Clear Choice Acupuncture and Wellness

213 N Thompson St., Conroe, Texas 77301
936-689-6975

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, Clear Choice Acupuncture and Wellness 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 Clear Choice Acupuncture and Wellness 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 ☐Alcoholism
☐ Smoking addiction ☐ Substance abuse
☐ Weight loss

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

Clear Choice Acupuncture and Wellness is not responsible for untrue statements made by patients.

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_____ ____/____/____
Acupuncturist's Signature Date

Patient Intake Form

Thank you for coming. Please help us to provide you with a complete evaluation by taking the time to fill out this questionnaire. All your information will be confidential. If you have questions please ask. Thank you.

Contact Information Today's Date:_____/_____/_____

Name:_____ Sex: F ☐ M ☐ DOB:__/__/___ Age:____

Street:_____ Email Address:_____

City:_____ State:_____ Zip:_____ Phone Number:_____

Martial Status: M ☐ S ☐ D ☐ W ☐ # of Children:_____ Alternative Phone Number:_____

Occupation:_____ Employer:_____

Emergency Contact:_____ Phone:_____

How did you find out about us? Walk By ☐ Friend/Relative ☐: _____ Insurance ☐

Website ☐ Internet Search Engine ☐ Doctor Referral ☐:_____ Other ☐: _____

Have you had acupuncture before? Y ☐ N ☐ Allow email/mail/phone contact by CCA? Y ☐ N ☐

Primary Insurance Company:_____ ID #:_____ Group #:_____

Name of Insured:_____ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐

Customer Service/Provider Phone Number:_____

Secondary Insurance:_____ ID #:_____ Group #:_____

Name of Insured:_____ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐

Customer Service/Provider Phone Number:_____

Major Health Complaint(s)

Please list in order of significance to you and **check which you would like us to focus on today**.

1. ☐_____ 4. ☐_____
2. ☐_____ 5. ☐_____
3. ☐_____ 6. ☐_____

When did the checked problem begin?_____

What are the precipitating factors?_____

Have you been given a diagnosis for this problem? If so, please describe._____

What kind of treatments have you tried?_____

What makes this problem worse?_____ Better?_____

Is there anybody in your family with the same problem?_____

Please describe how these conditions affect or impair your daily activities? Examples may include your overall quality of life, work, family life, hobbies or self-esteem.

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Past Medical History

Check any conditions that you have had in the past or are currently experiencing: **P=Past C=Current**

P	C		P	C		P	C		P	C	
☐	☐	Alcohol/Drug Abuse	☐	☐	Digestive Disorder	☐	☐	Hypertension	☐	☐	Nervous Disorder
☐	☐	Anemia	☐	☐	Epilepsy/Seizures	☐	☐	Jaundice	☐	☐	Pneumonia
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Liver Disease	☐	☐	Thyroid Disorder
☐	☐	Auto Immune	☐	☐	Heavy Bleeding/Hemorrhage				☐	☐	Tuberculosis
☐	☐	Blood Transfusion	☐	☐	Hepatitis	☐	☐	Mental Illness	☐	☐	Vein Condition
☐	☐	Cancer	☐	☐	High Cholesterol	☐	☐	Migraines	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	HIV/Hepatitis	☐	☐	Other:_____			

Known allergies (food, medications, or other):_____

Significant trauma (car accident, sports injuries etc.):_____

Immunizations:_____

Hospitalizations/Surgeries (procedures and dates):_____

Dental Procedures (include any silver fillings/mercury amalgams):_____

Do you have a history of frequent antibiotic use? Please Describe._____

Allergy shots? Currently ☐ In the past ☐ Never ☐

Please briefly describe your health as a child. (e.g. allergies/asthma, prone to illness, etc):

_____

Family Medical History (please specify family member)

☐	Alcoholism/Drug Abuse_____	☐	Heart Disease_____
☐	Asthma/Allergies_____	☐	Hypertension_____
☐	Cancer_____	☐	Miscarriage_____
☐	Depression/Mental Illness_____	☐	Osteoporosis_____
☐	Diabetes_____	☐	Stroke_____
☐	Other_____		

Current Health & Lifestyle

Do you smoke? Y ☐ N ☐ If yes, how many per day?_____ For how long?_____

Do you exercise? Y ☐ N ☐ If yes, how many times per week?_____ Please Describe._____

Do you travel frequently? Y ☐ N ☐ Have you traveled overseas to 'developing' countries? Y ☐ N ☐

Do you sit in traffic/commute as a daily routine? Y ☐ N ☐

Height:_____ Weight: Now_____ One year ago_____ Maximum_____in Year_____

How many hours do you sleep at night (average)?_____ When do you usually go to bed?_____

List 3 things you do currently that support your overall health.

