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, Sì Shòu Acupuncture & Wellness, PLLC 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 section 183.10(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 Sì Shòu Acupuncture & Wellness, PLLC 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
___Smoking addiction
___Weight loss
___Alcoholism
___Substance abuse
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

_____ _____
Acupuncturist's Signature Date

Sì Shòu Acupuncture & Wellness, PLLC is not responsible for untrue statements made by patients.

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the Sì Shòu Acupuncture & Wellness, PLLC (SSAW) "Notice of Privacy Practices". I understand that I have the right to review SSAW's "Notice of Privacy Practices" prior to signing this document. I understand that SSAW staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

I also understand that my clinical information may be used for educational and/or research purposes by SSAW or individuals authorized by SSAW. All information that can identify me personally will be removed.

By signing this form, I am giving SSAW authorization to contact me and am giving my informed consent to utilize my information for research and educational purposes. I acknowledge that all information discussed during the assessment and treatment at SSAW Clinics will be held confidential except in the instance where my safety or the safety of others may be at risk

_____ _____

Patient Name (print) Date

_____ _____

Patient Signature SSAW Privacy Rep/Date

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Sì Shòu Acupuncture & Wellness, PLLC the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____ _____

_____ _____

_____ _____

_____ _____

Patient's Signature Date

New Patient Intake

This is a confidential questionnaire that will help us to determine the optimal treatment plan specific to your needs. If you have any questions or concerns, please do not hesitate to ask us. Thank you.

Patient Name **Date**

General Information

Address City State

Home Phone Occupation Zip

Work Phone Mobile Phone SS# Date of Birth

Email Address

We value your privacy and from time to time we send out email, text and mail communication updates, some may be very important and timely, would you like to receive:

Emails ☐ Yes ☐ No
Texts ☐ Yes ☐ No
Mail ☐ Yes ☐ No

Emergency Contact Relationship Phone

Have you had Acupuncture or Oriental medicine before? ☐Yes ☐No

Family Physician Phone

What was your experience? ☐ Very good ☐ Good ☐ No change

☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Single

Are you presently under a doctor's care? ☐Yes ☐No Who and what for? _____

Are there any other therapies which you are involved in? ☐ Yes ☐ No Who and what for? _____

Insurance Information

Insurance Company Phone Date Called

ID # Co-Pay $ Covered %

Visit # Deductible Amount

Contact Name

Referral ☐ Yes ☐ No

Focus

What is the primary reason for seeking care at our office?

What was the initial cause?

When did it begin?

What makes it worse?

What makes it better?

How does this problem interfere with your daily activities?

☐ Work ☐ Standing ☐ Sexually ☐ Other
☐ Sleep ☐ Emotional ☐ Recreation
☐ Walking ☐ Relationships ☐ Bending
☐ Sitting ☐ Social Life ☐ Stretching

What have you done about this?

Are you interested in:

☐ Pain Relief ☐ Holistic Health ☐ Stress Relief ☐ Other
☐ Preventative Care ☐ Stretching/Yoga ☐ Herbal Therapy
☐ Oriental Nutrition ☐ Maintenance Care

What are your health goals?

List any past or future surgeries:

List any significant trauma & when it occurred
(e.g. auto accident, falls, emotional, sexual, etc.):

List exercise and sport activities you
have been or are currently involved in:

Medical History

Do you have any allergies? ☐ Yes ☐ No If so, to what?

Do you take medication? Yes No If so, what types and how often?

Do you take supplements? Yes No If so, what types and how often?

