



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? _____

Name _____

Date of birth ____/____/____

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

- Autoimmune disease
- Arthritis
- Hypertension
- Thyroid disease
- Allergies
- Asthma
- Depression
- Other mental illness
- Alcoholism
- Drug addiction

- Indigestion
- Nausea
- Vomiting
- Difficulty swallowing
- Heartburn/reflux
- Bitter taste in mouth
- Bad breath
- Gallstones

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

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

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

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

Name of OB/GYN or Reproductive Endocrinologist: _____

Age Menstrual Cycle Started: _____

Date of last two periods: ___/___/___ & ___/___/___

Times pregnant: _____

Term births: _____

Premature births: _____

Miscarriages: _____

Abortions: _____

Contraceptive method(s) used now and in the past: _____

Number of days between periods: _____

Number of days of flow: _____

What color is your menstrual flow?

- Bright red
- Dull red
- Purple
- Pink
- Brown
- Black

How heavy is your flow?

- Heavy
- Medium
- Light

Are your cycles regular?

- Yes
- No

Do you spot between periods?

- Yes
- No

Pelvic pain and/or cramps occur:

- Never
- Before period
- During period
- After period
- Midcycle
- All the time

Premenstrual symptoms occur:

- Every month
- Occasionally
- Never

Premenstrual symptoms include:

- Breast tenderness
- Lumps in breasts
- Cry easily
- Irritability
- Depression
- Insomnia
- Fatigue
- Bloating
- Food cravings
- Diarrhea
- Constipation
- Backache
- Acne
- Other _____

Do you have pain during or after intercourse?

- Yes
- No

Do you get yeast infections frequently?

- Yes
- No

Have you ever been diagnosed with fibroids?

- Yes
- No

Have you ever been diagnosed with endometriosis?

- Yes
- No

Have you ever had a sexually transmitted disease?

- Yes
- No

Have you ever been diagnosed with Chlamydia?

- Yes
- No

Do you do breast self-exams?

- Yes
- No

Date of your last pap smear: _____

Have you ever taken the birth control pill?

- Yes
- No

When? _____ How long? _____

Have you ever had an IUD?

- Yes
- No

When? _____ How long? _____

Have you ever used Depo Provera?

- Yes
- No

When? _____ How long? _____

How is your libido?

- Low
- Normal
- High

Do you douche regularly?

- Yes
- No

Do you use personal lubricants?

- Yes
- No

Do you consider yourself stressed or anxious?

- Yes
- No

Do you have excessive facial hair?

- Yes
- No

Do you have excessively oily skin or acne?

- Yes
- No

Have you ever noticed discharge from your nipples?

- Yes
- No

Have you ever had pelvic surgery?

- Yes
- No

Are you currently trying to conceive?

- Yes
- No

If yes, how long have you been trying? _____

If you are trying to conceive, please complete the remainder of this form. If not, please stop here.

Do you have a single partner with whom you have been trying to conceive?

- Yes
- No

Do you ovulate on your own?

- Yes
- No
- Don't know

Have you taken medication to help you ovulate?

- Yes
- No

When? _____

What were the results? _____

Have you had other fertility treatments?

- Yes
- No

When and where?

What were the results?

Have you had hormone tests?

- Yes
- No

What were the results?

Have your fallopian tubes been evaluated medically?

- Yes
- No

What were the results? _____

Has your partner had a semen analysis?

- Yes
- No

What were the results? _____

Have you and/or your partner had genetic tests?

- Yes
- No

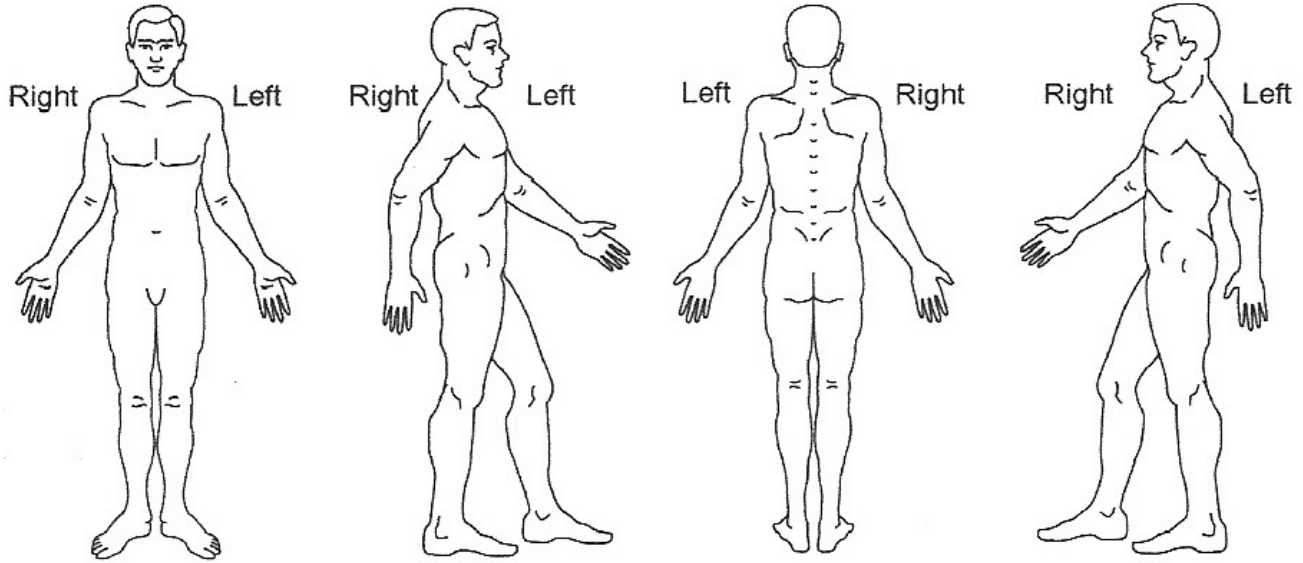
What were the results?

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 0	Minimal pain 1 2	Tolerable pain 3 4	Pain hinders some activities 5 6	Pain hinders most activities 7 8	Unbearable pain 9
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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? _____

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), I attest that my health concern has been evaluated by a physician within the past 12 months.

_____ 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