HEALING ACUPUNCTURE CENTER

Welcome to the Healing Acupuncture Center. Please print this form, fill it out and bring it with you to your first appointment.

To help us provide you with the best possible care, please fill out this form as accurately as you can.

All the information provided here will be held in strictest confidence. Feel free to ask if you have any questions.

Name _____ Age _____ Today's Date _____

Address _____ City _____ Zip _____

Gender _____ Marital status _____ Birthday _____ Work phone ( ) _____

Employer _____ Home phone ( ) _____

Occupation _____ Do you like your job? _____ Cell phone ( ) _____

Height _____ Weight _____ Referred by _____

Please initial here to give your permission for us to thank the person who referred you to our office _____

Emergency contact _____ Relationship & Phone _____

Have you received acupuncture therapy before? _____ Email address _____

MAIN COMPLAINT _____

Please rate your current pain or discomfort on a scale of 1 to 10: ***Very slight*** 1 2 3 4 5 6 7 8 9 10 ***Unbearable***

What makes it feel better? _____ Worse? _____

Who else have you seen for this condition? _____

Please sign here if we may contact them regarding your case _____

MEDICAL HISTORY (include dates). Surgeries _____

Describe any scars _____

Major illnesses _____

Significant trauma (emotional or physical) _____

Allergies _____

Medications, vitamins, & herbs taken within the last 3 months—please include reason, date, & dosage: _____

Occupational stress (chemical, physical, psychological) _____

Check any that apply: O tobacco O coffee O black (iced) tea O green tea O soft drinks O alcohol O artificial sweeteners O recreational drugs

How many ounces of water do you drink daily? _____ Any food sensitivities? _____

Exercise (please describe) _____

FAMILY MEDICAL HISTORY—Parents, siblings, aunts, uncles, grandparents (check all that apply)

O Diabetes O Cancer O High/Low blood pressure O Stroke O Asthma
O Allergies O Alcoholism/Addiction O Hysterectomy O Prostate Disorders O Heart disease
O Kidney Disorders O Depression/Mental Disorders

Please check any of the following that applies to you:

O Loose stools or diarrhea O Indigestion O Nausea or vomiting O Acid reflux
O Belching O Varicose veins O Anemia O Bruise easily
O Lack of appetite O Diabetes or hypoglycemia O HIV positive or AIDS O Sweat easily
O Feeling of retention of food in stomach O Prolapsed organs O Eating disorder O Suicidal feelings
O Tendency to become obsessive in your work or relationships

O Insomnia (what time?) _____ O Heart palpitations O Restlessness
O Dream-disturbed sleep/nightmares O Anxiety (attacks) O Easily startled O Chest pain
O Racing of the heart O Irregular heartbeat

O Headaches/migraines (where and when) _____ O Arthritis O Poor vision
O High/low blood pressure O Cataracts O Spots before eyes O Ringing in ears
O Dizziness O Gallstones O Shingles O Herpes
O Eczema O Shoulder or neck tension O Sciatica O Impatience
O Difficult bowel movements O Hemorrhoids O Hepatitis O Soft or brittle nails
O Depression O Fullness behind ribs O Indecisiveness O Easily angered
O Cough O Bronchitis O Sadness O Shallow breathing
O Sinus congestion/infections O Asthma O Sore throat O Shortness of breath
O Weak voice O Constipation O Recent use of antibiotics O Emphysema
O Nasal discharge: O Clear O White O Yellow O Green O Bloody O Thick O Thin and watery
O Skin problems: _____

O Hearing loss O Low back pain O Weak knees O Edema or swelling
O Hair loss O Prostate disorders O Impotence O Urinary disorders
O Osteoporosis O Teeth/gum problems O Reduced sexual energy O Fearfulness

O Spontaneous sweating O No energy to speak O Lack of strength
O Dislike physical movement O General physical weakness O General fatigue

O Blurred vision O Dry, brittle hair O Poor memory O Skin rashes
O Numbness (where) _____

O Aversion to cold O Cold hands and feet O Easily chilled
O Frequent clear urination O Lack of thirst O Desire for hot drinks

O Frequently thirsty O Hot hands and feet O Night sweats
O Low-grade afternoon fever O Dry throat O Red, flushed cheeks

Other _____

GYNECOLOGICAL

Is there any possibility that you are pregnant? O Yes O No Birth control _____

Pregnancies # Births _____ # Miscarriages _____ # Abortions _____ # C-sections _____

Menstrual flow: O Heavy O Light O Clots O Painful Color of menses _____ No. of days between periods _____

