American College of Acupuncture & Oriental Medicine
9100 Park West Dr., Houston, TX 77063 • Phone (713) 780.9786 • www.acaom.edu

Please print with black ink only. Thank you.

File No.: _____ Date: _____

Welcome

Please take a moment to provide us with some information about yourself and your health conditions, so that we can offer you the best treatment. ACAOM clinic considers this information privileged physician/patient communication and will keep it confidential.

Patient Information

Email _____ Phone for follow-up: _____

Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip Code _____

Sex: M ___ F ___ Age _____ Date of Birth: _____

Social Security No.: 000-00-_____ Driver's License #: _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Spouse's Name: _____ Phone _____

Patient Employed By: _____

Business Address: _____

Occupation: _____ Business Phone _____

In case of emergency who should be notified? _____

Relationship with patient: _____ Phone _____

Address: _____

Primary Physician: _____ Phone _____

Address: _____

Referred By: _____ Phone _____

What language do you speak at home?

___ English ___ Chinese ___ Japanese ___ Vietnamese

___ Spanish ___ Taiwanese ___ Korean

3. General Questions

___Fever ___Chill ___Both If both, which is more frequent? _____

___Spontaneous Sweating ___Night Sweating _____

Appetite: ___Normal ___Increased ___Decreased Special Craving: _____

Digestion: _____ Bowel Movement:

Frequent Thirst: ___ No ___Yes _____

Drink Temperature Preference: ___ Cold ___ Warm ___No Preference

Urine: ___Normal ___ Abnormal: _____

Body thermal feeling: ___Normal ___Abnormal: _____

Weight: ___Normal ___Loss ___Gain How much? _____ (kg/lbs.) In how long? (Time) ____

Menstruation: ___Regular ___Irregular ___PMS

___Clots _____

4. Have you ever received any treatment for this condition?

If yes, where? _____

When? _____

By whom? _____

What is the diagnosis? _____

What kind of treatment(s)? _____

Was the result satisfactory? _____

5. List medications you are currently taking

Medications	Strength	How many per day	For how long

6. Please list substances that you are allergic to: _____

7. (Female only) Are you pregnant or do you think that you may be pregnant? _____

8. List any major surgeries you have had:

Date	Problem

9. Hospitalization Other than Surgery/Significant Trauma (auto accident, falls, etc.)

_____

_____

10. Significant illness(Please check)

____Rheumatic fever	___Heart Disease	___Diabetes	__Thyroid Disease	___Cancer
____High Blood Pressure	___Tuberculosis	___STD	__Hepatitis	___AIDS
____Hyperlipidemia	___Coagulopathy	___Stroke	__Seizures	

___Others _____

11. Health Habits (tobacco, alcohol, illicit drugs, special diet, exercise, exposure to toxin, etc.)

_____

_____

12. Have you ever tried acupuncture or Chinese medicine before? ___Yes ___No

HEALTH HISTORY

(Confidential)

Name:_____ Today's Date: _____

Please check ☑ symptoms you currently have or have had in the past year

General

- ☐ Chills
- ☐ Dizziness
- ☐ Fatigue
- ☐ Fevers
- ☐ Forgetfulness
- ☐ Headache
- ☐ Insomnia
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Weight Gain
- ☐ Weight Loss

Cardio-Respiratory

- ☐ Asthma
- ☐ Chest Pain
- ☐ Coughing Blood
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Night Sweats
- ☐ Persistent Cough
- ☐ Phlegm Production
- ☐ Poor Circulation
- ☐ Recurrent Bronchitis
- ☐ Shortness of Breath
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Black Stools
- ☐ Bloating
- ☐ Blood in Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Gas
- ☐ Heartburn/Reflux
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary

- ☐ Abnormal Urine Color
- ☐ Blood or Pus in Urine
- ☐ Burning Urination
- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Poor Bladder Control
- ☐ Urgency to Urinate

