ZYGMONT CHIROPRACTIC CENTER

1700 S. Lamar Blvd., Suite 301, Austin, Texas, 78704
Telephone: (512) 442-7400 Fax: (512) 442-7405

ACUPUNCTURE INTAKE FORM

Personal Information

Today's Date_____

Name: _____ Sex: □ Male □ Female
Last First M.I.

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Phone Numbers: _____ _____ _____
Home Work Mobile

E-mail Address: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Status: □ Single □ Married □ Divorced □ Other Number of Children: _____

Whom may we thank for referring you to the acupuncturist? _____

Have you ever been treated with acupuncture before? _____

Main Problems

Please describe the main problems for which you are seeking treatment: _____
_____

When did this problem begin?_____

Has this ever happened before? _____

Symptoms developed from: □ injury □ illness □ gradual onset □ unknown causes

Symptoms □ come and go □ are constant □ are getting worse

Symptoms have persisted for: □ hours □ one day □ weeks □ months □ years

Symptoms are *better* in: □ morning □ noon □ night

Symptoms are *worse* in: □ morning □ noon □ night

Symptoms do not change with the time of day: □ yes □ no

What activities make the condition *worse*? _____

What activities make the condition *better*? _____

Remarks and additional information: _____

Past Medical History

Indicate any significant illness you have (please include date):

Cancer_____ Diabetes_____ Hepatitis_____ Seizures_____

Stroke_____ HIV/AIDS_____Other_____

List any accidents or surgeries you have had (include date): _____
_____

List all medications you are now taking (include prescription drugs, over-the-counter medications, herbs, and nutritional supplements):_____
_____

Please indicate the use and frequency of the following:
Tobacco_____ Coffee/ Black tea _____ Alcohol_____

Do you currently have a heart condition and/or a pacemaker? _____
Is there any possibility that you could be pregnant at this time? _____
Height _____ Weight _____

How do you feel about the following areas of your life? Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Your Comments
Spouse or Significant other					
Family					
Diet					
Self					
Work					
Exercise					
Rest/ Sleep					

Family Medical History
List any major diseases or health problems in your family:_____
_____

Symptom Survey Please check if you currently have, or have had in the last three months, any of the following:

___ sneezing/ runny nose
___ nasal congestion
___ post-nasal drip
___ sinus pain/ tenderness
___ sinus infection
___ sinus headaches
___ ear pain/infection
___ hay fever/ airborne allergies
___ cough
___ chest congestion
___ sore throat
___ hoarseness/laryngitis
___ bronchitis
___ asthma/wheezing
___ shortness of breath on exertion
___ decreased sense of smell
___ chronic cough
___ frequent colds or flu
___ fevers
___ chills
___ sweat easily

___ insomnia/sleep disorder

___ abdominal pain
___ intestinal gas/bloating
___ colitis or diverticulitis
___ irritable bowel
___ constipation
___ diarrhea or loose stools
___ hemorrhoids
___ food cravings
___ recent use of antibiotics
___ muscle/connective tissue pain
___ recent change in bowel habits
___ blood in stool
___ black "tarry" stool
___ cold hands/feet

Women:
___ pre-menstrual discomfort
___ irregular menstrual cycle
___ endometriosis
___ fertility concerns
___ hysterectomy
___ menopausal symptoms

___ loss of appetite
___ excessive appetite
___ anemia
___ indigestion
___ nausea/vomiting
___ belching/burping
___ acid reflux/heartburn
___ ulcer
___ hernia
___ easily bruised
___ bleeds easily
___ intolerance to weather changes
___ excessive moodiness
___ nosebleeds
___ jaw pain/ TMJ
___ facial pain
___ retention of food in the stomach

Men:
___ prostate problems
___ fertility concerns
___ impotence concerns

___ heart palpitations
___ shortness of breath at rest
___ cold hands and feet
___ nightmares
___ depression
___ anxiety/nervousness
___ angina/chest pain
___ high blood pressure
___ low blood pressure
___ high cholesterol
___ heart murmur
___ mitral valve prolapse
___ irregular heartbeat
___ swollen ankles/edema
___ dizziness/vertigo
___ fainting spells
___ leg pain
___ varicose veins/phlebitis
___ tremors

___ bone fracture/injury
___ gout/foot pain
___ phobias
___ knee problems
___ headaches at top of head
___ headaches at occiput
___ night sweats
___ frequent vaginal infections
___ breast tenderness
___ neck pain
___ shoulder pain
___ upper back pain
___ mid back pain
___ low back pain
___ hip pain
___ sciatica/pain radiating down leg
___ pain in sacrum/tailbone
___ hand/foot pain
___ scoliosis/curvature of spine
___ ear ringing/tinnitus
___ gravel/stones in urine
___ urinary tract infection
___ painful urination
___ incontinence/ dribbling
___ decreased sex drive
___ hair loss or thinning
___ chronic fatigue
___ sudden energy drop
___ multiple sclerosis
___ sudden weight loss
___ muscle weakness
___ memory loss/forgetfulness
___ arthritis/joint pain
___ difficulty concentrating
___ eye problems
___ poor vision
___ difficulty digesting oily foods
___ gallstones
___ gallbladder removed
___ light colored stools
___ jaundice
___ hepatitis
___ easily angered or agitated
___ difficulty making decisions
___ obsessiveness
___ muscle twitches
___ muscle cramps
___ numbness/tingling
___ skin problems
___ acne
___ rashes
___ hives/itching
___ psoriasis/eczema
___ soft or brittle nails
___ migraine headaches
___ headaches at temple/behind eye

Are there any other health issues you want to discuss? _____

_____

REQUEST AND CONSENT

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 acupuncturist: acupuncture and other oriental medical procedures, including diagnostic techniques, such as questioning, pulse evaluation, palpation on various areas of my body, observation, range of motion testing, electrical and thermal treatments, moxibustion, the recommendation of herbal, nutritional and dietary supplements, dietary recommendations, exercise advice and healthy lifestyle counseling.

I understand that I have an opportunity to discuss 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 allopathic 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: slight bleeding, bruising, strong sensation at the location of where a needle is inserted or radiating from that location, temporary aggravation of current symptoms and appearance of new symptoms. 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 determines, based on the facts then known, to be in my best interest.

I have read, or have had read to me, this informed consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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 this clinic.

Patient's name _____ Patient's representative (if applicable) _____

Signature of patient or patient's representative _____ Date: _____

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, Marty Calliham, 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.

_____*(initials of patient)* Date: _____

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: _____

Financial Responsibility

I understand that I am financially responsible for all charges whether or not reimbursable by insurance.

_____ _____ _____

Responsible Party Signature Relationship Date

Privacy Acknowledgement Form

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Zygmont Chiropractic's "Notice of Privacy Practices" has been provided to me. I understand I have a right to review Zygmont Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Zygmont Chiropractic. The Notice of Privacy Practices for Zygmont Chiropractic is also provided on request at the front desk of this practice. This Notice of Privacy Practices also describes my rights and Zygmont Chiropractic's duties with respect to my protected health information.

Zygmont Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Description of Personal Representative's Authority

*Marcy Salazar*_____

Privacy Officer

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

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

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

Patient's signature _____ Date _____

Acupuncturist's signature _____ Date _____