AcuBalance Center of Houston

Emma A. de McKenzie, M.S.,M.A.O.M.,L.Ac.
Diplomate of Oriental Medicine (NCCAOM)

Patient Information

Date:_____ Phone #:_____

Name_____

Address:_____

City_____State____ Zip/Postal Code _____

email:_____

Sex: Male_____Female_____ Date of Birth_____

Marital Status: Single____Married____Divorced____Separated____Widowed_____In a relationship____

Employer:_____

Employer address:_____

Ocupation/Type of work:_____

Business Phone #:_____

Emergency contact:_____Phone #:_____

Relationship to Patient:_____

Primary Care Physician/Doctor:_____ Phone#_____

Address:_____

Whom may we thank for referring you? _____

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Patient Information

1. Have you ever received treatment for this condition? Yes___No___

   If yes, where? _____
   By whom? _____
   What was their diagnosis? _____
   What treatments were performed? _____
   Was the result satisfactory? _____

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. (Females) Are you pregnant or do you think you could be pregnant ? _____

5. Major Surgeries:

Date	Procedure

6. Hospitalizations other than surgery or trauma:

Date	Hospitalization

7. Significant past or current illnesses:

___Cancer ___Heart Disease ___Diabetes ___High Blood Pressure ___High Cholesterol
___Thyroid Disease ___Tuberculosis (TB) ___STD ___Hepatitis ___HIV/AIDS
___Rheumatic Fever ___Blood clotting ___Stroke ___Seizures
___Others_____

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

   _____
   _____
   _____

9. Have you ever tried acupuncture or Chinese Medicine before? ___Yes___No If so, when and for what condition? _____

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HEALTH HISTORY

Name:_____ Date:_____

PLEASE CHECK ANY SYMPTOMS YOU ARE CURRENTLY HAVING 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
- ☐ Genital Sores
- ☐ Vaginal Discharge

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

Last Menses: __/__/__
Last Pap: __/__/__
Last Mammogram: __/__/__
Are You Pregnant? _____

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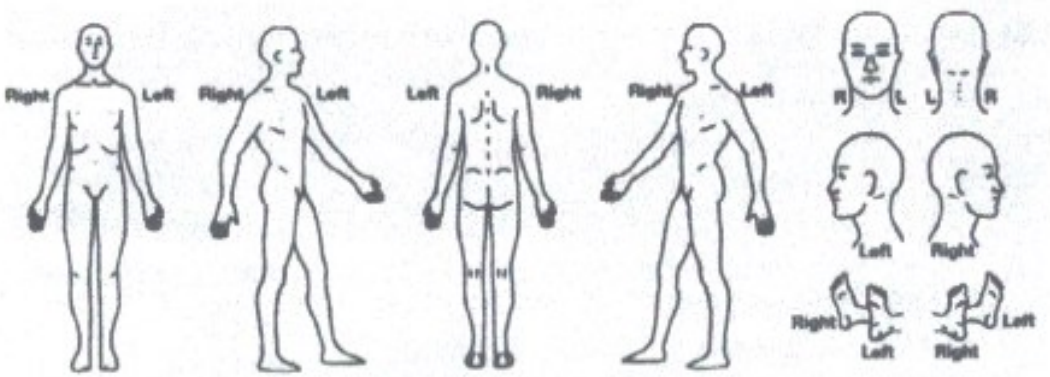
PAIN EVAULATION

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.

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COMFIRMATION OF PREVIOUS EVALUATION BY PHYSICIAN, AND OTHER INFORMATION

(Pursuant to the requirements of 22 T.A.C. §183./ 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.

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

BIRTHDATE _____ **SOCIAL SECURITY #** 000-00-_ _ _ _ (last 4)

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnostic information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

_____

_____

X_____ _____ _____

PATIENT SIGNATURE OR GUARDIAN **DATE** **WITNESS SIGNATURE**

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Informed Consent to Acupuncture and Oriental Medicine Treatment

I hereby consent to the performance of acupuncture treatment and other procedures within the scope of acupuncture on me (or the patient named below for whom I am legally responsible) by the licensed acupuncturist Emma McKenzie. I understand that the methods of treatment may include, but are not limited to, medicine and nutritional counselling. I will immediately notify the licensed acupuncturist of any un-anticipated or unpleasant effects associated with the consumption of herbal pills or formulas.

I have been informed that acupuncture is generally a safe method of treatment, but I may have some side effects, including bruising, numbness or tingling near the needle sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung (pneumothorax). Infection is another possible risk, although the acupuncturist uses only sterile single use disposable needles. Burns and/or scarring are a potential risk of moxibustion, and bruising is common for cupping. I understand that while this document describes the more common risks, other side effects may occur. The herbs and nutritional supplements which are from plant, animal and mineral sources, that will be recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, rashes and tingling of the tongue. I will notify the licensed acupuncturist if I become or suspect I have become pregnant. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her to exercise careful judgement during the course of treatment, which she believes, based on the facts known, is in my best interest. I understand results are not guaranteed. All my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I read, or have read to me, the above consent to treatment; have been told about the risks and benefits of acupuncture and other procedures and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment. I also understand that I will have to keep my appointments, but that in case of an emergency, I may cancel or reschedule at least 24 hours prior to my next appointment. If I fail to do so, I will be charged a no show charge of $25.00

Patient Signature _____ Date_____

Or Patient Representative Signature_____Date_____