupuncture's "Notice of Privacy Policies" prior to signing this document.

I understand that Salado Acupuncture 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. By signing this form, I am giving Salado Acupuncture authorization to contact me with these reminders.

_____ _____
Patient Name (print) Date

_____
Patient Signature

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Salado Acupuncture 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 Signature Date

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Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, Acupuncture and Oriental Medicine are not considered "Primary Health Care". As a result, Salado Acupuncture is 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 Salado Acupuncture of the following:

I have been evaluated by a physician or dentist for the condition being treated within 12 months before the Acupuncture was performed.

☐ Yes

☐ No

_____ *I recognize that I should be evaluated by a physician or dentist for the condition being treated by the Acupuncturist.*
Initial

OR

I have received a referral from my chiropractor within the last 30 days for Acupuncture.

☐ Yes

☐ No

_____ *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.*
Initial

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 Date

Salado Acupuncture is not responsible for untrue statements made by patients.

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Patient Intake Form

Full Name:	Sex: □ F □ M	Date:
Date of Birth:	Occupation:	Age:
Main Phone Number:	Other Phone Number:	
E-mail:		
Address: (Street)	(City)	(State, Zip)
Family Physician:	Chiropractor:	
Do you have health insurance? □ Yes □ No	If Yes, name of insurance company:	
Does your health insurance cover acupuncture?	□ Yes □ No	
Have you been treated by acupuncture before?	□ Yes □ No	
Emergency Contact Name and Phone Number:		
How did you find out about our clinic? □ *Friends/Relatives (Name)* _____ □ *Direct Mail* □ *Location or walk by* □ *Website* □ *Yellow Pages* □ *Other (Please specify)*_____		

Main problem(s): _____

What diagnosis, if any, have you received for this problem? _____

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

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

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? _____ Remarks and additional information: _____

_____

Medical History

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer			Breathing Problems			Tuberculosis		
Autoimmune Disorders			Stroke			Anemia		
Diabetes			Heart Disease			High Cholesterol		
Hepatitis			Digestive Disorders			High Blood Pressure		
Thyroid Disease			Venereal Disease			Emotional Disorders		
Seizures			Alcoholism			Other:		
Arthritis			Depression or Anxiety					

Surgeries: _____Hospitalization: _____

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

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

Medicines: Taken within the last two months (including vitamins, over-the-counter drugs, herbs, etc., and their dosages):

_____

Occupation: _____ Do you usually work: □ Indoors □ Outdoors?

Occupational stress (chemical, physical, psychological, etc): _____

Personal: Height:_____ Weight now:_____ Weight one year ago:_____

Weight maximum:_____@Year _____

Habits: Do you smoke ? □ Yes □ No What? _____ How many/day? _____ Since when? _____

Please describe any use of drugs for non-medical purposes:_____

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

How many hours do you sleep in general? _____ When time do you usually go to bed? _____

Diet: How much coffee do you drink? _____cups/day Colas: _____number/day Tea: _____ cups/day

What kind of alcoholic beverages do you usually drink, if any? _____ Average number of drinks/week? _____

How much water do you drink per day? _____

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

Remarks and additional diet information:_____

Please describe your average daily diet (Please be as specific as possible):

