AcuHerbia

Phone: (512) 731-3363

8500 Shoal Creek Blvd, Building 4, Suite 106, Austin TX 78757 – Central Clinic _____

7900 FM 1826, Building II Suite 100, Austin TX 78737 – South Clinic _____

New Patient Information

Patient Name: (Last)_____ (First) _____(MI) _____

(Please print)

Date of Birth: _____ Number of Children: _____ Occupation: _____

Sex: M / F Marital Status: M / S /D Driver's License #: _____ S.S.N: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work (or Cell): _____ Email:_____

Referred by: _____ Emergency Contact (Name) _____ Phone: _____

REQUEST FOR TREATMENT AND CONSENT

I hereby request ANN HUYNH, L.Ac., DAOM, referred to as "the acupuncturist", to perform on me the treatment known as "acupuncture", referred to as "the treatment", in the manner that she may deem fit and necessary to address my condition.

I authorize the acupuncturist to use acupuncture and any other related treatment modalities and/or therapeutic methods that, in her professional judgment, may be necessary and/or beneficial to me, whether or not they are commonly practiced and/or accepted in the community.

I further authorize the acupuncturist to modify, adjust, implement or terminate any treatment modality at any time, as she may deem advisable.

I understand and agree that the treatment I request may include but is not limited to the following:

1. Insertion of disposable, single use sterile acupuncture needles;
2. Use of thermal and/or electric stimulation;
3. Use of heat lamps;
4. Cupping
5. Moxibustion
6. Use of ear seeds
7. Acupressure

I have been explained and understand the nature and purpose of the treatment, the risks involved, the collateral hazards, and the possibility of unforeseen occurrences and complications during and as a result of the treatment.

I understand and agree that the acupuncturist has not made any guarantees or promises as to the results of the treatment.
With full knowledge of the above I hereby give my consent to the treatment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read, understand, and agree to the Notice of Privacy Policies provided to me by this office.

PATIENT'S CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I give my consent to the AcuHerbia Clinic for the use and disclosure of my individual identifiable health information or protected health information for the following purposes :

1) Providing treatment to me
2) Relating to the payment of the services this office has rendered to me
3) The general healthcare operations of this practice.

Protected health information is any information which includes:

1) Demographic data
2) Information gathered by this practice as it relates to my past, present and future physical or mental health or condition
3) Information gathered by this office for past, present or future payments for providing the healthcare services
4) Healthcare operations purposes will include quality assessment activities, business management and other general operation activities

I understand that I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Clinic, but the Clinic is not required to agree to these restrictions. However, if the Clinic agrees to the restriction that I request, the restriction is binding on the Clinic.

I understand that I have the right to read and discuss the Notice of Privacy Policies and Procedures from this Clinic before I sign this consent form regarding the use and disclosures of my Protected Health Information.

I understand that I have the right to revoke this consent in writing at any time except to the extent that the acupuncturist or the Clinic has acted in reliance on this consent.

Patient's Signature _____ Date _____

NOTICE OF PRIVACY POLICIES

The AcuHerbia Clinic is dedicated to providing services with respect to human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive from you;
- Information we receive from healthcare providers;
- Information we receive from third-party payers.

This information is used for treatment, payment, and healthcare operations. You should be aware that during the course of our relationship with you, we may use and disclose health information about you for treatment, payment and healthcare operations. You may specifically authorize us to use Protected Health Information for any purpose or to disclose your health information by submitting the authorization in writing, such disclosures will be made to any personal representative you choose to have your protected health information.

Marketing: This office will not use your health information for marketing communications without your written authorization. This office may send you birthday cards, newsletters, or appointment reminders by calls, postcards, or letter. This office may send you information to support your healthcare, information about alternative treatments, and health related services that may be of interest to you. Please advise this office if you do not wish to receive such communications, and will not use or disclose your information for such purposes. If you do not wish to receive such communication, you must advise our office in writing at our contact address.

Disclosure: This office may use or disclose your Protected Health Information when required by law. Without your consent or authorization, this clinic may disclose information about you only for the following purposes:

- To a public agency, for the purpose such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if your incapacitated of if it appears necessary to prevent serious harm to you or others.
- To health oversight authorities for regulatory, licensing and other legal purposes.
- In litigation, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- For medical research purposes, subject to your authorization or approval by an institutional review board.
- If you are in the United States military, national security or intelligence, or foreign service, to your authorized superiors or other authorized federal officials.

We may not disclose information about you for any other purpose without written authorization, provided separately from your written consent.

Patient Rights:

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office places additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; The request must be in writing.
5. You have the right to receive all notices in writing.

