



Texas College of Traditional Chinese Medicine - Student Intern Clinic

1707 Fortview Rd. Austin, TX 78704

This is a confidential questionnaire to help us determine the best treatment plan for you. If you have any questions, please do not hesitate to ask. Thank you.

Last Name: _____ First Name: _____ M.I. _____

Gender: M / F Date of Birth: ___ / ___ / ___ Driver's License #: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone #: _____

Work Phone #: _____ Cell Phone #: _____ Email: _____

Occupation: _____ Have you received acupuncture treatment before? _____

If you are suffering from any of the following conditions, please notify your acupuncturist at this time:

Heart Condition/Pacemaker: __ Stroke: __ Seizures: __ Bruise easily __ Fainting from Needles: _____

ACUPUNCTURE REQUEST AND CONSENT

I hereby request that the student intern(s) and/or licensed acupuncturist(s) of the Texas College of Traditional Chinese Medicine treat me. I also authorize him/her/them to perform on me the treatment known as "Acupuncture" as his/her/their judgment may indicate, and further authorize him/her/them to use whatever therapeutic methods he/she/they see fit, regardless of whether these methods are commonly and generally accepted and practiced in this community. I understand that acupuncture may include:

- 1) The non-surgical, non-incisive insertion of disposable needles in specific locations on the body;
2) The recommendation of herbal dietary supplements;
3) The recommendation of energy-flow exercises or other prescribed forms of movement;
4) The collection of data and information regarding the functioning of various physical processes, by interrogation, observation, palpation, and other methods specific to the practice of acupuncture; and
5) The use of localized heat and/or electrical stimulation, whether alone or in combination with the other procedures described above

The Student Intern and/or the Acupuncturist has clearly explained to me the nature and purpose of the treatment, the risks involved, the collateral hazards, and the possibilities of complications during or as a result of treatment. I understand the meaning of the term "complications", and in giving my consent to the treatment, I have in mind the Acupuncturists/Student Interns clear explanation. In the event that any unforeseen condition arises in the course of treatment, and in the judgment of the Acupuncturist it is advisable to use procedures in addition to or different than this now contemplated, I also request and authorize him/her to perform such treatments, use such procedures, or otherwise act in accordance with his/her professional opinion.

The Acupuncturist has made no guarantee or representation as to the results that may be obtained

I understand that I am fully liable for payment of expenses associated with the Student Intern and/or Acupuncturist's provision of acupuncture in accordance with this request and consent, and agree to pay or cause to be paid in full the amount billed for these services. In the event that my condition is such that treatment is beyond the normal capabilities of the Acupuncturist, I understand that I may be referred to other competent practitioners including, but not necessarily limited to, medical physicians or other practitioners. I also agree to give 24 hours notice if I am unable to make my scheduled appointment. I fully understand I may be charged the regular treatment fee (\$25.00) if I miss an appointment without giving 24 hours notice.

Patient Signature: _____

Date: _____



MEDICAL EVALUATION, REFERRAL, OR RECOMMENDATION

(Pursuant to the requirements of 22 T.A.C. 183.7 of the Texas State Board of Acupuncture Examiners' rule (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/Student Intern 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.

Note: In the case of patients seeking treatment for smoking addiction, weight loss, alcoholism, chronic pain (*defined as pain lasting longer than 6 months*), or substance abuse, referral by a physician, dentist, or chiropractor is not required.

After being referred by a chiropractor, if after 2 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.

Patient Signature _____

Date _____

**Optional Form to be Completed by Patient,
Attesting that the Acupuncturist Has Referred Him/Her**

(Pursuant to the requirements of 22 T.A.C. 183.7 of the Texas State Board of Acupuncture Examiners' rule (relating to Scope of Practice) and Tex. Occ. Code Ann. 205.351, governing the practice of acupuncture)

The Acupuncturist/Student Intern has referred me to see a physician. It is my responsibility and choice whether to follow his/her advice.

Patient Signature _____

Date _____

Acupuncturist/Student Intern Signature _____

Date _____

Neither the Clinic nor The Acupuncturist/Student Intern is liable for errors or false statements on this form.



NOTICE OF PRIVACY POLICIES

Austin Acupuncture is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive from you;
- Information we receive from other healthcare providers;
- Information we receive from third-party payers.

This information is used for treatment, payment, and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment and healthcare operations.