List your 3 favorite vices (eg smoking, social drinking, sweet tooth…)

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Overall, do you feel that your lifestyle contributes to or takes away from your health?

Diet

Soft drinks per day_____ Cups of tea per day_____ Cups of coffee per day_____

Glasses of water per day_____ Alcoholic beverages per week_____

Are you a vegetarian? Y ☐ N ☐ Yes, but not strict ☐ Explain:_____

Please describe your average daily diet:

Breakfast:_____

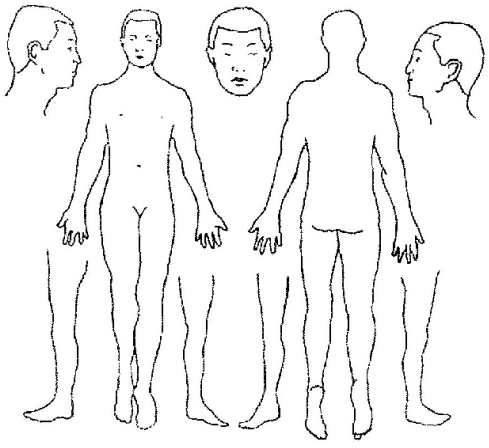
Lunch:_____

Dinner:_____

Snacks:_____

Foods you tend to crave:_____

Please indicate painful or distressed areas by using the symbol that best describes the feeling:



Mark with appropriate symbols:	
XXX	Sharp / Stabbing
PPP	Pins and Needles
DDD	Dull / Aching
NNN	Numbness

Please rate your **current** level of pain: Very mild 1 2 3 4 5 6 7 8 9 10 Very severe

Medications and Supplements

Medications you are currently taking (please include prescription medicines, vitamins, supplements, over the counter drugs, herbal supplements, etc.):

Profile

Please check any of the following symptoms that **currently** pertain to you.

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General

☐Cold hands	☐Hot body temperature	☐Profuse perspiration	☐Chills
☐Cold feet	☐Cold body temperature	☐Lack of perspiration	☐Fever
☐Sweaty hands	☐Afternoon flushing	☐Perspire easily	☐Strong thirst
☐Sweaty feet	☐Hot flashes	☐Night sweating	☐Lower back pain
☐Frequent cavities	☐Hearing loss	☐Weak knees	☐Cold lower back
☐Broken/loose teeth	☐Ringing in ears/tinnitus	☐Knee soreness	☐Cold hips/buttocks
☐Weak bones	☐Early graying of hair	☐Hair loss	☐Cold knees
☐Dizziness	☐Forgetfulness	☐Fainting	☐Weak nails

Emotions

☐Mood swings	☐Anxiety	☐Fits of laughter	☐Fear
☐Sadness	☐Panic attacks	☐Depression	☐Frequent worrying
☐Nervousness	☐Irritability	☐Anger	☐Easily stressed
☐Bipolar	☐Obsessive/Compulsive	☐Mania	

Skin

☐Acne	☐Dry or Flaky Skin	☐Hives	☐Rashes
☐Dandruff	☐Eczema	☐Psoriasis	☐Ulcerations/Boils

Neuro-Muscular

☐Seizures	☐Lack of coordination	☐Tingling in extremities	☐Numbness
☐Paralysis	☐Loss of balance	☐Muscle spasms	☐Joint pain
☐Arthritis	☐Muscle tightness	☐Tendonitis	☐Osteoporosis

Cardiovascular

☐Heart palpitations	☐Chest Pain/Angina	☐Tongue ulcers	☐Speech impediment
☐Restless dreams	☐Mental restlessness	☐Insomnia	☐Hallucinations