Please indicate if you or any family members have or had any of the following conditions:

☐ Pneumonia	☐ Drug reaction	☐ Mental breakdown	☐ Gonorrhea/Herpes	☐ Mental illness
☐ Tuberculosis	☐ Heart attack	☐ Jaundice	☐ HIV/AIDS	☐ Hypo/hyper thyroid
☐ Hepatitis	☐ Blood transfusion	☐ Parasites	☐ High/low blood pressure	☐ Premature graying
☐ Diabetes	☐ Anemia	☐ Measles	☐ Heart disease	☐ Seizures
☐ Epilepsy	☐ Arthritis	☐ Mumps	☐ Gout	☐ Multiple Sclerosis
☐ Kidney Stone	☐ Obesity	☐ Syphilis	☐ Cancer	

Do you sleep well? ☐ Yes ☐ No Do you dream? ☐ Yes ☐ No

Do you have a high point during the day? ☐ Yes ☐ No When? Do you have a low point during the day? ☐ Yes ☐ No When?

What are your indulgences?

What are your hobbies/pleasures?

Female Concerns

Date of last menstruation Is your cycle regular? ☐ Yes ☐ No Is your cycle painful? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No Birth control? ☐ Yes ☐ No How long?

☐ PMS ☐ Clotting ☐ Vaginal sores ☐ Vaginal pain ☐ Discharge

Other

Male Concerns

☐ Testicle pain ☐ Penis pain ☐ Penis sores ☐ Discharge ☐ Premature ejaculation ☐ Nocturnal emission ☐ Impotence

Other

Signs/Symptoms

☐ Abdominal pain/distention	☐ Coughing blood	☐ Hemorrhoids	☐ Muscle cramps/pain	☐ Sinus pressure
	☐ Dark stools	☐ Heart palpitations	☐ Nasal congestion	☐ Skin fungal infection
☐ Abuse survivor	☐ Decreased libido	☐ Hiccup	☐ Neck/shoulder pain	☐ Spots in eyes
☐ Acid regurgitation	☐ Depression	☐ High blood pressure	☐ Night sweat	☐ Sweat easily
☐ Acne	☐ Dizziness/vertigo	☐ Increased libido	☐ Nose bleeds	☐ Sore throat
☐ Asthma	☐ Dry throat/mouth	☐ Indigestion	☐ Numbness	☐ Sudden energy drop
☐ Bad breath	☐ Diarrhea	☐ Intestinal pain/cramps	☐ Odorous stools	☐ Swollen glands
☐ Blood in stools	☐ Ear aches	☐ Irritable	☐ Pain upon urination	☐ Teeth/gum problems
☐ Blood in urine	☐ Enlarged thyroid	☐ Itchy eyes	☐ Peculiar tastes	☐ Ulcerations
☐ Blurry vision	☐ Eye pain/strain/tension	☐ Itchy skin	☐ Poor appetite	☐ Upper back pain
☐ Breast lump/pain	☐ Excessive phlegm	☐ Joint pain	☐ Poor circulation	☐ Urgent urination
☐ Bruise easily	Color of	☐ Kidney stones	☐ Poor memory	☐ Vomiting
☐ Chest pains	☐ Excessive saliva	☐ Laxative use	☐ Poor sleep	☐ Wake to urinate
☐ Chills	☐ Fatigue	☐ Limited range of motion	☐ Psoriasis	☐ Weight loss/gain
☐ Cold hands/feet	☐ Fever	☐ Loss of hair	☐ Rash	☐ Wheezing
☐ Concussion	☐ Frequent urination	☐ Low back pain	☐ Redness of eyes	☐ Other:
☐ Confusion	☐ Gas/belching	☐ Migraine	☐ Seizures	
☐ Constipation	☐ Grinding teeth	☐ Mouth sores	☐ Short temper	
☐ Cough	☐ Headache	☐ Mucus in stools	☐ Shortness of breath	

Pain

Use the diagram and pain key to the right to indicate areas and type of pain. Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

☐ No Pain ☐ Moderate pain ☐ Severe pain ☐ Terrible pain

Sleeping

☐ No problem ☐ Disturbed ☐ Very disturbed ☐ Cannot sleep

Work - Can do:

☐ Usual work ☐ 50% of work ☐ 25% of work ☐ No work

Frequency of pain

☐ 25% of time ☐ 50% of time ☐ 75% of time ☐ 100% of time

Travel

☐ No problem ☐ Moderate pain on trips ☐ Severe pain

Recreation - Can do:

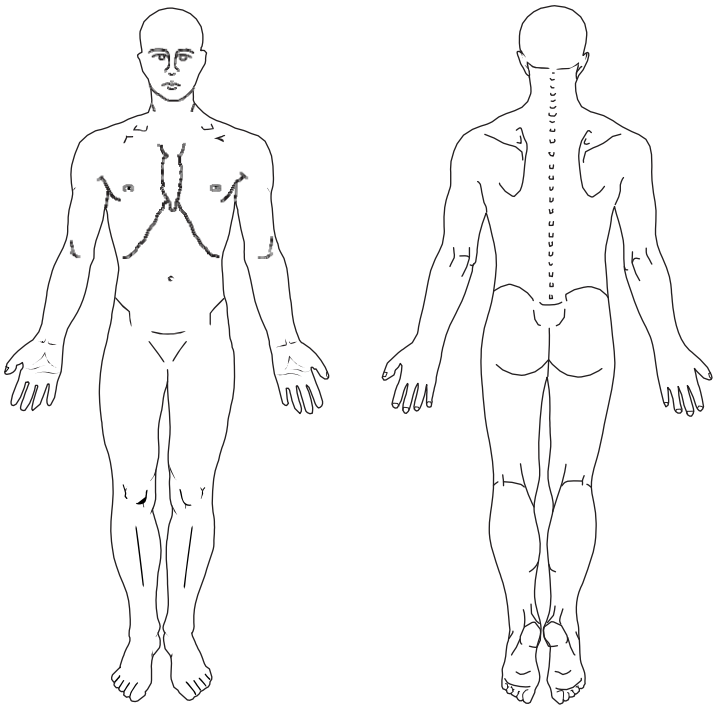
☐ All activities ☐ Some activities ☐ No activities

Walking

☐ Can walk fine ☐ Pain after 1/2 mile ☐ Cannot walk

Sitting

☐ No pain sitting ☐ Some pain while sitting ☐ Cannot sit



Pain Key

Ache	Numbness	Pins & Needles	Burning	Stabbing
^ ^ ^ ^	= = = =	0 0 0 0	X X X X	/ / / /