If you have questions, complaints, or want more information, please contact Ann Huynh, AcuHerbia 8500 Shoal Creek Blvd., Bldg. 4 Suite 106, Austin TX 78757

Complaints: Complaints about your privacy rights or how your privacy is handled at this office can be directed to privacy office by calling this office or directing a letter to his or her attention. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to: DHHS (Office of Civil Rights), 200 Independence Ave, S.W., Room 509F HHH Building, Washington, DC 20201.

I, _____(Patient's name)
Have read, reviewed, understand, and agree to the Notice of Privacy Policies for healthcare and/or other services provided to me.

Patient's Signature Date

INITIAL VISIT - HEALTH STATUS CHECK

Patient's Name (Please print)_____ Date _____

Describe your current health condition: ____ Good ____ Fair ____ Poor ____ Chronically ILL

Are you currently pregnant? ___YES ___NO. If yes, how many months?_____

Do you wear pace-maker or electronic device? ___ YES ___ NO

What is your chief complaint or reason for this visit?

_____

When did this problem begin or was noticed? _____

How often are the symptom(s) present? ____Constantly ____Frequently ____Intermittently ___Occasionally

What improves the condition? _____

What worsens the condition? _____

What treatments have you tried? _____

Menstrual (Female): Length of Period _____ Date of last period _____ Color _____ Amount _____
Clotting _____ Cramps _____

Bowel Movement _____
Stress _____
Energy _____
Thirst _____
Cough/Phlegm _____

Urination _____
Loss of sleep _____
Loss of appetite _____
Hot/Cold_____

Sense Organs:
Vision_____
Smell _____
Hearing _____
Taste _____

Do you have any of the following?
___Cancer ___Diabetes ___Hepatitis ___Seizures ___Heart Diseases ___High Blood Pressure
___Infectious Diseases ___Emotional Disorders ___Stroke ___Hypothyroid
___Sexually Transmitted Diseases (HIV/AIDS) ___Bruise Easily ___Hyperthyroid ___Others

What treatment have you been taking for the above condition(s)?

_____
_____

List other health problems you are having now _____
_____

List all medications are you taking? _____

List any allergies, food sensitivities you may have _____

If a family member has had any of the following, please check the appropriate items and explain:
___Arthritis ___Cancer ___Lupus ___Hypertension ___Heart Disease ___Diabetes

Explain: _____
_____

Please indicate the use of the following:
___Tobacco ___Coffee ___Tea ___Alcohol

FUNCTIONAL SELF-EVALUATION

Please circle today's level of pain. (0: No pain, 10: Worst pain ever)
0…….1…….2…….3…….4…….5…….6…….7…….8…….9…….10
Please circle your overall stress level. (0: No stress, 10: Unnerving stress)
0…….1…….2…….3…….4…….5…….6…….7…….8…….9…….10

Have you noticed any changes in your symptoms in the last 2 weeks? (Circle 1)
1. Positive change 2. Negative change 3. Little change 4. No change

Please indicate current sleeping pattern. Number of hours per night:____ Number of interruptions by pain: _____

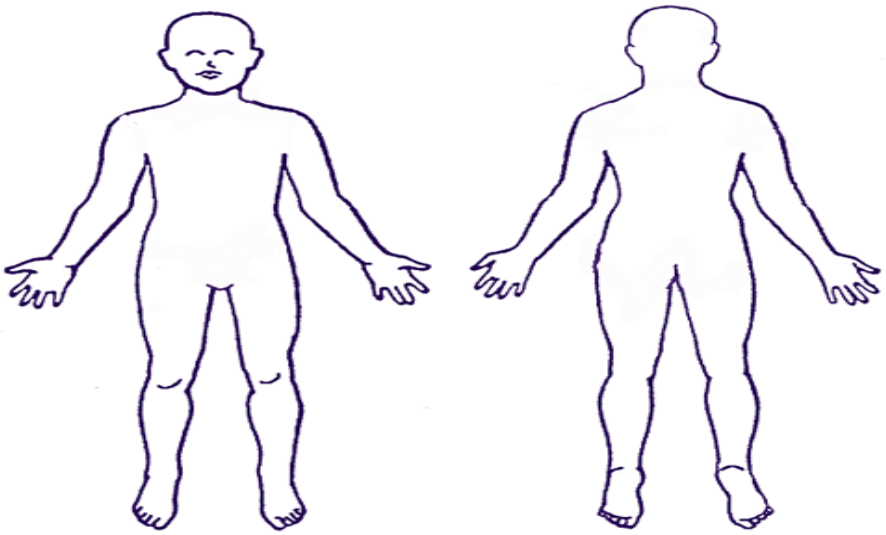
Check the following that apply to you.

