Healing Harmony

Acupuncture & Pain Care

Dear New Patient,

Welcome! Thank you so much for your interest in acupuncture and Oriental medicine. At Healing Harmony Acupuncture & Pain Care I do my best in every way possible to assure that you receive the best quality care. I want you to know that I will:

- Make sure that the customer service always meets the highest standards.
- Make sure that any questions you have about your care are answered in a way that you can understand.
- Make sure that your phone calls are returned promptly.
- Make sure that your private health care information is kept secure and private.

Enclosed you will find several forms that I'd like you to fill out and bring with you to your first appointment. If you have any questions about these forms, please call me at 832-563-9819 and I will be happy to help you.

Again, welcome to Healing Harmony Acupuncture and Pain Care. You have taken an important step on the road to more vibrant health. I look forward to serving you.

Yours sincerely,

Talitha Rodriguez

Talitha Rodriguez, L.Ac.
Licensed Acupuncturist

Healing Harmony
Acupuncture & Pain Care

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Welcome to Healing Harmony Acupuncture & Pain Care! Please take a moment to provide us with some information about yourself and your health condition so that we may do our best to treat you. We consider this information privileged physician/patient communication and will hold it in confidence.

Patient Information

Date: _____ Email for Follow-up: _____ Phone # _____

Name: (Last, First, Middle)_____

Address: _____

City: _____ State: _____ Zip: _____

Sex: ____Male ____Female Age: _____ Date of Birth: _____

Marital Status: ____Single ____Married ____Divorced ____Separated ____Widowed

Spouse's Name: _____ Phone # _____

Patient Employed by: _____

Business Address: _____

Occupation: _____ Business Phone: _____

In case of Emergency who should be notified? _____

Relationship to patient: _____Phone #: _____

Address: _____

Primary Physician: _____Phone #: _____

Address: _____

Whom may we thank for referring you? _____

Have you ever had acupuncture before? ____Yes ____No

HEALING HARMONY

ACUPUNCTURE & PAIN CARE

Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? _____

For what reason? _____

2. Please identify the health concerns that have brought you to the Healing Harmony Clinic in order of importance below:

Condition	**Past Treatment**
a. _____	_____
How does this condition affect you? _____	
b. _____	_____
How does this condition affect you? _____	
c. _____	_____
How does this condition affect you? _____	

3. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

4. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

5. Please list any allergies you have, including food, medication, dander, pollen, etc.: _____

_____

5. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

6. Do you have any infectious diseases? Y N If yes, please identify: _____

7. **Family History:** Check those applicable:	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

8. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

9. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

10. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

11. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps Pertussis Diphtheria Hib Hepatitis B

Others: _____

12. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	

13. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When
_____		_____	
_____		_____	

14. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Stress/Mental Tension Anxiety Depression

15. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

16. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

17. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: _____

18. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

19. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

20. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

21. **Female Reproductive/Breast** (please circle any that you experience now and underline any that you have experienced in the past)

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

22. **Menstrual/Birthing History:**

1. Age of First Menses: _____ 4. Clots, cramps or pain? _____ 7. # of Miscarriages: _____

2. # of Days of Menses: _____ 5. Birth Control Type: _____ 8. # of Abortions: _____

