true nature acupuncture

1804 W. Koenig Lane Austin, TX 78756 • 512 363-2756 • truenatureclinic.com

Patient Intake Form

First Name: _____ Middle Initial: _____ Last Name: _____

Today's Date: _____

Street Address: _____

City:_____State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email Address:_____ ❑ Please add me to your mailing list

Emergency Contact: _____ Phone Number: _____ Relationship to you: _____

Appointment Confirmations: We will contact you on the business day prior to your scheduled appointment with a reminder.

Please check your preferred location of contact: ❑ Home Phone ❑ Work Phone ❑ Mobile Phone ❑ Email

Birth Date: _____ Age: _____ Height: _____Weight:_____

Gender: ❑ Female ❑ Male

Marital Status: _____ Number of Children: _____ Ages of Children: _____

Occupation: _____ Employer: _____

Physician's Name (and address if available) _____ Month/Year of your last doctor visit: _____

Have you ever received acupuncture before? ❑ Yes ❑ No

Who can we thank for the referral: ❑ A friend ❑ A physician ❑ Another healthcare practitioner

Their Name: _____

If you weren't referred, how did you find out about us?

❑ Print advertisment (in_____) ❑ Brochure (where_____)

❑ Online (search engine_____) ❑ Other _____

(continued)

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Patient Intake Form (continued)

Medical History

Reason for today's visit: _____

Please write a brief description of how this problem began:

_____

_____

How long has it lasted: _____ ❑ days ❑ weeks ❑ months ❑ years

Have you had this or a similar condition before? ❑ Yes ❑ No

Does anything make it better? _____

Does anything make it worse? _____

Have you received prior treatment for this condition? ❑ Yes ❑ No If yes, when? _____

Where? _____ By whom? _____ What was the diagnosis? _____

What type(s) of treatment were used? _____ Result of that treatment: _____

What medications and supplements are you currently taking?

Name:	Dose:	How Often:	Taking since:

Have you had any major surgeries, accidents, or injuries?

Date:	Description:

Have you had any of the following illnesses?(check all that apply):

❑ Allergies	❑ Cancer	❑ Eye disorders	❑ Liver Disease
❑ Asthma	❑ Diabetes	❑ Epilepsy	❑ Ulcers
❑ Alcoholism	❑ High/Low blood pressure	❑ Tuberculosis	❑ Hepatitis B or C
❑ Arthritis	❑ Heart Disease	❑ Kidney Disease	❑ HIV/AIDS
❑ Clotting Disorder	❑ Herpes	❑ Mental Illness	❑ Spinal Injury/Problem
❑ Autoimmune Disease	❑ Connective Tissue Disease	❑ Multiple Sclerosis	❑ Neurological Disease
❑ Gallstones	❑ Pneumonia	❑ Drug addiction	❑ Venereal Disease
❑ Other			

Do you have any food, drug, or environmental allergies? What are they? _____

Any other health related issue not mentioned above? _____

Family Medical History: (please indicate family member)

❑ Cancer _____	❑ Diabetes _____	❑ Hepatitis _____
❑ Hypertension_____	❑ Heart Disease _____	❑ Stroke_____
❑ Asthma_____	❑ Alcoholism _____	❑ Miscarriage_____
❑ Other _____		

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Patient Lifestyle

Name: _____

Your occupation: _____ Any physical strain at work? ❑ Yes ❑ No What kind? _____

How many hours do you work per week: _____ Stress levels: ❑ Low ❑ Medium ❑ High

Height: _____ Current Weight: _____

Do you exercise? ❑ Yes ❑ No _____ What kind? _____ How often? _____

Do you smoke? ❑ Yes ❑ No _____How many per day? _____ When did you start? _____

Sleep

How much sleep do you typically get? _____ Do you feel rested in the morning? ❑ Yes ❑ No

Do you have a regular bedtime? ❑ Yes ❑ No When is it? _____

Do you have a regular wake up time? ❑ Yes ❑ No When is it? _____

Do dreams disturb your sleep? _____

Anything else we should know about your sleep? _____

Eating Habits

Meal	Do you eat this meal on most days?	Approximate time	A general list of the foods you tend to eat at this meal
Breakfast			
Lunch			
Dinner			

Snacking Habits

Approximate time	Types of food eaten

Foods

Food Type	How often?			
Sodas (regular and diet)	❑ Daily	❑ Most days	❑ Occasionally	❑ Never
Fried Foods (french fires, fried chicken etc.)	❑ Daily	❑ Most days	❑ Occasionally	❑ Never
Several cups of coffee in one day	❑ Daily	❑ Most days	❑ Occasionally	❑ Never
Donuts, ice cream, cookies, cakes	❑ Daily	❑ Most days	❑ Occasionally	❑ Never
Milk and cheese	❑ Daily	❑ Most days	❑ Occasionally	❑ Never
Meat products (chicken, lamb, beef and pork)	❑ Daily	❑ Most days	❑ Occasionally	❑ Never
Shellfish	❑ Daily	❑ Most days	❑ Occasionally	❑ Never
Freshwater and Ocean fish	❑ Daily	❑ Most days	❑ Occasionally	❑ Never