Respiratory

☐Persistent cough	☐Nasal dryness	☐Chest congestion	☐Chest tightness
☐Nosebleeds	☐Chronic allergies	☐Sneezing	☐Difficulty Breathing
☐Sinus congestion	☐Sore throats	☐Wheezing	☐Shortness of breath
☐Frequent colds/flu			

Gastrointestinal

☐Indigestion	☐Low or weak appetite	☐Fatigue following a meal	☐Hypoglycemia
☐Abrupt weight gain	☐Gurgling in intestines	☐Easily fatigued	☐Strong cravings
☐Abrupt weight loss	☐Bruise easily	☐Gas	☐Hemorrhoids
☐Stomach ache	☐Ravenous appetite	☐Stomach ulcer	☐Nausea
☐Acid reflux	☐Bleeding gums	☐Belching	☐Vomiting
☐Bad breath	☐Heartburn	☐Hiccups	☐Mouth ulcers
☐Loose stools	☐Blood in stools	☐Less than 1 BM per day	☐Constipation
☐Mucous in stools	☐Difficulty moving bowels	☐Small, hard, dry stools	☐Diarrhea

Lymphatic System/Accumulated Dampness

☐Swollen hands	☐Mental fogginess	☐Edema in the legs	☐Heavy limbs/head
☐Swollen feet	☐Mental sluggishness	☐Edema in the abdomen	☐Joint stiffness

Liver/Gall Bladder Function

☐Headaches ☐Migraines ☐Pain in ribcage ☐Gall stones ☐Chronic neck or shoulder tension

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Eyes

☐Itchy eyes ☐Watery eyes ☐Poor night vision ☐Cataracts
☐Dry eyes ☐Red and irritated eyes ☐Floaters/Seeing spots ☐Glaucoma
☐Blurry vision

Urinary

☐Cloudy ☐Small amount ☐Night-time urination ☐Incontinence
☐Dark yellow ☐Large amount ☐Difficulty initiating urination ☐Strong odor
☐Clear color ☐Dribbling ☐Very frequent ☐Pain or burning
☐Reddish color

MALE ONLY

☐Prostate Problems ☐Testicular pain/swelling ☐Ejaculation problems
☐Low sex drive ☐Premature ejaculation ☐Erectile dysfunction/impotence
☐Nocturnal emission ☐Infertility ☐Difficulty maintaining an erection
☐Low sperm count ☐Poor sperm motility ☐Irregular sperm morphology
☐Feeling of coldness or numbness of genitalia ☐Discharge

Do you have any bothersome symptoms? Y ☐ N ☐ Describe:_____

Do you get up at night to urinate? Y ☐ N ☐ How often?_____

To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?

_____

Have you sought medical intervention for these problems? If so, when?_____

_____

What treatment have you tried for these problems and how successful have they been?

_____

FEMALE ONLY

☐Pelvic infection ☐Endometriosis ☐Vaginal dryness ☐Frequent vaginal infections
☐Fibroids ☐Ovarian cysts ☐Abnormal pap smear ☐Abnormal vaginal discharge
☐Breast tenderness ☐Breast lumps ☐Spotting between periods ☐Hot flashes
☐Low sex drive ☐Fertility problems ☐Pain during intercourse ☐Night sweats

Do you experience any of the following associated with your period each month?

☐Water retention ☐Migraine/headache ☐Lower back pain ☐Change in bowel movement
☐Mood swings ☐Irritability ☐Abdominal cramps ☐Breast tenderness/swelling
☐Food cravings ☐Acne ☐Heavy bleeding ☐Scanty/light bleeding
☐Clots ☐Other:_____

_____number of pregnancies _____number of live births _____miscarriages _____abortions

_____premature births _____difficult delivery _____cesareans

At what age did you get your first period:_____ First day of last menstrual period:_____

Are your menstrual cycles spaced regularly? Y ☐ N ☐ Cycle length:_____ Period length :_____

Are you currently using birth control? Y ☐ N ☐ If yes, what type and for how long?_____

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Have you experienced menopause? Y ☐ N ☐ When?_____

Date of last PAP:_____

If you are experiencing menopausal symptoms, please describe:_____

_____

Is there <u>any</u> possibility you are pregnant now? Y ☐ N ☐

Patient Signature **Date**

Patient Printed Name:_____