3. Length of Cycle: _____ 6. # of Pregnancies: _____ 9. # of Live Births: _____

23. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

24. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

25. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

26. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

27. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

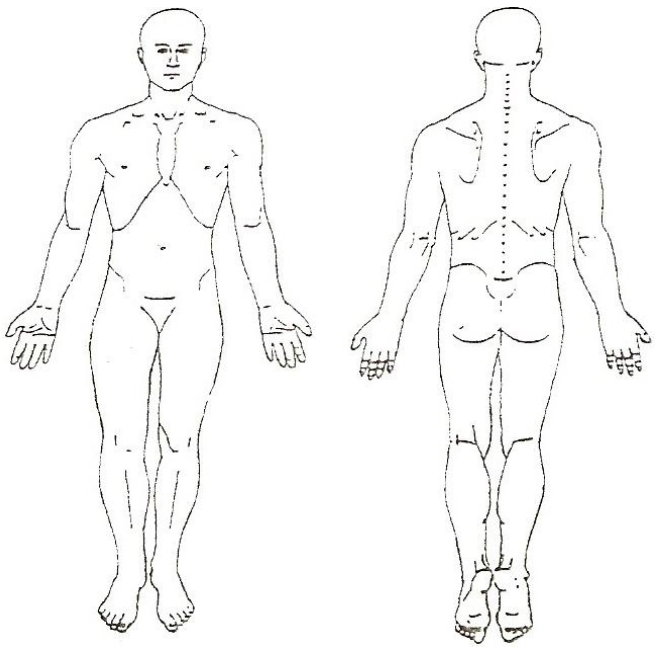
Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

28. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____
b. Exercise routine: _____
c. How many hours per night do you sleep? _____ Do you wake rested? Y N
d. Level of education completed: High School Bachelors Masters Doctorate Other
e. Occupation: _____ Employer: _____ Hours/Week: _____
Do you enjoy work? Y/N Why/Why not? _____
f. Nicotine/Alcohol/Caffeine Use: _____
g. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____
h. Have you experienced any major traumas? Y N Explain: _____

29. Pain: (Please mark your pain and rate each site from 1-10)



Healing Harmony
Acupuncture & Pain Care

Insurance Information/Assignment of Benefits

Patient Name: _____ Date: _____ / _____ /_____

Insurance Company: _____

Member Name (if different than patient): _____

Member Date of Birth: ____ /____ /_____ Patient Date of Birth (if different): ____ /____ /_____

Group Number: _____ Member Number: _____

Member/Provider Phone Number: _____

Insurance Company Address: _____

_____

_____

I authorize my insurance company to make payments directly to the practitioner, Talitha Rodriguez of Healing Harmony Acupuncture & Pain Care Center, for my treatment and service.

I authorize release of information concerning my (or my child's) healthcare, advice or treatment, provided only for the purpose of evaluating and administering claims for insurance benefits.

I understand that my signature requests that payment be made to Healing Harmony Acupuncture & Pain Care Center and authorizes release of any medical information necessary to evaluate benefits & pay the claim.

Signature of Patient: _____ Date: ____ /____ /_____
(or parent if minor)

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Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or herbs by Talitha Rodriguez, a licensed acupuncturist. I understand that acupuncturists practicing in the state of Texas are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this practitioner.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Healing Harmony Acupuncture and Pain Care as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Hulda Clark Zapper: I understand that I may be asked to have frequency generator called a "Zapper" administered with the acupuncture. I am aware that I must inform the acupuncturist if I am pregnant or wearing a pacemaker as this therapy is not approved for patients with either condition. I understand that I may refuse this treatment.

I understand that I will need to inform my acupuncturist if I have a pacemaker or any other implanted electronic device(s).

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

(Please Initial where true) _____**I am NOT pregnant** _____ **I do NOT have a pacemaker**
_____**I AM pregnant** _____ **I DO have a pacemaker**

Signature: _____ **Date:** _____

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ACUPUNCTURE & PAIN CARE

Notification of Physician Evaluation

(Pursuant to the requirement of 183.6(e) of this title (relating to Denial of License; Discipline of License) and Tex. Occ Ann. 205.351, governing the practice of acupuncture)

I (patient's name) _____ am notifying the acupuncturist, Talitha Rodriguez of the following:

(Please initial all that apply)

_____ I have been evaluated by a physician or dentist for the condition being treated within the last 12 months

_____I have received a referral from my chiropractor (within the last 30 days) for the condition being treated

(If after 2 months or 20 treatments, whichever comes first, no substantial improvement in the condition occurs, I understand that the acupuncturist is required to refer me to a physician).

_____I have NOT seen any physician, dentist, or chiropractor for this condition within the last 12 months

Exemptions according to Rule 183.6(e) Scope of Practice
3)…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.**

Patient's Signature_____ **Date:** _____