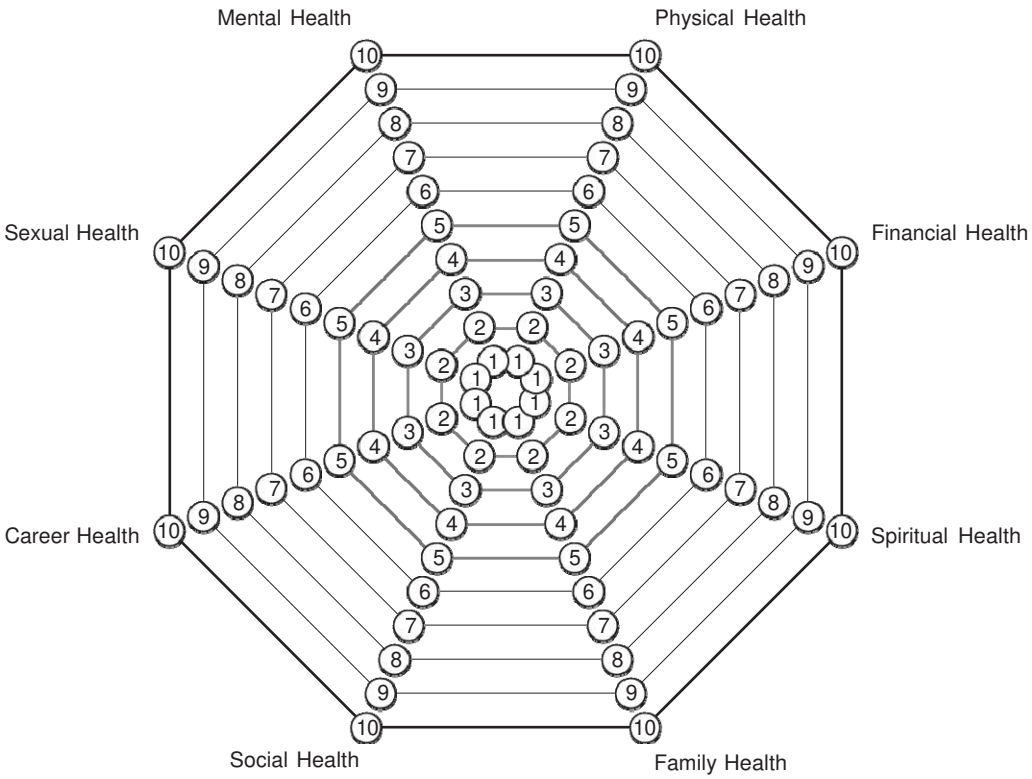
Web of Wellness

Health and wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas. For example, if you are extremely satisfied with your career, shade in the "10" circle on the career health line.

1 = Extremely unsatisfied

5 = Neutral
10 = Extremely satisfied



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

not committed 1 2 3 4 5 6 7 8 9 10 very committed

Consent to Oriental Medical Health Care/Terms of Acceptance

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 acupuncturists on staff at Sì Shòu Acupuncture & Wellness, PLLC (SSAW) who now or in the future treat me while employed by, working or associated with or substituting for SSAW, including those working at this clinic or any other associated clinics: acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping, guasha and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with my practitioners, and/or with other clinic personnel 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 conventional Western 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: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from those locations; nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I understand that acupuncture and Oriental medicine treatments may not have the desired therapeutic affect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is reasonable cause to believe that treatment is not appropriate for a patient who is under the influence of illegal drugs, alcohol, or appears to be overly medicated, then a treatment may not be performed at that time. The patient will be informed that they may not be treated at that time and will be requested to reschedule their appointment.

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

Patient's name (please print)	Patient's signature
Print Name of Patient's Representative (if applicable)	Relationship or Authority of Patient's Rep.
Signature of Patient's Representative (if applicable)	Date Signed

New Patient Information

Welcome to Sì Shòu Acupuncture & Wellness, PLLC (SSAW). Treatments are available from licensed acupuncturists in our clinic. Please initial next to each paragraph and sign below.

____**Cancellation Policy** – Treatments are by appointment, although walk-ins are often able to be accommodated. If you find you need to cancel an appointment, please call or email SSAW as soon as you are aware of the cancellation. We reserve the right to charge a $25.00 fee for an appointment canceled with less than 24 hour notice (Late cancels) or for a "no-show" appointment. If the appointment is rescheduled for an appointment the same day, this fee is waived. See website (www.acuwellnessclinic.com) for more details. In the event of inclement weather or other severe circumstances, SSAW will make every attempt to contact the patients, a message will be posted on the website and a message will be left on our phone line at 512-387-4002.

____**Payment for Clinic Services Rendered** – Payment is due at the time of service and may be paid by check or with a credit card. SSAW is not a Medicare/Medicaid provider. SSAW is not set up through any insurance carriers and is happy to provide a superbill so you may file with your insurance carrier.

____**Herbal Refills** – Please call no less than 24 hours before you wish to pick up an herbal refill from SSAW to allow us to process the request. Herbal formulas will not be prepared until you arrive unless they are guaranteed with valid credit card payment. If an herbal formula requires herbs which are not carried by SSAW, the patient has the option requesting a drop shipment from a reputable source(via SSAW) or to request that the formula be filled via AOMA Herbal Medicine and picked up by the patient during regular business hours.

Patient Signature Required: _____

Date: _____