Harmony & Health

Jagjit Khalsa, LAc, LMT

Patient Intake Form

Acupuncture OM
(512)921-9899
HarmonyAndHealth.com

Full name		Sex ☐ F ☐ M	Date
Date of Birth	Age	Occupation	
Main phone #		Other phone #	
E-mail address		Allow e-mail contact by H&H ☐ Yes ☐ No	
Emergency contact name & phone		Marital status	# of children
Address:		City	State Zip
Family physician		Chiropractor	
Do you have health insurance? ☐ Yes ☐ No If yes, name of insurance company			
Does your insurance cover acupuncture? ☐ Yes ☐ No			
How did you find out about our clinic?			

Main problem(s): _____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)?

_____

When did the problem begin? _____

What diagnosis, if any, have you received for this problem? _____

What kind of treatments have you tried? _____

Medical History

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			STD			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other		

Surgeries (types & dates): _____ Hospitalization (reason & dates): _____

Significant trauma (auto accidents, sport injuries, etc): _____

Significant dental work: _____

Allergies (drugs, chemicals, foods, environmental): _____

Stress (occupational, chemical, physical, psychological): _____

Birth History (prolonged labor, forceps, premature, etc.) _____

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Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

_____

Habits Do you smoke? ☐ Yes ☐ No What?_____How many per day? _____Since when?_____

Please describe any use of drugs for non-medical purposes: _____

Do you exercise regularly? ☐ Yes ☐ No Please describe your exercise program:_____

_____

Are you or have you been on a restricted diet? What kind and why? _____

_____

Please describe your average daily diet including beverages (Please be as specific as possible):

Morning _____

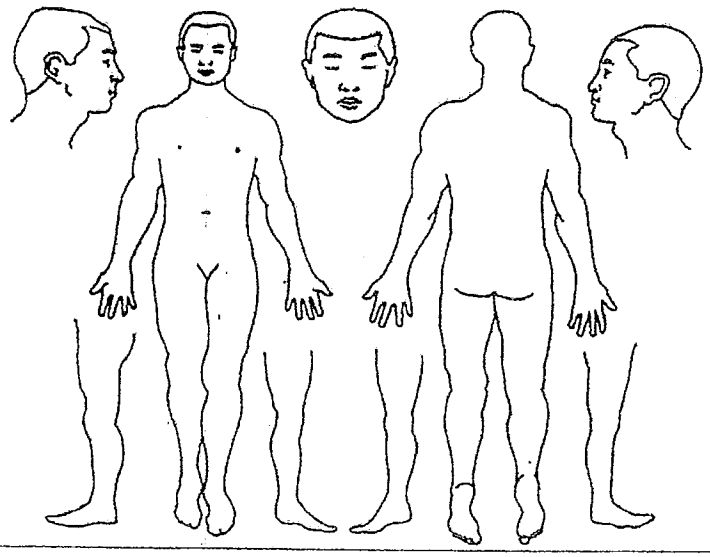
Afternoon _____

Evening _____

Snacks _____

Indicate painful or distressed areas.

Sharp/ Stabbing = XXXX
Shooting = <<<<<
Numbness = NNNNN
Dull/Aching = DDDDD
Burning = BBBBB
Cramps = CCCCC



Pain severity scale.

Please place a mark on the line that corresponds to your **current** pain

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN EVER

Please place a mark on the line that corresponds to your **average** pain

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN EVER

What brought the pain on?_____

What makes the pain better?_____ What makes it worse?_____

How often does the pain exist?_____And for how long?_____

Any prior injuries to the area of pain?_____

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Have you seen another healthcare practitioner for the pain/condition? ☐ Yes ☐ No If yes, who?_____

Check all that apply
Past: in the past 3 months
Current: Now and a week ago

ENERGY AND IMMUNITY

Past	Current	Condition
☐	☐	Fatigue
☐	☐	Catch cold easily
☐	☐	Fevers
☐	☐	Chills
☐	☐	Sweat easily
☐	☐	Night sweats
☐	☐	General weakness
☐	☐	Cravings
☐	☐	Poor balance
☐	☐	Slow wound healing
☐	☐	Chronic infection
☐	☐	Cold hands/feet
☐	☐	Peculiar tastes
☐	☐	Strong thirst [Cold or Hot drinks]
☐	☐	Sudden energy drop

