

Acupuncture Solutions, LLC
3900 Pebblecreek Ct. #101
Plano, TX 75023

PATIENT REGISTRATION

Last Name _____ First Name _____ Date _____

Address _____ Zip Code _____

Telephone Home _____ Work _____ Cellular _____

Email Address _____

Age _____ DOB _____ Occupation _____

Who to reach in case of an emergency? _____

How did you hear about our clinic? _____

Are you currently receiving health care? Please circle: Y N

If yes, name of physician: _____

Condition being treated: _____

What are your most important health concerns?	How long have you had this condition?
1 _____	1 _____
2 _____	2 _____
3 _____	3 _____

Please list tested or suspected allergies and related symptoms:

Foods _____

Seasonal _____

Drug / other _____

Current Medications: Please list any prescription medications or over-the-counter medications you are taking.

Daily Dosage _____

Do you have a current medical condition(s) (e.g. Epilepsy, Pregnant)? _____

Do you smoke? Please circle: Y N

Office Policies

- 24-hour cancellation of appointment is required. A \$25 late, cancellation, or no show fee may be charged.
- Please arrive 10 minutes prior to your appointment time. Late arrivals may result in a late cancellation fee.
- Payment is full due at the time services are rendered.

Signature _____ Date _____

(If under the age of 18, must be signed by Parent or Legal Guardian.)

Notice to Patient

(Pursuant to the requirements of Section 183.7(e) of this title (relating to Denial of License; Discipline of Licensee) and section 6.11, subsections (b) through (d), V.A.C.S., article 4495b, governing the practice of acupuncture)

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

Yes No I am being treated for smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse. If No, what is the condition that the acupuncturist is treating? _____

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) Date: _____

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 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.

Patient Signature: _____ Date: _____

Acupuncture Solutions, LLC

3900 Pebblecreek Ct. Suite 101

Plano, TX 75023

Phone: 972-612-4900

Fax: 972-612-3232

Informed Consent to Treatment

I hereby request and consent to the performance of acupuncture/acupressure treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Steven R. Homoky and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed above or any office or clinic whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, Advanced Allergy Therapeutics(AAT), Nambudripad's Allergy Elimination Treatment(NAET), acupuncture/acupressure, moxibustion, cupping, electrical stimulation, Tiu-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumptions of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness and fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scaring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely of the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I know that the clinic staff assumes no responsibility for medical conditions that require the attention of a medical doctor, or the necessary adjustments to prescribed medications during or after the completion of treatments.

I understand the unpredictable nature of allergies and related symptoms. The clinic cannot guarantee that new allergies will not develop in the future. Where we can treat most forms of allergies, some cases do not respond to treatment. I also understand that the only known risk with allergy desensitization (including medical immunotherapy, AAT or NAET) is the possibility of increased sensitivity. I assume all responsibility for unpredictable immune reactions, which may lead to increased symptomatology. In this event, I agree to seek immediate medical attention. I understand that the clinic does not treat cases of anaphylaxis and I agree to fully disclose all information regarding any life-threatening allergies or allergies resulting in anaphylaxis.

I understand the clinical and administrative staff may review my patient records and lab report, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. 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.

(Print Patient Name)

(Signature of Patient)

(Date)

(Print Name of Clinic Staff)

(Signature of Clinic Staff)

(Date)

Past Medical History

Check any of the following conditions you currently have or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS/ HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Gout | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Birth Trauma
(your own birth) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other (specify):
_____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | _____ |
| | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke | _____ |

List medications you are currently taking.

Medications	Strength	How many per day?	For how long?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List substances or medications you are allergic to.

List any major surgeries you have had.

Date	Problem
_____	_____
_____	_____
_____	_____

List significant trauma (Auto accident, falls).

List significant family history.

Your Diet

- | | | | |
|--|--|---|--|
| Appetite <input type="checkbox"/> High
<input type="checkbox"/> Low | <input type="checkbox"/> Coffee
<input type="checkbox"/> Soft Drinks
<input type="checkbox"/> Artificial Sweetener | <input type="checkbox"/> Sugar
<input type="checkbox"/> Salty Food | Thirst for Water:
of Glasses per Day: _____ |
|--|--|---|--|

Vitamins taken in the past two months: _____

Your Lifestyle

- | | | |
|--|--|---|
| <input type="checkbox"/> Alcohol
<input type="checkbox"/> Tobacco
<input type="checkbox"/> Marijuana | <input type="checkbox"/> Drugs
<input type="checkbox"/> Stress
<input type="checkbox"/> Occupational Hazards | <input type="checkbox"/> Regular Exercise
Type: _____ Frequency: _____
Type: _____ Frequency: _____ |
|--|--|---|