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Check all the symptoms you've had within the past three months

Office notes (leave blank)

Emotional

I would generally describe myself as: ❑ Happy ❑ Easy going ❑ Restless ❑ Irritable
❑ Indecisive ❑ Angry ❑ Cry easily ❑ Hurried ❑ Depressed ❑ Stressed out ❑ Anxious
❑ Hard to express emotions ❑ Short attention span ❑ Other _____

Energy

❑ Fluxuates ❑ Low ❑ High ❑ Lower in the afternoon ❑ Normal ❑ Tired after meals
❑ Other_____

Body Temperature

❑ Hot where_____ ❑ Cold where_____ ❑ Night sweats ❑ Hot flashes ❑ Chilled
❑ Flushing ❑ Other_____

Digestion

❑ Indigestion ❑ Bloating ❑ Heatrburn ❑ Nausea ❑ Vomiting ❑ Full feeling ❑ Belching ❑ Gas
❑ Abdominal pain or cramps ❑ Sensitivity to oily foods (upsets your stomach) ❑ Bitter taste in mouth
❑ Gallstones ❑ Other_____

Bowels

Frequency: #_____bowel movements_____times per ❑ day ❑ week ❑ loose stools ❑ Diarrhea
❑ Constipation ❑ Hemorrhoids ❑ Constipation ❑ Colon Problems ❑ Pain or Cramps ❑ Using laxatives
❑ Other_____

Urination

Frequency of urination:_____times per day **Color:** ❑ Clear ❑ Light yellow ❑ Yellow ❑ Bright Yellow
❑ Dark Symptoms: ❑ Burning ❑ Bladder Infection ❑ Urgency ❑ Nighttime ❑ Incontinence
❑ Kidney Stones ❑ Kidney Infections ❑ Other_____

Thirst

❑ Never thirsty ❑ Always thirsty ❑ Thirsty but doesn't drink Drinks _____(number of drinks)per day
Temperature preference for drinks: ❑ Cold ❑ Warm/hot ❑ Room Temperature

Cardiovascular

❑ Diagnosed heart problems ❑ Palpitations ❑ Bleeds easily ❑ Low blood pressure ❑ High blood pressure ❑ High Cholesterol ❑ Heart Murmur ❑ Varicose Veins ❑ Ankle Swelling ❑ Chest Pain
❑ Bruising easily ❑ Hands swelling ❑ Irregular Heart Beat ❑ Other_____

Sleep

Falling asleep: ❑ Easy ❑ Average ❑ Difficult **Staying asleep:** ❑ Easy ❑ Average ❑ Difficult
Waking up: ❑ Easy ❑ Average ❑ Difficult **Sleep quality:** ❑ Restless ❑ Lots of dreams ❑ Easily Awakened ❑ Nightmares ❑ Hard time getting back to sleep

Headaches/dizziness

❑ Headaches ❑ Migraines ❑ Vertigo ❑ Dizziness ❑ Motion sickness ❑ Poor Balance
❑ Faints easily ❑ Poor memory ❑ Other_____

Skin

❑ Dry ❑ Hives ❑ Itching ❑ Oily ❑ Acne ❑ Rashes ❑ Bruise easily ❑ Eczema
❑ Slowly healing cuts ❑ Other_____

Hair

❑ Dry ❑ Oily ❑ Dandruff ❑ Falling out ❑ Early greying ❑ Other_____

Nails

❑ Soft ❑ Spots ❑ Ridges/lines ❑ Grow slowly ❑ Grow fast ❑ Purple ❑ Pale ❑ Break easily
❑ Other_____

Ears

❑ Poor hearing ❑ High pitched ringing ❑ Low pitched ringing ❑ Discharges ❑ Ear aches
❑ Other_____

Eyes

❑ Wear contacts or glasses ❑ Puffy eyelids ❑ Dryness ❑ Itching ❑ Twitches ❑ Poor night vision
❑ Light sensitivity ❑ Color Blindness ❑ Watery ❑ Normal ❑ Other_____

Nose

❑ Congestion ❑ Hay fever ❑ Frequent sneezing ❑ Bleeding ❑ Loss of smell
❑ Sinusitis ❑ Rhinitis ❑ Normal ❑ Other_____

Mouth and Throat

❑ Dry ❑ Gum Problems ❑ Frequent colds ❑ Tight jaw muscles ❑ Lump in the throat
❑ Thyroid problems ❑ Grinding teeth ❑ Norman ❑ Other_____

Respiratory

❑ Short breath ❑ Difficulty inhaling ❑ Frequent sighing ❑ Dry cough ❑ Cough with phlegm
❑ Asthma ❑ Bronchitis ❑ Emphysema ❑ Coughing up blood ❑ Tight chest
❑ Other_____

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Form to be Completed by Patient, Notifying the Acupuncturist of Whether She/He Has Been Evaluated by a Physician, and Other Information

(Pursuant to the requirements of '183.6(e) of this title (relating to Denial of Licensee; Discipline of Licensee) and Texas Occ. Code Ann., '205.351, governing the practice of acupuncture.)

