Access Acupuncture

Erica W Chu, LAc || (210) 504-5544 || 12915 Jones Maltsberger Rd, Ste 600, San Antonio, TX 78247

PATIENT INFORMATION

Date ____ / ____ / _____

Name:_____

Address:_____

City / State / Zip:_____

Age: _____ Date of Birth ____ / ____ / _____

Living situation: Live w/other(s) Live alone

Single Married Separated Divorced Widowed

Occupation:_____

Employer:_____

Phone:_____

Email:_____

In case of emergency notify:

_____

Relation: _____ Phone: _____

Patient's Representative:

_____

(if under 18 or otherwise requiring guardianship)

Relation: _____

Your doctor or other primary care provider:

Have you tried acupuncture before? Yes No

How did you find us?

YOUR HEALTH CONCERNS: Why are you coming for treatment?

List any hospitalizations, surgeries, major injuries, or trauma: What and when?

Current medications and supplements:

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HEALTH QUESTIONNAIRE

Check all that apply:

- □ epilepsy/seizures
- □ Hepatitis A/B/C
- □ HIV+
- □ bleeding disorder or hemorrhage
- □ taking blood thinner
- □ addiction
- □ pacemaker
- □ fainting
- □ diabetes
- □ mental illness
- □ other _____

LIFESTYLE:

- □ Exercise regularly
- □ Eat much fried food
- □ Eat much meat
- □ Eat a lot of sweets / carbs
- □ Vegetarian / vegan
- □ Drink alcohol
- □ Drink coffee
- □ Smoke cigarettes
- □ Use drugs

SLEEP:

- □ Not rested upon waking
- □ Trouble falling / staying asleep
- □ Less than 6 – 8 hours
- □ Insomnia

GASTRO-INTESTINAL:

- □ Excessive / low appetite
- □ Fatigued after meals
- □ Hypoglycemic
- □ Indigestion / reflux / heartburn
- □ Nausea / vomiting
- □ Gas / bloating
- □ Stomach ache / abdominal pain
- □ Constipation
- □ Diarrhea / loose stools
- □ Hemorrhoids
- □ Gallstones

CARDIO-VASCULAR:

- □ High / low blood pressure
- □ High cholesterol
- □ Palpitations
- □ Poor circulation
- □ Rapid / irregular heartbeat

HEAD / FACE:

- □ Headaches / migraines
- □ TMJ / jaw pain

TEMPERATURE / PERSPIRATION:

- □ Hot / Cold body sensation overall
- □ Aversion to heat or cold
- □ Cold hands / feet
- □ Hot flashes / night sweats
- □ Spontaneous sweating
- □ Sweaty palms / feet

EYES / ENT / RESPIRATORY:

- □ Frequent colds / sinus infections
- □ Sinus problems
- □ Chronic / seasonal allergies
- □ Environmental sensitivity
- □ Cough
- □ Asthma / wheezing
- □ Difficulty breathing
- □ Sore throat
- □ Enlarged glands
- □ Ear ache
- □ Impaired hearing / hearing loss
- □ Ringing in ears
- □ Dizziness
- □ Red / inflamed / itchy eyes
- □ Teary / dry eyes
- □ Gum problems
- □ Nose bleeds

DERMATOLOGICAL:

- □ Rash / itching / hives
- □ Acne / boils
- □ Hair falling out
- □ Weak / brittle nails
- □ Slow wound healing

GENITO-URINARY:

- □ Frequent urination
- □ Poor bladder control
- □ Burning / pain on urination
- □ Frequent urinary tract infections
- □ Kidney stones

EMOTIONAL / PSYCHOLOGICAL:

- □ Anxiety
- □ Depression
- □ Mood swings
- □ Irritability
- □ Difficulty concentrating
- □ Worry
- □ Feel sad a lot
- □ Cry uncontrollably
- □ Much fear / terrors
- □ History of abuse
- □ Considered or attempted suicide

FEMALE ONLY:

- □ May be pregnant
- □ Irregular cycle
- □ Painful periods
- □ Heavy / scant periods
- □ Chronic vaginal infections
- □ Abnormal pap
- □ Endometriosis
- □ Ovarian cysts
- □ Uterine fibroids
- □ Partial / Total Hysterectomy

Number of:
Pregnancies -
Abortions -
Miscarriages -
Number of Births:
Vaginal -
Cesarean -
Cycle is ____ days.
Period lasts _____ days.