SLEEP

Past	Current	Condition
☐	☐	Trouble falling asleep
☐	☐	Trouble staying asleep
☐	☐	Nightmares
☐	☐	Tired upon waking
☐	☐	Excessive dreaming

What hour do you go to sleep?_____
What hour do you wake up?_____

SKIN & HAIR

Past	Current	Condition
☐	☐	Rashes
☐	☐	Acne
☐	☐	Ulcerations
☐	☐	Dandruff
☐	☐	Dry skin/scalp
☐	☐	Bleed or bruise easily
☐	☐	Itching
☐	☐	Recent moles
☐	☐	Loss of hair
☐	☐	Other:_____

HEAD & NECK

Past	Current	Condition
☐	☐	Dizziness/Vertigo
☐	☐	Headache/Migraine
☐	☐	Painting
☐	☐	Facial pain
☐	☐	Swollen gland
☐	☐	Other: _____

EARS

Past	Current	Condition
☐	☐	Infections
☐	☐	Earaches
☐	☐	Ringing
☐	☐	Decreased hearing
☐	☐	Other: _____

EYES

Past	Current	Condition
☐	☐	Blurred vision
☐	☐	Vision changes
☐	☐	Poor night vision
☐	☐	Spots
☐	☐	Cataracts
☐	☐	Eye strain
☐	☐	Eye pain
☐	☐	Glasses/contacts
☐	☐	Eye inflammation
☐	☐	Other:_____

NOSE, THROAT, MOUTH

Past	Current	Condition
☐	☐	Nose bleeds
☐	☐	Sinus problems
☐	☐	Sore throat
☐	☐	Grinding teeth
☐	☐	Difficulty swallowing
☐	☐	Sores on lips/tongue
☐	☐	Teeth problems
☐	☐	Jaw clicks/TMJ
☐	☐	Other:_____

CARDIOVASCULAR

Past	Current	Condition
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	High cholesterol
☐	☐	Palpitations
☐	☐	Chest pain
☐	☐	Irregular heart beat
☐	☐	Rapid heart beat
☐	☐	Fainting
☐	☐	Difficulty breathing
☐	☐	Varicose veins
☐	☐	Other: _____

RESPIRATORY

Past	Current	Condition
☐	☐	Asthma/Wheezing
☐	☐	Allergies
☐	☐	Cough
☐	☐	Short of breath
☐	☐	Bronchitis
☐	☐	Pneumonia
☐	☐	Other: _____

GASTRO-INTESTINAL

Past	Current	Condition
☐	☐	Poor appetite
☐	☐	Excessive appetite
☐	☐	Nausea/Vomiting
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Abdominal pain/cramps
☐	☐	Belching
☐	☐	Bad breath
☐	☐	Bloating
☐	☐	Gas
☐	☐	Heartburn
☐	☐	Hemorrhoids
☐	☐	Gallbladder problems
☐	☐	Chronic laxative use

Bowel movements:
Frequency _____
Color _____
Odor _____

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Texture/Form: ☐ Well-formed ☐ Hard ☐ Loose ☐ Watery

Feels complete? ☐ Yes ☐ No

GENITO-URINARY

Past	Current	Condition
☐	☐	Kidney stones
☐	☐	Painful / Burning urination
☐	☐	Frequent urination
☐	☐	Urgency to urinate
☐	☐	Unable to hold urine
☐	☐	Retention of urine
☐	☐	Dribbling
☐	☐	Profuse urination
☐	☐	Blood in urine
☐	☐	Urinary tract infection
☐	☐	Genital pain
☐	☐	Genital itching
☐	☐	Genital rashes
☐	☐	Other: _____

NEUROLOGICAL

Past	Current	Condition
☐	☐	Seizures
☐	☐	Tremors
☐	☐	Numbness / tingling of the limbs
☐	☐	Concussions
☐	☐	Loss of balance
☐	☐	Poor memory
☐	☐	Poor concentration
☐	☐	Paralysis
☐	☐	Lack of coordination
☐	☐	Other: _____

