INDIGO
HEALING ACUPUNCTURE

New Patient Application

Important: The information on this form will help your acupuncturist give you the best and most comprehensive care possible. It is important for you to complete this document as thoroughly as possible. Even though some of the questions may seem completely unrelated to your condition, they may play a contributing, or underlying role in diagnosis and treatment of your problem.

General Patient Information (*All of the information provided is strictly confidential – see permission to share medical information section*)

Last Name:_____First Name:_____Middle Initial:_____

Address:_____City:_____State:_____Zip:_____

Primary Telephone Phone #:_____Alternative Phone #:_____

E-Mail:_____Date of Birth:___/___/_____ Age:_____

Text Messages ok? (circle one): YES NO Height_____ Weight_____

Occupation:_____Employer:_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered

In case of emergency, whom should we notify?_____Relationship: _____

Emergency Contact Phone #: _____

Medical Evaluation

I was evaluated by a physician or chiropractor for the condition(s) being treated within the last 12 months.
☐Yes ☐ No

I recognize that I should be evaluated by a physician for the condition(s) being treated by the acupuncturist.
☐Yes ☐ No

Medical Providers

Physician Name:_____Phone Number:_____

Chiropractor Name:_____Phone Number:_____

Please list any medications or supplements you have used in the past year or currently:_____
_____

Please list any recreational drugs used in past year:_____

Do you drink alcohol? (circle one) YES / NO If Yes, how many drinks per week? _____

General Health Information

Major Health Complaint(s). Please list any health concerns or complaints that you have in order of their significance.

Major Health Complaints / Symptoms	Additional Health Complaints / Symptoms
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Please explain how these conditions affect or impair your daily activities:

_____

_____

Describe your symptoms when they are at their worst:

_____

_____

Are there any other complaints or conditions that you would like us to know about?_____

_____

Have you had any hospitalizations/surgeries? Y / N If so, note date & reason: _____

_____

Do you have any allergies? Y / N If so, describe:

_____

Do You Exercise Regularly? Y / N If so, what forms of exercise?_____

Do You Smoke? Y / N If yes, do you want to quit? Y / N

Medical Conditions and History
(Check any conditions that you have had in the past, or are currently experiencing):

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Malaria
☐ Heart Disease	☐ Stroke	☐ Vein condition	☐ Thyroid disorder
☐ Asthma	☐ Pneumonia	☐ Tuberculosis	☐ Emphysema
☐ Hepatitis	☐ Gonorrhea	☐ Mumps	☐ Bleeding or hemorrhage
☐ Syphilis	☐ Measles	☐ ChickenPox/Shingles	☐ Nervous disorder
☐ Meningitis	☐ HIV	☐ Polio	☐ Autoimmune Disease
☐ Epilepsy	☐ High Fever	☐ Hepatitis	☐ Hypertension
☐ Paralysis	☐ Cancer	☐ Migraines	☐ Mental Illness
☐ Lung disease	☐ Heart disease	☐ Liver disease	☐ Kidney disease
☐ Headaches	☐ Herpes Simplex	☐ High Cholesterol	☐ Irregular Pap Smear

☐ Other (Explain):

Stress Assessment

Managing stress effectively is an essential component of wellness. The more effectively stress is managed, the more your body and mind become relaxed, receptive and open to healing.

Is your life stressful, or fast paced? Y / N

How would you rate your current stress level? (Low 1 2 3 4 5 6 7 8 9 10 High)

In what areas of your life do you feel the most stressed? Circle all that apply: - Job/Career - Financial Partner/Spouse relationship - Parents/Family - Friends - Other(s): _____

How does this stress impact your:

Health: _____

Sleep: _____

Thoughts about self: _____

Thoughts about others: _____

Feelings/Mood: _____

Actions: _____

How would you describe your current level of hopefulness towards attaining your health goals?

(1 being the lowest feeling of hope, and 10 being the most hopeful) 1 2 3 4 5 6 7 8 9 10

What are your main source(s) of support? Spouse/Partner - Family - Friends - Workplace - Church Support group - Therapist - God/Prayer - Myself (I primarily rely on myself alone to deal with difficult issues)

Are you using any of the following methods of relaxation and/or healing? - Massage therapy - Physical exercise Meditation - Prayer - Yoga - Guided imagery - Energy Work - Others: _____

Permission to maintain medical privacy and share medical information

All of the information that you provide to us is strictly confidential. It is our policy never to disclose any personal or medical information about any patients under our care without first obtaining your express permission to do so. There are, however, a few instances where we feel that sharing information about your case helps to provide the best possible clinical outcome, and we would like to ask your permission to share information.

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1) Many of our patients are under the care of a Physician. In an effort to maximize your clinical results, we may want to contact your Doctor(s) and send them periodic updates about your case and your progress. Do you grant your permission for us to discuss the details of your case with your Physician(s)?

□ Yes ☐ No

_____ Patient Signature

_____ Date

Informed Consent to Treatment

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 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, cold laser, 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 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 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 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.

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 some 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. (Women Initial Here: _____)

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 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 understand that 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.

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.

Any appointment missed, late cancelled, or changed without 24 hours notice will result in a charge equal to 100% of the reserved service amount. The appointment may be taken off of a plan/package or charged individually at the prevailing per session rate.

_____ _____ _____

Patient Name (please print) Patient Signature Date

If under 18 years old

_____ _____

Print name of patient's representative (if applicable) Relationship or authority of patient's rep.

_____ _____

Signature of patient's representative (if applicable) Date Signed

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number:

1-800-201-9353

For more information please visit our website at

www.tmb.state.tx.us

AVISO SOBRE LAS QUEJAS

Las quejas sobre médicos, así como sobre otros profesionales acreditados e inscritos en la Junta de Examinadores Médicos del Estado de Texas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugía, se pueden presentar en la siguiente dirección para ser investigadas:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Si necesita ayuda para presentar una queja, llame al:

1-800-201-9353

Para obtener más información, visite nuestro sitio web en

www.tmb.state.tx.us