HOLISTIC
PHYSICAL THERAPY
6225 FM 2920, Suite 130, Spring, Texas 77379

ACUPUNCTURE QUESTIONNAIRE

Name: _____ Sex: [ ]M [ ]F

Address: _____ Date of Birth: _____

City: _____State: _____ Zip: _____ Social Security #: _____

Home Phone: _____ Marital Status: [ ] Married [ ] Single

Cell Phone: _____ Referring Physician: _____

Email Address: _____ Primary Care Physician: _____

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Not Employed

Employer:_____

Phone: _____

EMERGENCY CONTACTS (NAME & PHONE)

_____

_____

_____

_____

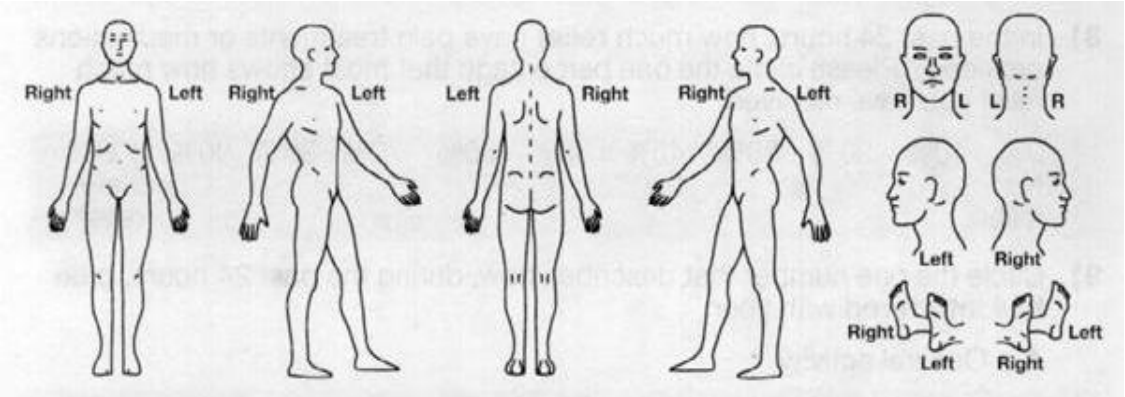
Patient/Responsibility Party Signature: _____

CHIEF COMPLAINT: _____

PAIN EVALUATION

Pain Scale:

no pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**severe pain**



Mark each area where you are having pain according to the pain scale above.

HEALTH HISTORY

Name:_____ Date:_____

PLEASE CHECK ANY SYMPTOMS YOU HAVE ON A REGULAR BASIS:

General

- ☐ Chills
- ☐ Dizziness
- ☐ Fatigue
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Insomnia
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweating
- ☐ Weight Gain
- ☐ Weight Loss

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Black Stools
- ☐ Bloating
- ☐ Bloody Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult Swallowing
- ☐ Gas
- ☐ Heartburn/GERD
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Vomiting
- ☐ Vomiting Blood

Heart/Cardio-Respiratory

- ☐ Asthma
- ☐ Chest Pain
- ☐ Coughing Blood
- ☐ Blood Pressure (High/Low)
- ☐ Irregular Heart Beat
- ☐ Night Sweating
- ☐ Chronic Cough
- ☐ Phlegm/Sputum
- ☐ Poor Circulation
- ☐ Chronic Bronchitis
- ☐ Short of Breath
- ☐ Swelling of Ankles/Feet
- ☐ Varicose Veins

Eyes/Ears/Mouth/Nose/Throat

- ☐ Blurry Vision
- ☐ Bleeding Gums
- ☐ Cataracts
- ☐ Double Vision
- ☐ Earache
- ☐ Eye Pain
- ☐ Wear Glasses/Contacts
- ☐ Hay Fever/Allergies
- ☐ Hearing Loss
- ☐ Hoarseness/Loss of Voice
- ☐ Nose Bleeds
- ☐ Loss of Smell
- ☐ Chronic Sore Throat
- ☐ Red Eyes
- ☐ Ringing in the Ears
- ☐ Sinus Problems
- ☐ Sores on Lips/Tongue
- ☐ Taste Changes or Loss of Taste
- ☐ Teeth/Gum Problems
- ☐ Vertigo/Spinning Sensation

Genitourinary

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

Musculoskeletal

(Pain, Weakness or Numbness)

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Joints
- ☐ Knees
- ☐ Legs
- ☐ Muscles
- ☐ Neck
- ☐ Shoulders