Length of period _____ Date of last period _____ Date of last PAP _____ PAP results _____

Age at first menses _____ O Spotting between periods O Vaginal sores _____

Premenstrual Syndrome: O Breast tenderness O Bloating O Moodiness O Irritability O Cramps Other_____

Perimenopausal: O Skipped/irregular periods O Hot flashes O Moodiness O Vaginal dryness

Menopause/age: _____ Hysterectomy/age and reason: _____

O Vaginal discharge (describe) _____

O Breast lumps/cysts _____ Endometriosis/When: _____

Other_____

OTHER

What is your favorite season? _____ Least favorite? _____

How would you describe your overall emotional state?_____

_____

Are there any other issues that you would like to discuss?_____

_____

PLEASE READ AND SIGN:

1) **Our office policy is to charge a $30 missed appointment fee if we don't receive a 24 hour notice of cancellation of your appointment.** Missed appointments inconvenience those individuals who need access to health care. Thank you for your understanding.
2) **PLEASE DO NOT WEAR COLOGNE, PERFUME, OR STRONGLY SCENTED LOTION ON THE DAY OF YOUR APPOINTMENT WITH US. STRONG SCENTS CAN TRIGGER ALLERGIES, OR EVEN ASTHMA IN SOME OF OUR PATIENTS.**
3) Only sterile, disposable needles are used here at The Healing Acupuncture Center. Occasionally you may get a small hematoma (a little bruise under the skin) after an acupuncture needle is removed. This is not a cause for concern—it will go away after a few days. Gentle pressure applied to the site will stop any small amount of bleeding that is occurring under the skin.
4) Herbal prescriptions and herbal patent medicines are intended only for the person for whom they are prescribed. Please do not give your herbal prescriptions to anyone else.
5) After receiving an acupuncture treatment, you may feel a little light-headed. If so, please have a seat in the reception room or take a short walk around our building. In a few minutes, you will feel relaxed and clear-headed.

I have read the above information. I hereby request to be treated with acupuncture and/or Chinese herbal medicine for my condition.

Signature_____ Date _____

The following documentation is required by law pursuant to the Texas Revised Civil Statutes, Article 4495, Medical Practice Act of Texas, Subchapter F., regarding Acupuncture Practice, Sec. 6.11, subsections (b) through (d):

Please read and check the appropriate answers:

1) I have been evaluated by a physician or dentist for the condition being treated within the last twelve months prior to having acupuncture performed.
   O Yes O No
2) I have received a referral from my chiropractor within the last 30 days for acupuncture. O Yes O No

I recognize that I should be evaluated by a physician for the condition being treated by the acupuncturist. In being referred by my chiropractor, if after 120 days or 30 treatments, whichever comes first, if no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician.

Signature_____ Date _____

If you answered no to both of the above questions, I, Karen E. Nunley, am requesting that you see a physician. It is your responsibility and your choice whether to follow this advice.

***Karen E. Nunley*, Licensed Acupuncturist, M.S. Oriental Medicine**
The Healing Acupuncture Center
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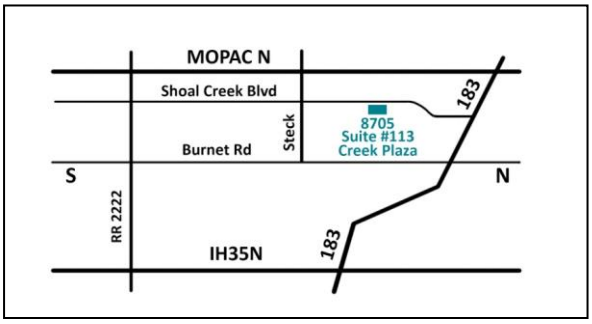
Texas State Board of Acupuncture Examiners License Number AC00300



HEALTH INSURANCE COVERAGE

Patient's name_____

Patient's date of birth_____

1) Do you have health insurance? Yes No

Insurance company name_____

Insurance claims mailing address_____

City_____State_____Zip_____

Member ID_____

Group no._____

Insurance company phone number_____

Insured's name_____

Current employer_____

Insured's date of birth_____Relationship to patient_____

2) Are you covered under another health insurance plan? Yes No

If so, who is your secondary carrier?_____

Member ID_____

Group no._____

Insurance company phone number_____

Insured's name_____

Insured's date of birth_____Relationship to patient_____

3) Is your condition related to:

Employment Yes No

Auto accident Yes No

Other accident Yes No

4) Is another party responsible? Yes No