Patient Information

CONFIDENTIAL

305 Londonderry Drive, suite 3 ▪ Waco, Texas 76712 ▪ (254) 741-6030

Name ______________________________ Date of birth ___/___/___

Street Address ______________________________

City, State, Zip ______________________ E-mail address______________________

Occupation ______________________ Marital status ____ Number of children ______

Home phone ______________ Work phone ______________ Cell phone ______________

Emergency contact (name and phone) ______________________________

How did you hear about us? ______________________________

Referred by ______________________________

Are you under the care of a physician at this time? *Yes* *No*

If yes, for what reason?______________________________

Physician (name and phone) ______________________________

If you are currently taking any medications, nutritional supplements, or herbs, please list below or attach another sheet:

Medications (prescription & over the counter)	**Nutritional Supplements and/or Herbs**
______________________	______________________
______________________	______________________
______________________	______________________

Reason for today's visit? ______________________________

Please describe your major symptoms:

____

Describe what caused your primary complaint (if known) and how/when it started:

____

Have you received treatment for this condition? ______________________________

By whom? ______________________________

Diagnosis? ______________________________

Results of treatment? ______________________________

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LIVE OAK
ACUPUNCTURE
& HERBAL MEDICINE

Medical History

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Name ______________________________ **Date of birth** _____/_____/_____

Please list any surgeries, major illnesses, or accidents (include date):

____

____

____

____

Age: _______ years

Height: _____ feet _____ inches

Weight: ________ pounds

Do you have any allergies? Please list:

____

____

Are you allergic to tree nuts?

- ❑ No
- ❑ Yes

Is it possible that you are pregnant?

- ❑ No
- ❑ Yes

Do you have herpes (oral or genital)?

- ❑ No
- ❑ Yes

Do you have a pacemaker?

- ❑ No
- ❑ Yes

Do you have a heart valve prosthesis?

- ❑ No
- ❑ Yes

Medical History

- ❑ Cancer
- ❑ Heart disease
- ❑ Diabetes
- ❑ Congestive heart failure
- ❑ Epilepsy
- ❑ Autoimmune disease
- ❑ Arthritis
- ❑ Hypertension
- ❑ Thyroid disease
- ❑ Allergies
- ❑ Asthma
- ❑ Depression
- ❑ Other mental illness
- ❑ Alcoholism
- ❑ Drug addiction

Contagious Diseases

Have you ever been diagnosed with any of the following?

- ❑ HIV/AIDS
- ❑ Hepatitis C
- ❑ Hepatitis B

Respiratory System

- ❑ Shortness of breath
- ❑ Asthma
- ❑ Recurrent bronchitis
- ❑ Difficulty inhaling
- ❑ Difficulty exhaling
- ❑ Tightness in chest
- ❑ Dry cough
- ❑ Cough with phlegm
- ❑ Cough with blood
- ❑ Snoring
- ❑ Sleep apnea
- ❑ Hayfever
- ❑ Sinus problems

Circulatory System

- ❑ History of heart attack
- ❑ History of blood clot
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest pain or pressure
- ❑ High cholesterol
- ❑ Heart palpitations
- ❑ Varicose veins
- ❑ Bruise easily
- ❑ Ankle swelling

Digestive System

- ❑ Abdominal pain
- ❑ Bloating
- ❑ Belching
- ❑ Gas
- ❑ Indigestion
- ❑ Nausea
- ❑ Vomiting
- ❑ Difficulty swallowing
- ❑ Heartburn/reflux
- ❑ Bitter taste in mouth
- ❑ Bad breath
- ❑ Gallstones

Bowel Habits

How often do you have a bowel movement? ________________

- ❑ Loose stool
- ❑ Diarrhea
- ❑ Hard or dry stool
- ❑ Mucus in stool
- ❑ Pain or cramps with BM
- ❑ Blood in stool
- ❑ Undigested food in stool
- ❑ Use laxatives often
- ❑ Hemorrhoids
- ❑ Incontinence of stool

