Patient Information

Date:

Name:	Pronouns (optional):
Address:	Date of Birth:
City: State: Zip:	Phone:
Occupation:	Email:
Emergency contact:	Patient's Legal Guardian/Representative:
Relation:	Relation:
Phone:	Phone:

Your doctor or primary care provider: _____

Have you tried acupuncture before? Yes No

How did you find us? _____

Are you currently taking any blood thinners (Coumadin, Aspirin, Etc.)? _____

What is the main condition you would like to address today? What makes it better? What makes it worse?
Share below any secondary conditions you would like to address and what makes them better or worse:
Please list any hospitalizations, surgeries, major injuries, or trauma (what and when):
Please list current medications and supplements:
Please list any known allergies:

Check all that apply: ▫ Epilepsy/seizures ▫ Hepatitis A/B/C ▫ HIV+ ▫ Bleeding disorder or hemorrhage ▫ Taking blood thinners	▫ Pacemaker ▫ Fainting ▫ Diabetes ▫ Mental illness ▫ Addiction ▫ Other

LIFESTYLE: ▫ Exercise regularly ▫ Eat much fried food ▫ Eat much meat ▫ Eat gluten ▫ Crave sweets / carbs ▫ Crave salty foods ▫ Vegetarian / vegan ▫ Drink alcohol: # drinks/wk __ ▫ Drink coffee: # cups/day __ ▫ Smoke tobacco: # packs/wk __ ▫ Use drugs SLEEP: ▫ Not rested upon waking ▫ Trouble falling / staying asleep ▫ Less than 6 – 8 hours ▫ Insomnia GASTRO-INTESTINAL: ▫ Excessive / low appetite ▫ Fatigued after meals ▫ Hypoglycemic ▫ Indigestion / reflux / heartburn ▫ Nausea / vomiting ▫ Gas / bloating ▫ Stomach ache / abdominal pain ▫ Difficulty passing stools ▫ Diarrhea / loose stools ▫ Hemorrhoids ▫ Gallstones ▫ Gallbladder removed CARDIO-VASCULAR: ▫ High / low blood pressure ▫ High cholesterol ▫ Palpitations ▫ Poor circulation ▫ Rapid / irregular heartbeat HEAD / FACE: ▫ Headaches / migraines ▫ TMJ / jaw pain ▫ Loss of sensation/motion	TEMPERATURE / PERSPIRATION: ▫ Hot / Cold body sensation overall ▫ Aversion to heat or cold ▫ Cold hands / feet ▫ Hot flashes / night sweats ▫ Spontaneous sweating ▫ Sweaty palms / feet EYES / ENT / RESPIRATORY: ▫ Frequent colds / sinus infections ▫ Sinus problems ▫ Chronic / seasonal allergies ▫ Environmental sensitivity ▫ Cough ▫ Asthma / wheezing ▫ Difficulty breathing ▫ Sore throat ▫ Enlarged glands ▫ Ear ache ▫ Impaired hearing / hearing loss ▫ Ringing in ears ▫ Dizziness ▫ Red / inflamed / itchy eyes ▫ Teary / dry eyes ▫ Gum problems ▫ Nose bleeds DERMATOLOGICAL: ▫ Rash / itching / hives ▫ Acne / boils ▫ Hair falling out ▫ Weak / brittle nails ▫ Slow wound healing GENITO-URINARY: ▫ Frequent urination ▫ Poor bladder control / urgency ▫ Burning / pain on urination ▫ Frequent urinary tract infections ▫ Kidney stones	EMOTIONAL / PSYCHOLOGICAL: ▫ Anxiety ▫ Depression ▫ Mood swings ▫ Irritability, impatient ▫ Difficulty concentrating ▫ Worry ▫ Feel sad a lot ▫ Cry uncontrollably ▫ Much fear / terrors ▫ History of abuse ▫ Considered or attempted suicide FEMALE ONLY: ▫ May be pregnant ▫ Irregular cycle ▫ Painful periods (cramps, back pain, knee pain) ▫ Heavy / scant periods ▫ Light periods ▫ Clots present ▫ Low libido ▫ Chronic vaginal infections ▫ Abnormal pap ▫ Endometriosis ▫ Ovarian cysts ▫ Uterine fibroids ▫ Partial / Total Hysterectomy Number of: Pregnancies __ Abortions__ Miscarriages __ Number of Births: Vaginal __ Cesarean __ Cycle is: __ days. Period lasts __ days. MALE ONLY: ▫ Erection difficulties ▫ Premature ejaculation ▫ Low libido ▫ Genital or groin pain ▫ Hernia ▫ Penis discharge ▫ Prostate problems

Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, Andy Bishop, L.Ac., is required to have you respond affirmatively to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no.

(Pursuant to the requirements of section 183.10(a)(11) of this title and section 205.302 V.A.C.S. article 4495b, governing the practice of acupuncture)

I (patient's name) _____
am notifying Andy Bishop L.Ac. and Cardinal Wellness, PLLC of the following:

___ Yes ___ No I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within 12 months before the acupuncture was performed. I recognize that a physician or dentist for the condition being treated by the acupuncturist should evaluate evaluate evaluate me.

OR

___ Yes ___ No I have received a referral from my chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of treatment prior to acupuncture treatment is _____. 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.

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

___ Chronic Pain
___ Smoking addiction
___ Weight loss
___ Alcoholism
___ Substance abuse

Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

_____ Date_____
Patient Signature Required

The acupuncturist has referred me to a physician. It is my responsibility and choice to follow his/her advice.

_____ Date_____
Patient Signature Required

_____ Date_____
Acupuncturist's Signature

INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by Andy Bishop, L.Ac. and Cardinal Wellness, PLLC who now or in the future treat me while employed by, working or associated with Cardinal Wellness, PLLC: acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with Andy Bishop, L.Ac. and/or with other clinic personnel the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from those locations; nerve pain, burns, infection of insertion site, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. 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 judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I understand that acupuncture and Oriental medicine treatments may not have the desired therapeutic effect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is reasonable cause to believe that treatment is not appropriate for a patient who is under the influence of illegal drugs, alcohol, or appears to be overly medicated, then a treatment may not be performed at that time. The patient will be informed that they may not be treated at that time and will be requested to reschedule their appointment.

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 and conditions of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at Cardinal Wellness, PLLC.

_____	_____
Patient's name (please print)	Patient's signature
_____	_____
Print Name of Patient's Representative (if applicable)	Relationship or Authority of Patient's Rep.
_____	_____
Signature of Patient's Representative (if applicable)	Date Signed

HIPAA Acknowledgement and Appointment Reminders Form

I understand that Andy Bishop, L.Ac. and Cardinal Wellness, PLLC members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

I also understand that my clinical information may be used for educational and/or research purposes by Andy Bishop, L.Ac. and Cardinal Wellness, PLLC or individuals authorized by Andy Bishop, L.Ac. and Cardinal Wellness, PLLC. All information that can identify me personally will be removed.

By signing this form, I am giving Andy Bishop, L.Ac. and Cardinal Wellness, PLLC authorization to contact me. I acknowledge that all information discussed during the assessment and treatment by Andy Bishop, L.Ac. and Cardinal Wellness, PLLC will be held confidential except in the instance where my safety or the safety of others may be at risk.

I acknowledge that I have been provided access to Andy Bishop, L.Ac. and Cardinal Wellness, PLLC "Notice of Privacy Practices". I understand that I have the right to review the "Notice of Privacy Practices" prior to signing this document.

_____ _____

Patient Name (print) Date

_____ _____

Patient Signature Date

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize the Andy Bishop, L.Ac. and Cardinal Wellness, PLLC the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____ _____

_____ _____

_____ _____

Patient's Signature Date