MALE ONLY:

- □ Erection difficulties
- □ Premature ejaculation
- □ Penis discharge
- □ Prostate problems

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CANCELLATION POLICY

Fees for missed appointments:

There is a fee equal to that your you missed appointment (no more than 10 minutes past the start time) or for cancellations *without* a 24-hour notice. Appointment reminders will be sent to you via email and text; please make sure to check junk folders for our communications. 48-hour advance cancellation is *preferred* and 24 hour notification is ***required***.

If you are unable to keep your appointment, please notify us **as soon as possible**. You may also cancel your appointment by email or text. As time and space is limited, other patients may not be able to be seen if we are not given adequate notice. We value your time and resources and expect the same in retrun.

I, (print name) _____understand Access Acupuncture's appointment cancellation policy and understand my responsibility to plan appointments accordingly and notify Access Acupuncture at least 24 hours prior to my scheduled appointments if I am unable to attend.

_____ _____

Patient Signature **Date**

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INFORMED CONSENT TO TREATMENT

At Access Acupuncture we principally practice acupuncture, cupping, and Chinese herbal medicine, and moxibustion. We may also recommend dietary supplements or make dietary recommendations, suggest exercises, or do minimal bodywork.

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of acupuncture. I am hereby informed that the treatment methods are all generally safe but that there may be some side effects or risks, as follows:

Acupuncture may potentially cause temporary bruising, swelling, bleeding, numbness and tingling, or soreness at the site of needling. Highly unlikely risks of acupuncture include lung puncture (pneumothorax), nerve damage, organ puncture, and infection - although Access Acupuncture uses only sterile, disposable needles and maintains a clean and safe environment. Acupuncture can cause aggravation of symptoms existing prior to treatment and appearance of new symptoms.

Common side effect of cupping and gua sha are temporary bruising and redness lasting a few days. Cupping can also cause blistering of the skin in some instances.

The herbal and nutritional supplements (which may be from plant, animal, or mineral sources) recommended to me by my practitioner are generally safe in the traditionally recommended doses. Possible side effects of herbs include nausea, gas, stomach ache, diarrhea, and headache. Unusual side effects of plant herbs include vomiting, rashes, hives, and tingling of the tongue. I understand I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reaction.

I understand that I have the right to refuse any part of the treatment. I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I intend this form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with Access Acupuncture.

I will notify my acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs may be contraindicated during pregnancy.

Signature of patient or guardian Date

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GETTING ACUPUNCTURE IN TEXAS

In Texas, Licensed Acupuncturists are allowed to treat the following conditions without any prior evaluation or referral requirements. If you are coming for one of these things, indicate this with a checkmark and skip the rest of this page.

___ Chronic pain
___ Smoking addiction
___ Substance abuse
___ Alcoholism
___ Weight loss

<u>If you are coming for anything else, please fill out the following state prescribed form below:</u>

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

(Pursuant to the requirements of 22 TAC §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 Access Acupuncture 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: _____

or

___ 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 _____

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Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Access Acupuncture, PLLC (the "Practice") has put in place preventative measures to reduce the spread of COVID-19; however, the Practice cannot guarantee that you will not become infected with COVID-19 or that you are not already an asymptomatic carrier of COVID-19. Further, receiving services at the Practice could increase your risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by receiving services at the Practice and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at the Practice may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Practice owners and employees.

In consideration for being permitted to receive services at the Practice, I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with receiving services at the Practice. On my behalf, and on behalf of my heirs, executors, administrators, personal representatives, and assigns, I hereby release, covenant not to sue, discharge, and hold harmless the Practice, its employees, agents, and representatives, of and from any claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of the Practice, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after receiving services at the Practice.

Signature of Patient/Parent/Guardian

Print Name Date

_____