Eye, Ear, Nose, Mouth, Throat

- ☐ Blurred Vision
- ☐ Bleeding Gums
- ☐ Cataract
- ☐ Double Vision
- ☐ Earache
- ☐ Eye Pain/Strain
- ☐ Glasses
- ☐ Hay Fever
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Olfactory Problems
- ☐ Recurrent Sore Throat
- ☐ Red/Inflamed Eye
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Sores on Lips/Tongue
- ☐ Taste Changes
- ☐ Teeth Problems
- ☐ Vision of Halos

Musculoskeletal

Pain, Weakness, Numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Joints
- ☐ Legs
- ☐ Muscle
- ☐ Neck
- ☐ Shoulders

Men Only

- ☐ Breast Lump
- ☐ Genital Pain
- ☐ Impotence
- ☐ Lump in Testicles
- ☐ Penile Discharge

Women Only

- ☐ Abnormal PAP smear
- ☐ Bleeding Between Periods
- ☐ Breast Lump
- ☐ Contraceptives (B.C.P.)
- ☐ Irregular Periods
- ☐ Menopause Status
- ☐ Painful Periods
- ☐ Sores on Genitals
- ☐ Vaginal Discharge

Skin

- ☐ Blood not clotting
- ☐ Bruise Easily
- ☐ Discoloration
- ☐ Lumps in Groin
- ☐ Lumps Underarm
- ☐ Skin Problem

How Many?

_____ Pregnancies

_____ Miscarriages

_____ Children Born

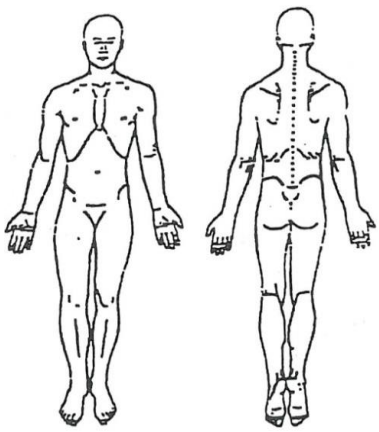
_____ Abortions

Last Menses: _____

Last PAP: _____

Mammogram: _____

Are you pregnant? ____



PAIN EVALUATION

/ / / STABBING	X X X BURNING	O O O PINS & NEEDLES	= = = NUMBNESS

PAIN SCALE

SEVERE PAIN: 10/10

NO PAIN: 0/10

1. PLEASE REFER TO THE GRAPHIC FOR PAIN AREAS
2. MARK THE AREAS ACCORDING TO TYPE OF PAIN GIVEN IN GRAPHICS
3. FOR EACH PAIN AREA USE A "FRACTION SCALE" FOR INTENSITY

   Slight pain = 2-3/10 Moderate Pain = 5-7/10

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Please read the following symptoms or issues carefully and decide how much they bothered or distressed you in the last month, including today.

	None	A little bit	Quite a bit	Very often
1. Suddenly scared for no reason	1	2	3	4
2. Feeling fearful	1	2	3	4
3. Faintness, dizziness, or weakness	1	2	3	4
4. Nervousness or shakiness inside	1	2	3	4
5. Heart pounding	1	2	3	4
6. Trembling	1	2	3	4
7. Feeling tense or keyed up	1	2	3	4
8. Headaches	1	2	3	4
9. Spells of terror or panic	1	2	3	4
10. Feeling restless can't sit still	1	2	3	4
11. Feeling low in energy, slowed down	1	2	3	4
12. Blaming yourself for things	1	2	3	4
13. Crying easily	1	2	3	4
14. Loss of sexual interest or pleasure	1	2	3	4
15. Poor appetite	1	2	3	4
16. Difficulty falling asleep, staying asleep	1	2	3	4
17. Feeling hopeless about the future	1	2	3	4
18. Feeling blue	1	2	3	4
19. Feeling lonely	1	2	3	4
20. Thoughts of ending your life	1	2	3	4
21. Worrying too much about things	1	2	3	4
22. Feeling no interest in things	1	2	3	4
23. Feeling of being trapped or caught	1	2	3	4
24. Feeling everything is an effort	1	2	3	4
25. Feelings of worthlessness	1	2	3	4