Skin

- ☐ Blood Clotting Problems
- ☐ Bruise Easily
- ☐ Discoloration
- ☐ Lumps

Men Only

- ☐ Breast Lumps/Enlargement/Discharge
- ☐ Genital Pain
- ☐ Testicular Lumps
- ☐ Penile Discharge
- ☐ Genital Sores
- ☐ Impotence

Women Only

- ☐ Abnormal Pap Smear
- ☐ Bleeding/Spotting Between Periods
- ☐ Breast Lumps/Discharge/Skin Chg
- ☐ Birth Control/Contraceptive Use
- ☐ Irregular Periods
- ☐ Menopausal
- ☐ Painful Periods
- ☐ Genital Sores
- ☐ Vaginal Discharge

( ) Pregnancies
( ) Abortions
( ) Miscarriages
( ) Children Born

Last Menses: ___/___/___
Last Pap: ___/___/___

Last Mammogram: ___/___/___
Are You Pregnant? _____

1. Have you ever received treatment for this condition? Yes___No___

   If yes, where? _____
   By whom? _____
   What was their diagnosis? _____
   What treatments were performed? _____
   Was the result satisfactory? _____

2. Please list all medications, vitamins, supplements and/or herbs you are currently taking.

Medication Name	Dose	How many per day?	For how long?

3. Please list any allergies: _____
   _____

4. (Females) Are you pregnant or do you think you could be pregnant? _____

5. Major Surgeries:

Date	Procedure

6. Hospitalizations other than surgery or trauma:

Date	Hospitalization

7. Significant past or current illnesses:

___Cancer ___Heart Disease ___Diabetes ___High Blood Pressure ___High Cholesterol
___Thyroid Disease ___Tuberculosis (TB) ___STD ___Hepatitis ___HIV/AIDS
___Rheumatic Fever ___Blood clotting ___Stroke ___Seizures
___Others_____

8. Health Habits (use of tobacco, alcohol, drugs, special diet, exercise, exposure to chemicals, toxins, etc.)

   _____
   _____
   _____

INFORMED CONSENT TO TREATMENT AND DISCLOSURES

By signing below, I voluntarily consent to be treated with one or all of the modalities listed below by a Texas licensed acupuncturist at The Woodlands Acupuncture & Herbal Clinic. I understand that acupuncturists practicing in the state of Texas **are not** primary care providers and that regular primary care by a licensed physician (M.D. or D.O.) is very important.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, modify or prevent pain perception, and normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, infection, burns, scars, fainting, pain, discomfort, numbness or tingling at the needling site that may last a up to a few days. More unusual and very rare risks include spontaneous miscarriage, nerve damage and organ puncture.

Chinese/Western Herbs and Nutritional Supplements: I understand that substances from the Oriental Materia Medica and German Commission E Monographs may be recommended to treat bodily dysfunction or diseases, modify or prevent pain perception, and normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain herbs may be inappropriate during pregnancy and that I will notify a clinical staff member who is caring for me if I am or become pregnant. I am aware that adverse side effects may result from taking these substances, including changes in bowel/bladder function, nausea/vomiting, abdominal pain/discomfort, gas, belching, rashes, hives and tingling of the tongue. Should I experience any problems which I associate with these substances, I will stop taking them and call 713.377.1832 as soon as possible.

Acupressure/Tui-Na/Gua Sha/Cupping: I understand that I may also be treated with acupressure, tui-na, gua sha and/or cupping as a way to modify or prevent pain perception and normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, bleeding, sore muscles or aches.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort.

With all modalities listed above I may experience an aggravation of symptoms existing prior to treatment. I understand that I may refuse any or all treatments at anytime and do not expect the staff to be able to anticipate all possible risks or complications of the treatments. I wish to rely on the staff to exercise judgment during the course of treatment which the staff thinks at the time, based upon the facts then known, and is in my best interest. I understand that acupuncture, herbs and related treatments, as in any medical therapy; make no guarantee as to the results.

By voluntarily signing below, I acknowledge that I have read, or had read to me, all of the above information and am fully aware of what I am signing. I understand that I may ask the staff for a more detailed explanation. I give my permission and consent to treatment for the entire course of treatment for my current condition and for any future condition(s) for which I seek treatment.

Signature of Patient/Representative: _____ Date: _____

Print Patient/Representative Name: _____

Form to be Completed by Patient, Notifying the Acupuncturist of Whether He/She Has Been Evaluated by a Physician, and Other Information.

(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 of the following:

_____Yes____ No

I have been evaluated by a physician or dentist 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.

_____ (initials of patient) Date: _____

_____Yes____ No

I have received a referral from my chiropractor within the last 30 days for acupuncture.

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 responsibility and choice whether to follow this advice.

Signature_____ Date_____