I (patient's name) _____ am notifying True Nature 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. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist. (check one) _____ Yes _____ No Initials of patient _____ Date _____

I have received a referral from my chiropractor within the last 30 days for acupuncture.
(check one) _____ Yes _____ No Initials of patient _____ Date _____

After being referred by a chiropractor, if after 120 days or 30 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.

I am seeking acupuncture and Oriental Medicine for one of more of the following: (please circle)

chronic pain weight loss smoking addiction alcoholism substance abuse

_____

Patient or Patient Representative (Print)

_____

Signature Date

_____

Relation to patient (if not patient)

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Informed Consent

I herby request and consent to the performance of oriental medical health care on myself (or the patient named below, for whom I am legally responsible) by Rebecca Hindman L.Ac. or any licensed acupuncturist working with her.

I understand that oriental medical health care includes acupuncture, diagnostic techniques such as questioning, pulse evaluation, palpation, observation of range of motion, muscle and orthopedic testing, massage, joint and or viscera manipulation, heat and/or cold therapy, electrical/magnetic stimulation, cupping, recommendation of herbal and homeopathic preparations for ingestion and/or external application, dietary recommendations, and healthy lifestyle counseling.

I understand that there are risks of treatment involved in the practice of Oriental Medicine. I understand and am informed that, as in allopathic medicine, in the practice of Oriental Medicine there are some risks of treatment. I understand that although these risks are unlikely to occur, they are possible. These risks include but are not limited to bleeding, bruising, nerve pain, punctured organ, aggravation of symptoms, appearance of new symptoms, fainting and fatigue. 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 judgement to be in my best interest based on the known facts at a the time.

I have had the opportunity to discuss with my professional practitioner and/or other clinic personnel the nature and purpose of acupuncture and Oriental Medicine procedures. Although I am aware that Oriental Medicine has helped millions of people, I am also aware that each person is different in their response to acupuncture and that it is possible that I may not see any improvement in my condition or my symptoms may worsen. I understand that no guarantee of cure or improvement in my condition is given or implied.

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 that this consent form cover the entire course of treatment for my present and any future conditions for which I seek treatment with this practitioner.

Patient's name (please print)	Patient's Signature	Date

Patient's representative & relationship to patient	Signature of patient's representative

Office Policies

Appointments

If you need to cancel an appointment we require 24 hours notice. This allows us to to make necessary schedule adjustments. Appointments cancelled with less than 24 hours notice will be charged the full fee for that session. If you are more than 20 minutes late for an appointment it will be cancelled and you will be charged for the missed session.

Payment for Services Rendered

Payment is due at the time of service and can be paid by cash, credit card, or check.

Patient's name (please print)	Patient's Signature	Date

Patient's representative & relationship to patient	Signature of patient's representative

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Notice of Privacy Policy

I understand that I have the right to review the document "Notice of Privacy Policy" prior to signing this document. This notice has been provided to me in my intake packet.

The Notice of Privacy Policy (Notice) describes the types of uses and disclosures of my "protected health information (PHI)" that will occur in my treatment, payment of bills, or in the performance of healthcare operations of this clinic. My protected health information means health information including my demographic information (name, address, phone number, etc.) that is collected from me and created or received by this clinic or its agents or employees. PHI is information that relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me. The Notice also describes other potential releases of my PHI that may occur with or without my authorization, and my rights regarding my PHI.

By signing this form, you consent to our use and disclosure of your PHI as specified in the Notice of Privacy Policy, and acknowledge receipt of the Notice.

PLEASE NOTE: Unless you are claiming insurance for your treatments here, your protected health information (PHI) will NEVER be discussed, verbally or in writing, with anyone but you or your spouse. We will only disclose information to others (i.e. family members, other physicians, etc…) once we have obtained your express written permission. If you wish to keep your information private from your spouse as well, please indicate below.

_____ I wish to keep my PHI (protected health information) private from my spouse.

_____

Patient or Patient Representative (Print)

_____

Signature Date

_____

Patient or Patient Representative (Print)

_____

Signature Date

_____

Relation to patient (if not patient)