General Symptoms

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Poor Appetite
<input type="checkbox"/> Heavy Appetite
<input type="checkbox"/> Strongly like Cold Drinks
<input type="checkbox"/> Strongly like Hot Drinks
<input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> Recent Weight Gain | <input type="checkbox"/> Poor Sleep
<input type="checkbox"/> Heavy Sleep
<input type="checkbox"/> Dream-disturbed Sleep
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Lack of Strength
<input type="checkbox"/> Bodily Heaviness | <input type="checkbox"/> Cold Hands or Feet
<input type="checkbox"/> Poor Circulation
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Fever
<input type="checkbox"/> Chills
<input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sweats Easily
<input type="checkbox"/> Muscle Cramps
<input type="checkbox"/> Vertigo or Dizziness
<input type="checkbox"/> Bleed or Bruise Easily
<input type="checkbox"/> Peculiar Taste (describe):
_____ |
|--|---|--|--|

- Glasses
- Eye Strain
- Eye Pain
- Red Eyes
- Itchy Eyes
- Spots in Eyes
- Poor Vision
- Blurred Vision
- Night Blindness

- Glaucoma
- Cataracts
- Teeth Problems
- Grind Teeth
- TMJ
- Facial Pain
- Gum Problems
- Sores on Lips or Tongue
- Dry Mouth

- Excessive Saliva
- Sinus Problems
- Excessive Phlegm
- Color of Phlegm: _____
- Recurrent Sore Throat
- Swollen Glands
- Lumps in Throat
- Enlarged Thyroid

- Nose Bleeds
- Ringing in Ears
- Poor Hearing
- Earaches
- Headaches
- Migraines
- Concussions
- Other Head/Neck Problems

Respiratory

- Pneumonia
- Difficulty Breathing when lying down

- Shortness of Breath
- Tight Chest
- Asthma/ Wheezing

- Cough
- Wet or Dry? _____
- Thick or Thin? _____

Color of Phlegm: _____

- Coughing Blood

Cardiovascular

- High Blood Pressure
- Low Blood Pressure
- Blood Clots

- Fainting
- Chest Pain
- Difficulty Breathing

- Tachycardia
- Heart Palpitations
- Phlebitis

- Irregular Heartbeat

Gastrointestinal

- Nausea
- Vomiting
- Acid Regurgitation
- Gas
- Hiccups
- Bloating

- Bad Breath
- Diarrhea
- Constipation
- Laxative Use
- Black Stools
- Mucous in Stools

- Intestinal Pain or Cramping
- Itchy Anus
- Burning Anus
- Rectal Pain
- Hemorrhoids
- Anal Fissures

Bowel Movements:

Frequency: _____

Color: _____

Odor: _____

Texture/ Form: _____

Musculoskeletal

- Neck/ Shoulder Pain
- Muscle Pain
- Upper Back Pain

- Lower Back Pain
- Joint Pain
- Rib Pain

- Limited Range of Motion
- Limited Use

- Other (describe):

Skin and Hair

- Rashes
- Hives
- Ulceration
- Eczema

- Psoriasis
- Acne
- Dandruff
- Itching

- Hair Loss
- Change in Hair/ Skin Texture
- Fungal Infection

- Other Hair/Skin Problems:

Neuropsychological

- Seizures
- Numbness
- Tics
- Poor Memory

- Depression
- Anxiety
- Irritability
- Easily Stressed

- Abuse Survivor
- Considered/ Attempted Suicide
- Seeing a Therapist
- Other (specify): _____

Genitourinary

- Pain on Urination
- Frequent Urination
- Urgent Urination
- Blood in Urine

- Incontinent
- Incomplete Urination
- Venereal Disease
- Bedwetting

- Wake to Urinate
- Increased Libido
- Decreased Libido
- Kidney Stones

- Impotence
- Premature Ejaculation
- Nocturnal Emission
- Other: _____

Gynecological

Age Menses Began: _____

Length of Cycle (Day 1 to Day 1) _____

Duration of Flow: _____

Date Last Period Began: _____

- Irregular Periods
- Painful Period
- Vaginal Odor
- Vaginal Sores
- Vaginal Discharge

Color: _____

Date of Last PAP: _____

- Clots
- PMS
- Breast Lumps

of Pregnancies: _____

of Live Births: _____

of Premature Births: _____

Age at Menopause: _____