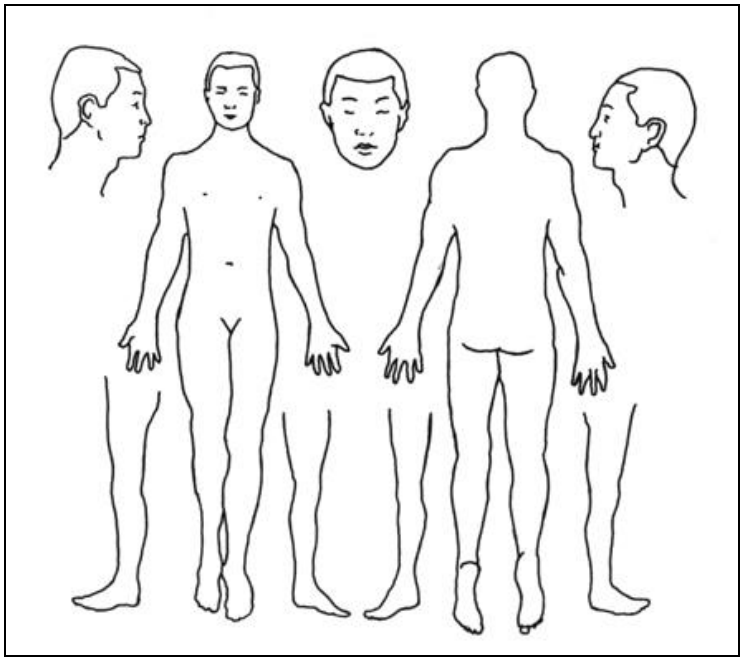
Morning _____

Afternoon _____

Evening _____

Snacks _____

Indicate painful or distressed areas:



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General

- ☐ Poor appetite
- ☐ Poor sleep
- ☐ Fatigue
- ☐ Fevers
- ☐ Chills
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Tremors
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor balance
- ☐ Weight loss
- ☐ Weight gain
- ☐ Peculiar tastes
- ☐ Desire hot food
- ☐ Desire cold food
- ☐ Strong thirst (cold or hot drinks)
- ☐ Bleed or bruise easily
- ☐ Localized weakness

☐ Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____

Skin & hair

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Acne
- ☐ Dandruff
- ☐ Dry skin
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Purpura
- ☐ Change in hair or skin texture
- ☐ Other?

Musculoskeletal

- ☐ Joint disorders
- ☐ Muscle weakness
- ☐ Pain/soreness in the muscles
- ☐ Tremors
- ☐ Cold hands/feet
- ☐ Difficulty walking
- ☐ Swelling of hands/feet
- ☐ Spinal curvature
- ☐ Back pain
- ☐ Hernia
- ☐ Numbness
- ☐ Tingling
- ☐ Paralysis
- ☐ Neck tightness
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Joint sprain
- ☐ Other?

Head, eyes, ears, nose, and throat

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses/lens
- ☐ Eye strain
- ☐ Eye pain
- ☐ Color blindness
- ☐ Night blindness
- ☐ Poor vision
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Spots in front of eyes
- ☐ Sinus problems
- ☐ Nose bleeding
- ☐ Sore throat
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Sores on lips/tongue
- ☐ Difficulty swallowing
- ☐ Other?

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Palpitation
- ☐ Fainting
- ☐ Phlebitis
- ☐ Irregular heartbeat
- ☐ Rapid heartbeat
- ☐ Varicose veins
- ☐ Other?

Respiratory

- ☐ Cough
- ☐ Coughing blood
- ☐ Wheezing
- ☐ Difficulty breathing
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Chest pain
- ☐ Production of phlegm – What color? _____

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Abdominal pain/cramps
- ☐ Gallbladder problems
- ☐ Parasites
- ☐ Chronic laxative use

Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____

Neuro-psychological
□ Loss of balance □ Lack of coordination □ Concussion
□ Depression □ Anxiety □ Stress
□ Bad temper □ Bi-polar □ Post Traumatic Stress Disorder (PTSD)

Genito-Urinary
□ Painful urination □ Frequent urination □ Blood in urine
□ Urgency to urinate □ Kidney stones □ Unable to hold urine
□ Dribbling □ Pause of flow □ Frequent urinary tract infection
□ Genital pain □ Genital itching □ Genital rashes
□ STD □ Other?

Female
□ Frequent vaginal infections □ Pelvic infection □ Endometriosis
□ Vaginal/genital discharge □ Fibroids □ Ovarian cysts
□ Irregular periods □ Clots □ Pain/cramps prior/during periods
□ Breast tenderness □ Breast Lumps □ Fertility Problems
□ Hot flashes □ Moodiness related to periods

Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions_____

Premature births _____ C-section _____ Difficult delivery _____

First date of last period _____ Age of first period _____ Duration of periods _____days, cycle ____ days

Do you practice birth control ? □ Yes □ No. If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long? _____

Male
□ Prostate problems □ Discharge □ Erectile dysfunction
□ Ejaculation problems □ Frequent seminal emission □ Fertility problems
□ Painful/swollen testicles □ Other:_____

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

Signature: _____ □ Adult Patient □ Parent or Guardian □ Spouse

Are there any other health issues you want to discuss with us?

Signature:_____ Date:_____