You may specifically authorize us to use Protected Health Information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose to have your protected health information.

Marketing: This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters, or appointment reminders by calls, postcards, or letters. This office may send you information to support your health care, information about alternative treatments, and health-related services that may be of interest to you. Please advise this office if you do not wish to receive such communications, and we will not use or disclose your information for such purposes. If you do not wish to receive such communication, you must advise our office in writing at our contact address.

Disclosure: This office may use or disclose your Protected Health Information when required by law. Without your consent or authorization, this clinic may disclose information about you only for the following purposes:

- To a public health agency, for the purpose such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or if it appears necessary to prevent serious harm to you or others.
- To health oversight authorities for regulatory, licensing and other legal purposes.
- In litigation, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- For medical research purposes, subject to your authorization or approval by an institutional review board.
- If you are in the United State military, national security or intelligence, or Foreign Service, to your authorized superiors or other authorized federal officials.

We may not disclose information about you for any other purpose without your written authorization, provided separately from your written consent.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

If you have questions, complaints or want more information, please contact this office. Contact: Privacy Officer.

Complaints: Complaints about your privacy rights or how your privacy is handled at this office can be directed to the privacy officer by calling this office or directing a letter to his or her attention. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to: DHHS (Office of Civil Rights), 200 Independence Ave., S. W., Room 509F HHH Building, Washington, D.C. 20201.

I, _____ (Printed Name), have read, reviewed, understand, and agree to the Notice of Privacy Policies for healthcare and/or other services provided through this office.

This office has attempted to provide each patient with a Notice of Privacy Policies.

X

Patient Signature or Signature of Parent/Guardian if under the age of 18

Date



**PATIENT'S CONSENT
FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

I, _____ (Printed Name) give consent to _____
the use and disclosure of my individual identifiable health information or Protected Health Information for the following specific purposes:

- A. Providing treatment to me;
- B. Relating to the payment of the service this office has rendered to me;
- C. The general administrative operations this practice provides to me.

The Purpose of this Consent:

Protected Health Information is any information which includes:

- A. Demographic information;
- B. Information gathered by this practice as it relates to my past, present or future physical or mental health or condition;
- C. Information gathered by this office for past, present or future payments for providing the healthcare services;
- D. Healthcare operations will include quality assessment activities, credentialing, business management, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, and other general operations procedures or activities.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Clinic, but the Clinic is not required to agree to these restrictions. However, if the Clinic agrees to a restriction that I request, the restriction is binding on the Clinic.

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures from this Clinic before I sign this consent form regarding the use and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the Clinic has acted in reliance on this consent.

Signature of Patient/Personal Representative or Signature of Parent/Guardian if under the age of 18

Date

Description of Personal Representative's Authority



Medical History

Please check any of the following symptoms you currently or have previously experienced

General Symptoms

Poor appetite	Poor sleep	Body heaviness	Shortness of breath	Chills
Heavy appetite	Heavy sleep	Cold hands or feet	Night sweats	Muscle cramps
Dream disturbed sleep	Poor circulation	Fatigue	Sweat easily	Vertigo/Dizziness

Head, Eyes, Ears, Nose, Throat

Glasses/Contacts	Night Blindness	Recurrent sore throat	Headaches	Migraines
Eye strain	Glaucoma	Dry mouth	Swollen glands	Concussions
Eye pain	Cataracts	Excessive saliva	Nose bleeds	Sinus problems
Red eyes	Itchy eyes	Spots in eyes	Poor Vision	Blurred vision
Teeth problems	Grinding teeth	TMJ	Facial pain	Gum problems
Ringing in ears	Poor hearing	Earaches	Excessive phlegm	

Respiratory

Difficult breathing	Tight chest	Asthma/wheezing	Pneumonia
Lying down	Cough	Cough w/phlegm	Cough w/blood

Cardiovascular

High blood pressure	Chest pain	Fainting	Blood clots	Palpitations
Low blood pressure	Irregular heartbeat	Difficult breathing	Pacemaker	Phlebitis

Gastrointestinal

Nausea	Vomiting	Diarrhea	Constipation	Gas
Intestinal pain/cramp	Acid reflux	Hiccup	Bloating	Bad breath
Hemorrhoids	Bloody stool	Mucous in stool	Rectal pain	