Please circle the number that best describes:

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst possible pain
Not tired	0	1	2	3	4	5	6	7	8	9	10	Worst possible tiredness
Not nauseated	0	1	2	3	4	5	6	7	8	9	10	Worst possible nausea
Not depressed	0	1	2	3	4	5	6	7	8	9	10	Worst possible depression
Not anxious	0	1	2	3	4	5	6	7	8	9	10	Worst possible anxiety
Not drowsy	0	1	2	3	4	5	6	7	8	9	10	Worst possible drowsiness
Best appetite	0	1	2	3	4	5	6	7	8	9	10	Worst possible appetite
Best feeling of wellbeing	0	1	2	3	4	5	6	7	8	9	10	Worst possible feeling of wellbeing
No shortness of breath	0	1	2	3	4	5	6	7	8	9	10	Worst possible shortness of breath
Other problem	0	1	2	3	4	5	6	7	8	9	10	

Patient's Name _____

Date _____ Time _____

Complete by *(check one)*

- ☐ Patient
- ☐ Caregiver
- ☐ Caregiver assisted

BODY DIAGRAM ON REVERSE SIDE

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Patient Bill of Rights

The American Academy of Pain Management endorses a Patient's bill of Rights. It is an expectation that compliance with the patient's rights can contribute to an effective patient care program. A modification of the American Hospital Association's statement on a Patient's Bill of Rights has been incorporated as part of the framework of the American Academy of Pain Management.

The modifications consist of the following:

1. The patient has the right to considerate and respectful care.

2. The patient has the right to obtain from their credentialed practitioner complete and current information concerning the diagnosis, proposed treatment, and expected prognosis in terms that the patient may reasonably be expected to understand. When it is not advisable to give such information to the patient, the information should be made available to an appropriate person (medical proxy) on the patient's behalf.

3. The patient has the right to receive the necessary information for medical decision making and the granting of informed consent from the treating credentialed practitioner prior to the start of any procedure or treatment. This information shall include at the minimum: the expected procedure or treatment to be used, who will perform the procedure or treatment, what are the likely benefits from the procedure or treatment, what alternatives exist if any, what are the likely risks from the procedure or treatment, what may occur if no treatment is undertaken, and length of probable duration of incapacitation if any is expected.

4. The patient has the right to refuse any and all treatment to the extent permitted by law, and to be informed of any medical consequences of this action.

5. The patient has the right to every consideration of privacy concerning the medical care provided except when there is an imminent risk to the individual or others, or when the practitioner is ordered by a court to breach confidentiality.

6. The patient has the right to be advised if the practitioner, agency, or facility propose to engage in any form of human experimentation affecting the care or treatment provided. The patient has the right to refuse to participate in research projects or to withdraw continued consent to participate without repercussions.

7. The patient has the right to examine and receive an explanation of the bill for professional services rendered.

All pain management activities are to be provided with an overriding concern for the patient, and above all, with the recognition of the patient's dignity as a human being.

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Patient Consent to Use or Disclose Personal Health Information

I understand I have the right to review ACAOM's Notice Privacy Practice prior to signing document. The Notice of Privacy Practices has been provided to me _____.

The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information (PHI) that will occur in my treatment, Payment of my bills or in the performance of healthcare operations of the agency. My "protected health information: means health information, including my demographic information (name, address, phone number and others), that is collected from me and created or received by my healthcare providers or health insurer. This PHI relates to my past, present or future physical or mental health or 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 health information.

ACAOM reserves the right to change the privacy practices that are described in the Notice. ACAOM will provide me with a copy of any revisions to the Notice. The Notice is posted in ACAOM clinic reception area. I may obtain a revised Notice by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my exist visit.

I understand that I have the right to request restrictions on how PHI is used or disclosed to carry out treatment, payment or the agency's healthcare operations. (*Agency*) is not required to agree to the requested restrictions, however, if there is agreement, the restrictions is binding on (*Agency*) until the agreement is terminated.