PSYCHOLOGICAL

Past	Current	Condition
☐	☐	Sadness
☐	☐	Nervousness
☐	☐	Fear
☐	☐	Anxiety/Panic attacks
☐	☐	Frequent worrying
☐	☐	Irritability
☐	☐	Bad temper
☐	☐	Mood swings
☐	☐	Mania
☐	☐	Depression

MUSCULOSKELETAL

Past	Current	Condition
☐	☐	Joint disorders
☐	☐	Paralysis
☐	☐	Muscle weakness
☐	☐	Muscle spasm/ twitching/ cramps
☐	☐	Muscle soreness/ pain
☐	☐	Swelling of hands/feet
☐	☐	Spinal curvature
☐	☐	Hernia
☐	☐	Other:_____

FOR MEN ONLY

Past	Current	Condition
☐	☐	Prostatitis
☐	☐	Benign prostatic hyperplasia
☐	☐	Erectile dysfunction
☐	☐	Testicular pain
☐	☐	Frequent seminal emission
☐	☐	Nocturnal emissions
☐	☐	Painful / swollen testicles
☐	☐	Low sex drive
☐	☐	Low sperm count
☐	☐	Poor sperm motility
☐	☐	Fertility problems
☐	☐	Other:

FOR WOMEN ONLY

Is your menstrual cycle regular?

☐ Yes ☐ No

Date of last period: _____

Length of menstrual period: _____

Length of cycle____

Age of first period: _____

Do you practice birth control?

☐ Yes ☐ No

If Yes, what type and for how long?

_____

Are you pregnant now? ☐Yes ☐No

Do you have the following menstrual related signs and symptoms?

☐ Abdominal cramps
☐ Lower back pain
☐ Acne
☐ Breast distension
☐ Nausea
☐ Water retention
☐ Mood swings
☐ Irritability
☐ Food cravings
☐ Migraines
☐ Changes in bowel movement
☐ Clots
☐ Spotting between periods
☐ Other: _____

Check all that apply:

☐ Vaginal itching
☐ Vaginal dryness
☐ Pain during intercourse
☐ Abnormal vaginal discharge
☐ Fibroids
☐ Ovarian cysts
☐ Breast lumps
☐ Fertility problems
☐ Hot flashes
☐ Low sex drive
☐ Abnormal pap smear
☐ Other: _____

Indicate number of occurrences:
Pregnancies: _____
Live Births: _____
Miscarriages: _____
Abortions: _____
Premature births: _____
C-section: _____
Difficult delivery: _____

Perimenopause since_____
Menopause:since when?_____

Signature: _____ Date: _____

HARMONY AND HEALTH ACUPUNCTURE & BODYWORK
HIPAA Acknowledgement and Appointments Reminders Form

I acknowledge that I have been provided access to the Harmony and Health Acupuncture & Bodywork "Notice of Privacy Practices". I understand that I have the right to review Harmony and Health Acupuncture & Bodywork's "Notice of Privacy Practices" prior to signing this document.

I understand that Harmony and Health Acupuncture & Bodywork 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.

Information stripped of any personal identifiers may also be used for research and educational purposes by individual practitioners or Harmony and Health Acupuncture & Bodywork. By signing this form, I am giving Harmony and Health Acupuncture & Bodywork authorization to contact me with these reminders and to utilize my information for research and education purposes.

_____ _____
Patient's Name (print) Date

_____
Patient Signature

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Harmony and Health Acupuncture & Bodywork the use or disclose of my individually 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

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture 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 the acupuncturist indicated below 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 below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese 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 consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include 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.

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 Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on 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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 an opportunity to ask questions. I agree with the current or future recommendations for care. 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.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

Harmony & Health

DECLARATION OF EVALUATION OR REFERRAL

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care." As a result, Harmony & Health *is required to have you respond 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 either statements A or B is" no". Harmony & Health is not responsible for untrue statements made by patients.*

(Pursuant to the requirements of 22 TAC §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) _____ am notifying the practitioners at *Harmony & Health* of the following:

A. ___ 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.

OR

B. ___ 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 two months or 20 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

_____ _____

Patient Signature Required Date