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Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, Earthspring Acupuncture, PLLC (Earthspring) 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 section183.10(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 Earthspring Acupuncture, 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 I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

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.

_____ _____

Patient Signature Required Date

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

_____ _____

Patient Signature Required Date

_____ _____

Acupuncturist's Signature Date

Earthspring Acupuncture, PLLC is not responsible for untrue statements made by patients.

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HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the Earthspring Acupuncture, PLLC (Earthspring) "Notice of Privacy Practices". I understand that I have the right to review "Notice of Privacy Practices" prior to signing this document.

I understand that Earthspring staff 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 Earthspring. All information that can identify me personally will be removed.

By signing this form, I am giving Earthspring authorization to contact me and am giving my informed consent to utilize my information for research and educational purposes. I acknowledge that all information discussed during the assessment and treatment at Earthspring Acupuncture will be held confidential except in the instance where my safety or the safety of others may be at risk

_____ _____

Patient Name (print) Date

_____

Patient Signature

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Earthspring Acupuncture, 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

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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 the licensed acupuncturists on staff at Earthspring Acupuncture (Earthspring) who now or in the future treat me while employed by, working or associated with or substituting for Earthspring, including those working at this clinic or any other associated clinics: 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 my practitioner, 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, 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 practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners 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 affect 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 Earthspring Acupuncture.

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

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New Patient Information

Name _____ Today's Date _____

Street Address _____ Ste./Apt. _____

City _____ State _____ Zip _____

Preferred Phone _____ Email _____

Birth Date _____/_____/_____ Age _____ Gender _____

Occupation _____ Employer _____

Relationship Status_____ Number of Children_____

Referred by (if applicable) _____

Emergency Contact: Name _____ Phone _____

Cancellation Policy:

If you need to change or cancel your appointment, please do so with a minimum of 24 hours notice. Failure to do so will result in being charged the full appointment fee.

□ I understand the cancellation policy.

Signature:_____ Date: _____/_____/_____ *(continued onto next pages)*

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HEALTH HISTORY

Have you had acupuncture before? _____ If so, for what reason? _____

_____

What is the main issue you are seeking treatment for today? _____

_____

What diagnosis have you received for this problem, if any?_____

_____

When did this problem begin? _____

Do you know what caused it? _____

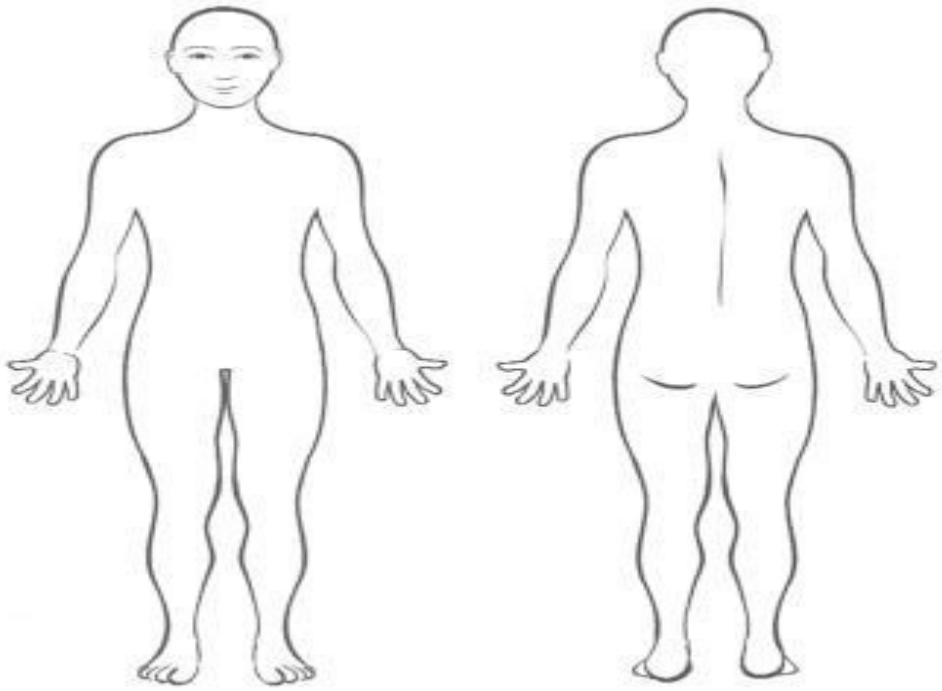
_____

Are there any other health issues you would like to work on? _____

_____

_____

Please mark any areas of pain or discomfort, if that is the reason for your visit today:



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Check any symptoms that you are currently experiencing or have experienced in the last 6 months:

GENERAL

Sweating easily during the day	□	Fatigue	□
Night sweating	□	Fevers	□
Bleed or bruise easily	□	Chills	□
Change in appetite	□	Weight loss/gain	□
Run hot	□	Poor sleep	□
Run cold	□	Sudden energy drop -What time of day? _____	□
Favorite time of year? _____		Worst time of year? _____	