___ Pain worse in AM
___ Pain worse in PM
___ Worst pain with activity
___ Can't turn head while driving
___ Can't sit very long
___ Can't stand very long
___ Can't bend over
___ Can't walk very far
___ Can't lift with ease
___ Can't perform overhead tasks
___ Can't squat or kneel
___ Can't go up or go down stairs with ease
___ Can't do household tasks
___ Can't do self-care task
___ Can't change positions easily
___ Can't exercise in usual manner
___ I do breathing exercises
___ I meditate

In the following space, make note of things you think you should be able to do that you can't. Include specific difficulties with daily activities and/or sporting and exercise activities.

_____
_____
_____
_____

On the diagram below, please mark the area of pain or abnormal sensation. Also, note whether the pain is sharp, dull, throbbing, aching, tingling, or numb.



Medical Evaluation, Referral, or Recommendation

(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, Ann Huynh 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** (Circle One). If Yes, Physician's / Dentist's Name _____
- I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncture. Patient's Initials_____ Date_____
- I have received a referral from my chiropractor within the last 30 days for acupuncture. **YES / NO** (Circle one). If YES, chiropractor 's Name _____

Note: In the case of patients' seeking treatment for smoking addiction, weight loss, alcoholism, chronic pain (Defined as pain lasting longer than 6 months), or substance abuse, referral by a physician, dentist, or chiropractor is not required.

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 prerogative to follow or not follow this advice.

Signature_____ Date _____

Optional Form to be completed by Patient
Attest that the Acupuncturist has referred him/her

(Pursuant to the requirement 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.)

The acupuncturist has referred me to see a physician. It is my prerogative to follow or not follow her advice.

Patient's Signature _____ Date _____

Acupuncturist's signature _____ Date _____

Initial Visit - Observation and Examination

(For Acupuncturist Only)

Date: _____

Chief Complaint (S)

_____

_____

_____

Symptoms and Signs:

_____

_____

_____

OBSERVATION

Vitality & Demeanor_____

Body color _____

PULSE

Left Overall _____

Cun (HR) _____

Guan (Liv) _____

Chi (K) _____

Right Overall _____

Cun (Lu) _____

Guan (Sp) _____

Chi (K) _____

TONGUE

Proper_____

Coating_____

Others_____

PAIN

Location _____

Frequency _____

Time of the day _____

Characteristics _____

TEMPERATURE _____ **BLOOD PRESSURE** _____ **PULSE**_____

AcuHerbia

TCM Assessment (A)
(For Acupuncturist only)

TCM Eight Principles: Yin Yang Deficiency Excess Heat Cold Interior Exterior

ZANG-FU Organ/Channel: Lung Kidney Small Intestine Large Intestine Spleen
Liver Heart Stomach Gall Bladder Bladder

Qi: Stagnation Deficiency Sinking

Blood: Stagnation Deficiency Heat Cold

Diagnosis/Differentiation: _____

_____

_____

Treatment Principle: _____

_____

_____

Acupuncture Treatment

Needle set #1:	**Needle set #2:**
Face to Face time: _____ **Minutes**	**Face to Face time:** _____ **Minutes**
Points needled: _____	**Points needled:** _____
_____	_____
_____	_____
_____	_____
Position: Subpine _____ Prone _____ Side _____	**Position:** Subpine _____ Prone _____ Side _____
E-stim added to: _____	**E-stim added to:** _____
Needle retention time after insertion _____ **Minutes**	**Needle retention time after insertion** _____ **Minutes**
Needle guage: _____ **Needle length:** _____	**Needle guage:** _____ **Needle length:** _____

Needle set #3:	**Needle set #4:**
Face to Face time: _____ **Minutes**	**Face to Face time:** _____ **Minutes**
Points needled: _____	**Points needled:** _____
_____	_____
Position: Subpine _____ Prone _____ Side _____	**Position:** Subpine _____ Prone _____ Side _____
E-stim added to: _____	**E-stim added to:** _____
Needle retention time after insertion _____ **Minutes**	**Needle retention time after insertion** _____ **Minutes**
Needle guage: _____ **Needle length:** _____	**Needle guage:** _____ **Needle length:** _____

Additional Therapies Used:

Manual Therapy location: _____

_____

_____ **;** _____ **Mins**

Cupping location: _____

_____ **;** _____ **Mins**

Moxibustion location: _____ **;** _____ **Mins**

Infrared Heat location: _____ **;** _____ **Mins**

Ear Seed location: _____**;** _____ **Mins**

Herbs Treatment:

Pills: _____

Granula: _____

Raw: _____

Treatment Plan (P)

_____

_____

_____