Urination

- ❑ Up at night to urinate
- ❑ Burning or painful
- ❑ Blood in urine
- ❑ Cloudy urine
- ❑ Dribbling
- ❑ Urinary tract infections
- ❑ Poor bladder control
- ❑ Urgency
- ❑ Stones

Skin & Hair

- ❑ Dry
- ❑ Oily
- ❑ Rashes
- ❑ Itching
- ❑ Hives
- ❑ Pimples or acne
- ❑ Spider veins
- ❑ Eczema
- ❑ Psoriasis
- ❑ Brittle nails
- ❑ Prematurely grey hair
- ❑ Dry, brittle hair
- ❑ Hair falling out
- ❑ Dandruff

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Eyes, Ears & Nose
- ❑ Wear glasses or contacts
- ❑ See spots in vision
- ❑ Poor night vision
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Dry eyes
- ❑ Painful or burning eyes
- ❑ Twitching eyelid(s)
- ❑ Light sensitive eyes
- ❑ Poor hearing
- ❑ Ear aches or infections
- ❑ Ringing (high pitched)
- ❑ Ringing (low pitched)
- ❑ Ear discharge
- ❑ Nasal congestion
- ❑ Nose bleeds
- ❑ Sinusitis

Mouth & Throat
- ❑ Dry mouth or throat
- ❑ Trouble swallowing
- ❑ Swollen glands
- ❑ Tooth problems
- ❑ Gum problems
- ❑ Mouth or tongue sores
- ❑ TMJ clicking or pain
- ❑ Teeth grinding or jaw clenching
- ❑ Drooling at night

Headaches/Dizziness
- ❑ Headaches
- ❑ Dizzy upon standing
- ❑ Dizziness
- ❑ Faint easily
- ❑ Vertigo
- ❑ Motion sickness
- ❑ Migraines
- ❑ Poor balance

Pain
- ❑ Low back
- ❑ Sciatica
- ❑ Upper back
- ❑ Mid back
- ❑ Neck
- ❑ Shoulder
- ❑ Hand or wrist
- ❑ Hip
- ❑ Knee
- ❑ Foot or ankle
- ❑ Torso
- ❑ Muscle cramps
- ❑ Muscle spasm
- ❑ Nerve problems

Habits
- ❑ Tobacco
- ❑ Coffee
- ❑ Diet soft drinks
- ❑ Regular soft drinks
- ❑ Alcohol
- ❑ Black tea
- ❑ Recreational drugs

Exercise
- ❑ Never
- ❑ Little
- ❑ Moderate
- ❑ Heavy

Emotions
- ❑ Often angry
- ❑ Difficult to express emotions
- ❑ Depressed
- ❑ Often worried
- ❑ Easily irritated
- ❑ Cry easily
- ❑ Stressed or anxious
- ❑ Over-think everything
- ❑ Indecisive
- ❑ Hyper
- ❑ Restless
- ❑ Sad or grieving
- ❑ Fearful

Appetite
- ❑ Excessive
- ❑ Poor
- ❑ Irregular
- ❑ Food cravings

Weight
- ❑ Recent gain
- ❑ Recent loss
- ❑ Trying to lose weight

Energy
- ❑ Up and down
- ❑ Jittery or hyper
- ❑ Always fatigued
- ❑ Tired in the morning
- ❑ Tired in the afternoon
- ❑ Difficulty concentrating

Body Temperature
- ❑ Warm natured
- ❑ Flushed face or cheeks
- ❑ Warm in afternoon or evening
- ❑ Night sweats
- ❑ Cold natured
- ❑ Cold hands and feet
- ❑ Cold nose

Perspiration
- ❑ Very little or none
- ❑ Occurs without exertion
- ❑ Profuse
- ❑ Night sweats

Sleep
- ❑ Trouble falling asleep
- ❑ Trouble staying asleep
- ❑ Very light sleeper
- ❑ Restless legs
- ❑ Many vivid dreams
- ❑ Many nightmares
- ❑ Tired in the morning
- ❑ Pain interferes with sleep