By signing the form, you consent to our use and disclosure protected health information about you for treatment, payment and healthcare operations and acknowledge receipt of our Notice of Privacy practices.

_____	_____	_____
Print Client or Personal Representative Name	Client Personal Representative Signature	Date

_____
Description of Authority of Personal Representative

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Student Intern Clinic Patient Informed Consent to Treatment

I, _____, as a patient of the Student Intern Clinic of the American College of Acupuncture & Oriental Medicine (ACAOM), consent to any and all diagnostic procedures, tests, medical treatment, and care required in the diagnosis of my condition/illness and course of treatment by the practitioner or his/her designee, medical staff and other agents, and/or employees of the ACAOM, including residents and medical students. I recognize that ACAOM is a teaching facility and that my treatment and care will be observed and in some instances aided by medical students in their course of training. I therefore further acknowledge and consent to the observation of my care and treatment by students and faculty at the clinic as a part of ACAOM's mission as a professional teaching institution. Additionally, I consent to the use of my medical data and non-identifiable photographs for educational and research purposes. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of tests, examinations, treatments, procedures or any services rendered.

I understand that the Student Intern Clinic **does not** accept insurance assignment. All fees are due and payable at the time treatment is given. It will, however provide me with the appropriate receipt for filing with my insurance carrier. Acupuncture treatment coverage by insurance carriers varies by policy and company, and I should read my policy or check with my insurance company to determine eligibility for benefits in my case. Acupuncture is a lawfully deductible medical expense for purposes of U.S. Federal Income Tax. Acupuncture treatment is currently not covered by Medicare.

I acknowledge that for best result during my acupuncture treatment, I should not obtain treatment within one (1) hour after a meal or on an empty stomach. I should also not obtain treatment within 24 hours of donating blood, or if I plan to donate blood within 24 hours period. I also understand that I should abstain from any alcoholic drinking beverages while undergoing acupuncture treatment.

I acknowledge fully and specifically state that I understand that treatment with acupuncture (like treatment by other branches of health services) cannot, will not, and does not guarantee specific result or cure, and that treatment with acupuncture, just like leaving my condition untreated, carries risk. I also understand that acupuncture treatment may cause bruising, temporary soreness after needling, temporary dizziness, light-headedness, and rarely may cause fainting or blistering of the skin following cupping and/or moxabustion.

I acknowledge that I am legally and mentally competent to sign this authorization and that I have read and do fully understand it. I further understand that I may revoke this authorization at any time by notifying ACAOM in writing.

I release the College and the facilities in which services are rendered from liability resulting from the loss by theft or negligence of any employee of the institution or of any third party. I agree that I am responsible for any item(s) I keep with me in my possession, including, but not limited to electronic equipment, money, eyeglasses, jewelry or any other personal items.

_____ _____

Signature Date

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Notification Form Regarding Evaluation of Patient by Physician

This form is to be completed by patient, notifying the acupuncturist of whether he/she has been evaluated by a physician, and other information.

(Pursuant to the requirement of '183.6(e)' of this (relating to Denial of License, Discipline of Licensee) and Tex. Occ. Code Ann., '205.351', governing the practice of acupuncture)

I (patient's name), _____ am notifying the acupuncturist

(practitioner's name) _____ of the following:

Yes ____ No ____
I have been evaluated by a physician or dentist for the condition being treated within six (6 months) before the acupuncture is performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

_____ (Signature of patient) Date: _____

Yes ____ No ____
I have received a referral from a chiropractor within 30 days before the acupuncture is performed. After being referred by a chiropractor, I may have acupuncture up to 20 times or for 30 days, whichever occurs first. If substantial improvement does not occur in the condition for which the referral was made, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow this advice.

_____ (Signature of patient) Date: _____

Note:
Exemptions according to Rule 183.6(e) Scope of Practice:

3) …an acupuncturist holding a current and valid license may without evaluation or referral from a physician, dentist, or chiropractor performed acupuncture on a person for **smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse.**