Musculoskeletal

Shoulder pain	Neck pain	Upper back pain	Low back pain	Muscle pain
Joint pain	Rib pain	Limited use	Limited range of motion	

Genito-urinary

Painful urination	Blood in urine	Frequent urination	Urgent urination	Bedwetting
Incomplete urination	Unable to hold urine	Wake to urinate	Kidney stone	Impotence
Premature ejaculation	Nocturnal emission	Increased libido	Decreased libido	

Gynecology

Irregular Periods	Vaginal discharge	Blood clots	PMS
Menopause	Breast Lumps	# of pregnancies	# of miscarriages

Neuropsychological

Seizures	Numbness	Poor memory	Depression	Anxiety
Irritability	Easily stressed	Tics		

Skin and Hair

Rashes	Psoriasis	Acne	Dandruff	Ulcerations
Hives	Itching	Fungal infection	Hair loss	



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Please describe current health problem(s) for which you are seeking treatment:

Date problem(s) began (mm/dd/yy): _____

How often are your symptoms present?

Constantly _____ *Frequently* _____ *Intermittently* _____ *Occasionally* _____

Describe your current health condition. *Good* _____ *Fair* _____ *Poor* _____ *Chronically ill* _____

Indicate any significant illness(es) you have:

Cancer _____ Diabetes _____ Hepatitis _____ Seizures _____ Heart Disease _____

High blood pressure _____ Rheumatic Fever _____ Emotional disorder _____

Infectious disease _____ STD _____

Other conditions _____

What treatment(s) have you been receiving for the above condition(s)? (*surgery, medications, injections, chiropractic, massage, etc.*)

List any accidents, surgeries, or hospitalizations (include date):

If a family member has had any of the following, please indicate:

Arthritis _____ Cancer _____ Hypertension _____ Heart disease _____ Mental disorder _____

Others conditions: _____

Please indicate the use and frequency of the following:

Tobacco _____ Coffee/Tea _____ Alcohol _____

Non-medical drugs _____ Exercise _____

Patient Name: _____

Patient Signature: _____ **Date:** _____



The Following Form is For Acupuncturist/Student Intern Use Only
INITIAL VISIT DETAILED INTAKE

Please confirm that your Acupuncturist/Student Intern has shown you the disposable needles
Patient Signature: _____

Date: _____ Patient Name: _____

Chief Complaint: _____

History of Present Illness (including previous diagnosis & treatment): _____

Other Symptoms & Signs: _____

INQUIRING

Hot or Cold _____
Perspiration _____
Bowel Movement _____
Thirst _____
Appetite _____
Stress _____
Urination _____
Sleep Pattern _____
Energy _____

MENSTRUATION (Normal/Abnormal)

Length of Period _____
Date of Last Period _____
Color _____
Amount _____
Clotting (YES/NO) _____

VITALS

Cramps (YES/NO) _____

OBSERVATION

Vitality/Demeanor _____
Body Color _____
Height & Weight _____

Sense Organs

Eyes/Vision _____
Ears/Hearing _____
Mouth/Taste _____

TONGUE

Proper _____
Coating _____
Sublingual _____
Other _____

LISTENING & SMELLING

Speech _____
Respiration _____
Cough/Phlegm _____
Odor _____

PULSE

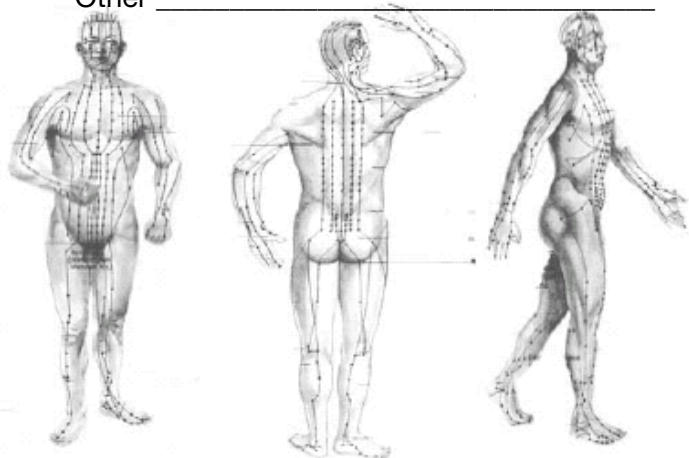
LEFT Overall _____
Cun (HT) _____
Guan (LV) _____
Chi (KI) _____