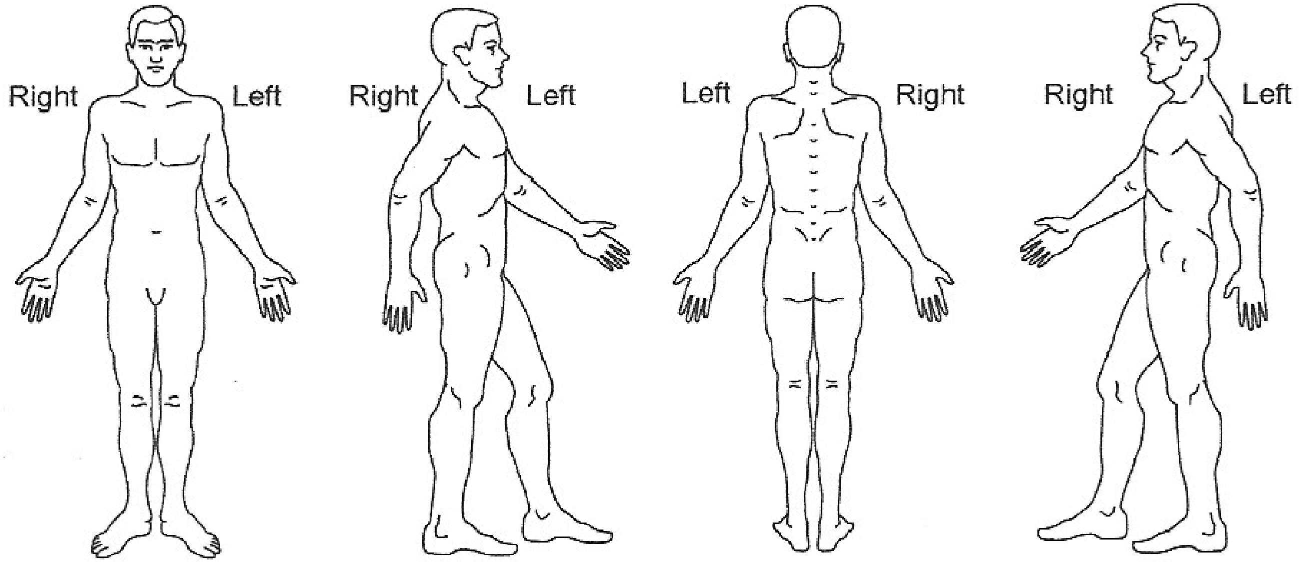
Males
- ❑ Prostate problems
- ❑ Impotence
- ❑ Painful urination
- ❑ Low sex drive
- ❑ Very high sex drive
- ❑ Dribbling urination

Females
- ❑ Spotting between periods
- ❑ Irregular periods
- ❑ Heavy periods
- ❑ <25 day cycle
- ❑ >35 day cycle
- ❑ Endometriosis
- ❑ Painful periods
- ❑ PMS
- ❑ Breast lumps
- ❑ Low sex drive
- ❑ Uterine prolapse
- ❑ Facial hair
- ❑ Perimenopausal
- ❑ Menopausal

Pain Assessment

Name ____ **Date** _____/_____/_____

Please circle or shade the area(s) on the diagram where you feel pain today:



Next to each area marked above, please note the intensity of the pain using the following scale:

No pain	Minimal pain	Tolerable pain	Pain hinders some activities	Pain hinders most activities	Unbearable pain
0	1 2	3 4	5 6	7 8	9

Are you currently taking pain medication?

- ❑ Yes
- ❑ No

If yes, what medication(s) are you taking? ____

How often do you take pain medication(s)? ____

Does your pain disturb your sleep?

