

# AcuHerbia

8500 Shoal Creek Blvd, Building 4, Suite 106, Austin TX 78757 - TEL: (512) 731 3363

## 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 or 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.

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Patient's Signature

Date

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## 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 \_\_\_\_\_

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

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## 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.

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

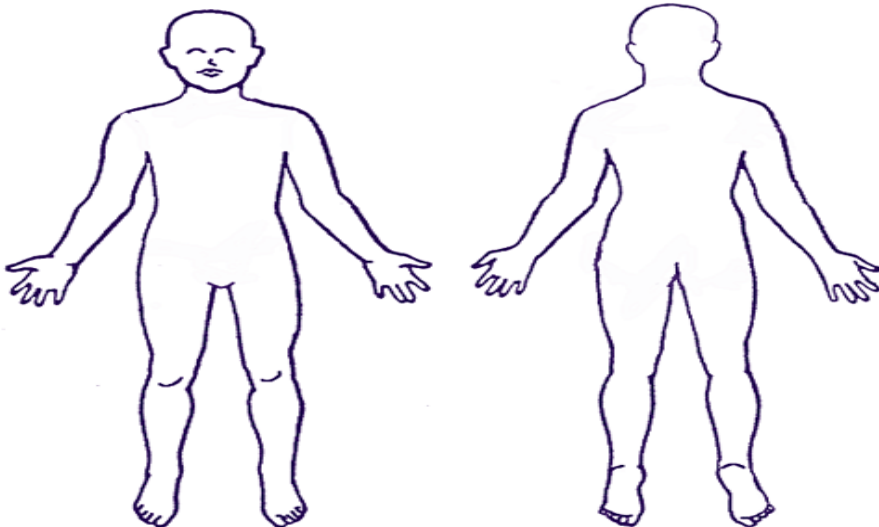
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On the diagram below, please mark the area of pain or abnormal sensation. Also, note whether the pain is sharp, dull, throbbing, aching, tingling, or numb.



## 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 \_\_\_\_\_

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## Initial Visit - Observation and Examination (For Acupuncturist Only)

Date: \_\_\_\_\_

### Chief Complaint:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Symptoms and Signs:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### INQUIRING

Bowel Movement \_\_\_\_\_  
Stress \_\_\_\_\_  
Energy \_\_\_\_\_  
Thirst \_\_\_\_\_  
Cough/Phlegm \_\_\_\_\_

Urination \_\_\_\_\_  
Loss of sleep \_\_\_\_\_  
Loss of appetite \_\_\_\_\_  
Hot/Cold \_\_\_\_\_

#### OBSERVATION

Vitality & Demeanor \_\_\_\_\_  
Body color \_\_\_\_\_

##### Sense Organs

Vision \_\_\_\_\_  
Smell \_\_\_\_\_  
Hearing \_\_\_\_\_  
Taste \_\_\_\_\_

##### Tongue

Proper \_\_\_\_\_  
Coating \_\_\_\_\_  
Others \_\_\_\_\_

#### PULSE

Right Overall \_\_\_\_\_  
Cun (Lu) \_\_\_\_\_  
Guan (Sp) \_\_\_\_\_  
Chi (K) \_\_\_\_\_  
Left Overall \_\_\_\_\_  
Cun (HR) \_\_\_\_\_  
Guan (Liv) \_\_\_\_\_  
Chi (K) \_\_\_\_\_

#### PAIN

Location \_\_\_\_\_  
Frequency \_\_\_\_\_  
Time of the day \_\_\_\_\_  
Characteristics \_\_\_\_\_

TEMPERATURE \_\_\_\_\_

BLOOD PRESSURE \_\_\_\_\_

PULSE \_\_\_\_\_

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## Diagnosis and Differentiation (For Acupuncturist only)

<b>TCM Eight Principles:</b>	Yin	Yang	Deficiency	Excess	Heat	Cold	Interior	Exterior
<b>ZANG-FU Organ/Channel:</b>	Lung	Kidney	Small Intestine	Large Intestine	Spleen			
	Liver	Heart	Stomach	Gall Bladder	Bladder			
<b>Qi:</b>	Stagnation	Deficiency	Sinking					
<b>Blood:</b>	Stagnation	Deficiency	Heat	Cold				

### TCM Diagnosis/Differentiation:

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### Treatment Principle:

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### Points Used:

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### Herbs used: Raw / Granules / Pills

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<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

### Additional Therapies Used:

Heat lamp\_\_\_ Moxibustion\_\_\_ Cupping\_\_\_ Ear seed\_\_\_ Acupressure\_\_\_ Electric stimulation

Manual Therapy\_\_\_ Others\_\_\_

### Treatment Plan:

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