RIGHT Overall _____
Cun (LU) _____
Guan (SP) _____
Chi (KI) _____

Temperature _____ Pulse _____
Respiration _____ BP _____

PAIN

Location _____
Frequency _____
Time of Day _____
Characteristics _____
Other _____





DIFFERENTIATION

EIGHT PRINCIPLES

Deficiency Excess Interior Exterior Heat Cold Yin Yang

QI & BLOOD

QI: stagnation deficiency sinking perversion

BLOOD: stagnation deficiency heat cold

ZANG-FU ORGAN/CHANNEL

Lung Small intestine Large Intestine Urinary bladder Stomach
 Kidney Spleen Liver Heart Gallbladder

DIAGNOSIS & DIFFERENTIATION

Name of Disease (TCM) Type of Syndrome

- 1) _____
- 2) _____
- 3) _____

TREATMENT

TREATMENT PRINCIPLES _____

POINTS USED _____

ADDITIONAL THERAPIES USED

Moxibustion Others _____
Electric Stimulation _____
Three-edge Needle _____

Patent Herb (Name and Dosage):

Herb Decoction (Name of Basic Formula(s), Name and Dosage of Ingredients, Number of bags, days each bag last)

TREATMENT PLAN

Frequency of treatments__ Projected duration_
Future strategy_____

1st Intern: _____ Observer(s)__

2nd intern: _____ Instructor_____



Follow Up Visit Notes

Patient Name: _____

Date: _____

Subjective:

Chief Complaint: _____

Previous Symptom Progress: _____

New Symptom's: _____

Check: energy, sleep, sweating, thirst, urination, appetite, digestion, stools, head, eyes, ears, nose, limbs, emotions

Women: LMP: _____ Color: _____ Interval: _____ Duration: _____ Flow: _____ Clots: _____

For Patients with Pain: Pain Scale: None 0 1 2 3 4 5 6 7 8 9 10

Severe Location: _____

Pain Type:: Sharp/Stabbing Pins & Needles Dull/Aching Numbness Improve w/pressure Improve w/hot or cold

Objective Signs:

Blood Pressure: _____ Temperature: _____ Pulse Rate: _____ Respiration: _____

TCM Pulses:

Cun: L _____ R _____

Guan: L _____ R _____

Chi: L _____ R _____

Overall: _____

Tongue Body: _____

Tongue Coating: _____

Sublingual Vein: _____

Assessment/Diagnosis:

TCM

Diagnosis: _____

TCM

Differentiation: _____

Plan of Treatment:

Treatment Principle: _____

Acupuncture:

Bilateral PTS:

Right: _____

Left: _____

Additional Technique's: _____

Herbs/Patient Recommendations: _____

Future Treatment Plan: _____

Intern #1: _____ Supervisor _____

Intern #2: _____ Observer _____



Follow Up Visit Notes

Patient Name: _____

Date: _____

Subjective:

Chief Complaint: _____

Previous Symptom Progress: _____

New Symptom's: _____

Check: energy, sleep, sweating, thirst, urination, appetite, digestion, stools, head, eyes, ears, nose, limbs, emotions

Women: LMP: _____ Color: _____ Interval: _____ Duration: _____ Flow: _____ Clots: _____

For Patients with Pain: Pain Scale: None 0 1 2 3 4 5 6 7 8 9 10

Severe Location: _____

Pain Type:: Sharp/Stabbing Pins & Needles Dull/Aching Numbness Improve w/pressure Improve w/hot or cold

Objective Signs:

Blood Pressure: _____ Temperature: _____ Pulse Rate: _____ Respiration: _____

TCM Pulses:

Cun: L _____ R _____

Guan: L _____ R _____

Chi: L _____ R _____

Overall: _____

Tongue Body: _____

Tongue Coating: _____

Sublingual Vein: _____

Assessment/Diagnosis:

TCM

Diagnosis: _____

TCM

Differentiation: _____

Plan of Treatment:

Treatment Principle: _____

Acupuncture:

Bilateral PTS:

Right: _____

Left: _____

Additional Technique's: _____

Herbs/Patient Recommendations: _____

Future Treatment Plan: _____

Intern #1: _____ Supervisor _____

Intern #2: _____ Observer _____