- ❑ Yes
- ❑ No

Has your condition changed since your last visit? If yes, how has it changed? ____________

____

____

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Fee Schedule and Office Policies

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Fee Schedule, effective May 1, 2008
Payment is due at the time of service. **Cash or checks accepted. NO CREDIT OR DEBIT CARDS.**

Initial Consultation & Treatment	$85.00
Comprehensive Follow-up Treatment	$60.00
Missed Appointment Fee (less than 24 hours notice given)	$60.00
Stop smoking (up to 6 sessions)	$225.00 (payable at first session)

Fees are subject to change without notice.

Office Policies
I believe that your time is just as valuable as mine is and I make every effort to maintain an on-time schedule. Rarely will you have to wait in my reception room for more than a few minutes, all aspects of your care will be handled by me, and you will never be rushed through your appointment. In order to help me maintain this type of practice, please be aware of the following policies:

- Prior to your initial appointment, you were e-mailed or postal mailed several forms to fill out and sign. Please complete these forms prior to your Initial Consultation. If you are unable to complete the forms prior to your visit, you should arrive 30 minutes early to complete the forms in the office.
- Please be courteous and make every effort to notify our office if you are unable to keep an appointment. Because we do not double book, your appointment time cannot be used by anyone else if you cancel on short notice or do not show up. **Cancellations with less than 24 hours notice given or no-shows will be subject to a $60.00 Missed Appointment Fee**.
- Patients who habitually arrive late, fail to show up, or cancel on short notice will be dismissed from the practice.
- If you are more than 15 minutes late for your appointment, you will have to reschedule.
- We do not participate in any insurance billing and payment is due on the day of your visit.
- Monthly superbills are available upon request. You are responsible for all aspects of filing your own insurance claims and your responsibility for payment to this office is not contingent upon reimbursement from your insurance company. Fees will not be negotiated or reduced, even if your insurance company's allowable amount for acupuncture services is less than you have paid.
- Returned checks are subject to a $25.00 fee.
- Please note that children must remain under the direct supervision of a parent or guardian at all times.

______________________________ _______________
Patient or Guardian signature Date

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According to Texas state law:

A. An acupuncturist may perform acupuncture on a person who has been evaluated by a physician or dentist, as appropriate, for the condition being treated within twelve months before the date acupuncture was performed.
B. The holder of a license may perform acupuncture on a person who was referred by a doctor licensed to practice chiropractic by the Texas Board of Chiropractic Examiners if the licensee commences the treatment within 30 days of the date of the referral. The licensee shall refer the person to a physician after performing acupuncture 20 times or for two months, whichever occurs first, if no substantial improvement occurs in the person's condition for which the referral was made.
C. Notwithstanding subsections (A) and (B) of this section, an acupuncturist holding a current and valid license may without an evaluation or a referral from a physician, dentist, or chiropractor perform acupuncture on a person for smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse.
D. A licensed acupuncturist must recommend an evaluation by a licensed Texas physician or dentist, if after performing acupuncture 20 times or for two months, whichever occurs first, there is no substantial improvement of the patient's chronic pain.
E. A licensed acupuncturist shall recommend an evaluation by a licensed Texas physician or dentist, as appropriate, if after performing acupuncture 20 times or for two months, whichever occurs first, there is no substantial improvement of the patient's alcoholism or substance abuse.

Please initial below to indicate your agreement with the following five statements:

_______ Pursuant to the requirement of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules and Tex. Occ. Code Ann. §205.35 (above), <u>I attest that my health concern has been evaluated by a physician within the past 12 months</u>.

_______ I understand that the diagnosis and treatment plan I will be given by Kristen E. Horner, L.Ac. is based upon Traditional Chinese Medical (TCM) principles and does not constitute a Western medical diagnosis. I understand that I am not to rely on TCM diagnosis and treatment as my sole remedy.

_______ I understand that if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice and treatment from a licensed physician.

_______ If I am concurrently undergoing Western medical treatments, it is my responsibility to advise my physician of any herbs or supplements I am taking.

_______ 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.

_______________________________ _______________
Patient or Guardian signature Date

_______________________________ _______________
Acupuncturist signature Date