SKIN | NAILS

Rashes/hives	□	Psoriasis	□
Eczema	□	Dry skin	□
Acne	□	Itching	□
Bruise easily	□	Slow wound healing	□
Weak/brittle nails	□		

MUSCULOSKELETAL

Neck pain/tightness	□	Muscle soreness	□
Shoulder pain	□	Tremors	□
Back pain	□	Spinal curvature	□
Knee pain	□	Joint pain	□
Hip pain	□	Pain all over body	□
Leg/arm pain	□	Hand/foot pain	□

HEAD | EARS | EYES | NOSE | THROAT

Earaches/pressure in the ears	□	Headaches/migraines	□
Ringing in the ears	□	Sinus pressure	□
Hearing loss	□	Nose bleeds	□
Eye floaters (spots)	□	Dizziness/vertigo	□
Itchy eyes	□	Teeth/gum problems	□
Dry eyes	□	Teeth/jaw clenching	□
Blurry vision	□	Difficulty swallowing	□

CARDIOVASCULAR | CIRCULATORY

Chest pain	□	Swelling/edema	□
Fainting	□	High blood pressure	□
Lightheadedness	□	Low blood pressure	□
Cold hands & feet	□	Palpitations	□
Irregular heartbeat	□	Blood clots	□

RESPIRATORY

Pain on inhaling	□	Sneezing	□
Chest tightness	□	Seasonal/other allergies	□
Cough	□	Phlegm production	□
Asthma or wheezing	□	Frequent colds/flu	□

DIGESTIVE

Heartburn/reflux	□	Gallbladder problems	□
Belching	□	Diarrhea	□
Gas/bloating	□	Constipation	□
Nausea/vomiting	□	Abdominal pain/cramps	□
Ulcer	□	Mucus in stool	□
Chronic bad breath	□	Blood in stool	□
Sores on lips/tongue	□	Hemorrhoids	□

URINARY | GENITAL

Difficulty urinating	□	Urgent/freq. urination	□
Blood in urine	□	Frequent UTIs	□
Pain upon urination	□	Genital pain	□

EMOTIONAL | PSYCHOLOGICAL

Anxiety	□	Difficulty concentrating	□
Depression	□	Irritability/anger	□
Susceptible to stress	□	Worry a lot	□
Trouble falling asleep	□	Frequent crying	□
Trouble staying asleep	□	History of abuse/trauma	□

NEUROLOGICAL

Loss of balance/coordination	□	History of concussion	□
Areas of numbness/paralysis	□	Poor memory	□

FOR WOMEN ONLY:

Irregular periods	□	Breast pain	□
Vaginal discharge	□	Ovarian cysts	□
Bleeding between periods	□	Fibroid cysts	□
Period clots	□	Endometriosis	□
Menstrual cramping	□	Fertility issues	□
Hot flashes	□	Night sweating	□

Age at first menses _____ Duration of typical cycle _____

# of pregnancies _____ # of births _____

# of miscarriages _____ # of abortions _____

Have you been through menopause? If so, what age? _____

Do you practice birth control? If yes, what type and for how long? _____

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

_____

_____

Are you now or are you currently trying to become pregnant? _____

Are you currently breastfeeding? _____

FOR MEN ONLY:

Erectile dysfunction/impotence	□	Ejaculatory pain	□
Fertility problems	□	Prostate problems	□

LIFESTYLE

Current medications, herbs, vitamins and/or supplements:

_____

_____

Do you follow any certain way of eating? (vegetarian, vegan, gluten-free, dairy-free, paleo, etc.)

_____

_____

How much water do you drink per day? _____

Do you exercise? What and how often?_____

_____

Do you use tobacco? If so, how often?_____

_____

Do you drink alcohol? If so, how many drinks per week/ day? _____

Are you currently taking any of the following medications? *(circle if yes)*

Advil/Motrin/Ibuprofen	Aleve/Naproxen	Bayer/Aspirin
Celebrex/Celecoxib	Prednisone/Prednisolone	

Allergies (medications/foods/chemicals/etc.):

_____

_____

_____

Have you ever had a seizure? If yes, indicate date of most recent: _____

Please circle any significant illnesses and indicate date:

Cancer (specify diagnosis)	Hepatitis	Diabetes
High blood pressure	Epilepsy	Heart disease
Breathing problems	Arthritis	Thyroid disease
Stroke	Ulcer	Gallbladder disease
Substance abuse	Tuberculosis	Anemia
Other _____		

Please list any major surgeries/hospitalizations or significant trauma and approximate dates:

_____

_____

FAMILY MEDICAL HISTORY

□ Cancer □ Seizures □ High blood pressure □ Stroke □ Diabetes

□ Heart attack □ Hepatitis □ Asthma □ Substance abuse □ Emotional disorders

□ Other _____

Please list any other relevant information or issues you would like to discuss:

_____ _____

Patient Signature **Date**