MEDICAL ARTS ACUPUNCTURE
and Oriental Medicine

@ Atlas Chiropractic and Wellness Center
6010 Balcones Dr, Ste 101 Austin, TX 78731
www.medicalartsacupuncture.com
(512) 465-9355

FEMALE PATIENT INTAKE FORM

Please attach an additional paper if you need more space.

Name: Date of birth: / / Marital status:

Address: Zip:

Cell: Home: Email:

Best way to contact: Cell / Home / Email Best time to contact: AM / PM / Evening

Emergency contact name: Phone: Relationship:

How did you hear about us? Prior acupuncture experience? Y / N

Please initial here to give us permission to thank the person who referred you:

Main Complaint:

What is your chief complaint?

When did it begin? Does it run in your family? Y / N

What led up to this problem?

What kind of treatments have you tried?

What makes it better?

What makes it worse?

Past Medical History: (please check)

	You	Family		You	Family		You	Family
Addiction/Alcoholism			Diabetes			Hypertension		
Allergies			Digestive Disorders			Insomnia		
Anemia			Emotional imbalance			Seizures		
Arthritis			Heart Disease			Tuberculosis		
Asthma			Hepatitis			Thyroid Disease		
Cancer			High cholesterol			Urinary problem		

Trauma (auto accidents, sports injury):

Surgeries/hospitalization (please list):

Others (please list):

Occupation:

Your occupation:	How many hours/week?	Do you enjoy your job?: Y / N
Do you work: indoor / outdoor	How stressful?:	

Personal Information:

Height:	Weight:	Max weight:	When:

Do you exercise?: Y / N	What kind?	How often?
Do you smoke? Y / N	How many?	Since when?
How many hours do you sleep?	What time do you go to bed?	Do you dream often? Y / N
Favorite flavor of food:	Favorite time of year:	Favorite time of day
Predominate emotion:	Energy level (1~10):	Stress level (1~10):

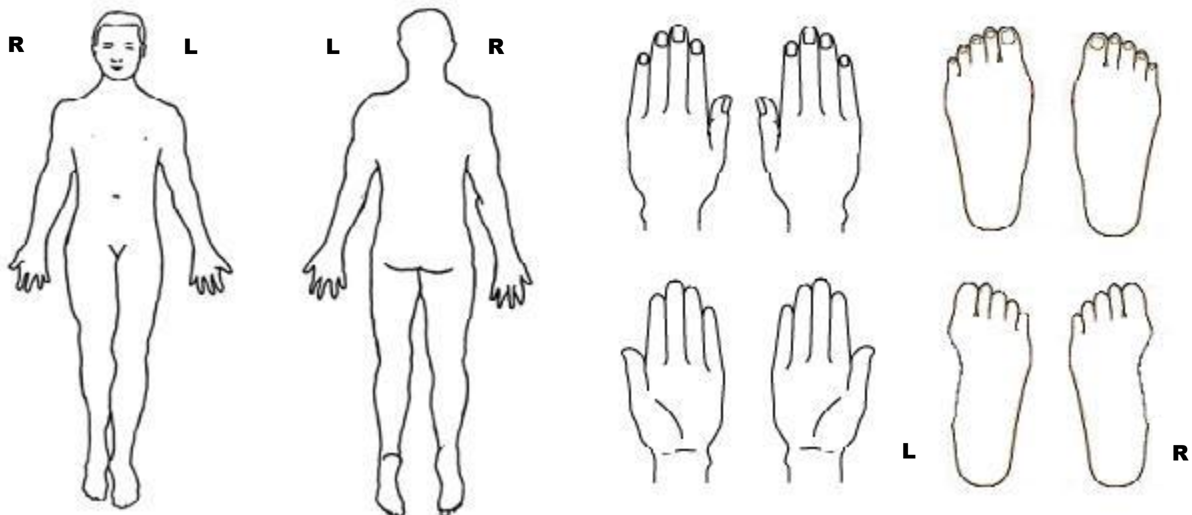
Diet:

How much do you drink:	Water:	Coffee:	Soda:	Alcohol:
Do you often eat (circle):	Sugary food, Spicy food, Greasy food, Processed food, Fast food			
Do you often skip (circle):	Breakfast, Lunch, Dinner, Snacks			
Vegetarian?: Y / N	If yes, any fish/egg/dairy?		Since when?	

Female Patient Only:

Age of 1st menses:	1st date of last period (Day 1 of bleeding):	
Duration of periods: days	Duration of cycle: days	Bleeding: Heavy, Medium, Light
Irregular menses?: Y / N	Bad cramps? Y / N	Any clots?: Y / N
Number of pregnancies ( ), births ( ), miscarriages ( ), abortions ( )		
Do you practice birth control?: Y / N	What type?	How long?

Indicate Painful or Distressed Areas



Please list medications, supplements, and herbs you are currently taking

Signature: ____ **Date:**____

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NOTIFICATION FORM REGARDING EVALUATION OF PATIENT BY PHYSICIAN

(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 am notifying Medical Arts Acupuncture of one or more of the following (**please check one or more**):

☐ 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.

☐ 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.

☐ I am seeking acupuncture and Oriental Medicine for one or more of the following:
(Please circle) Chronic pain, Weight loss, Smoking addiction, Alcoholism, Substance abuse

PRIVACY NOTICES

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I understand I have a right to review the "Notice of Privacy Practices" prior to signing this document. The "Notice of Privacy Practices" describes the types of uses and disclosures of my Protected Health Information that will occur in my treatment, payment of my bills or in the performance of health care operations. "The Notice of Privacy Practices" is available upon request. This Notice of Privacy Practices also describes my rights and Medical Arts Acupuncture's duties with respect to my Protected Health Information.

Appointment Reminders and Health Care Information Authorization

Medical Arts Acupuncture, and other associated practitioners, may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with whoever answers the phone. Thank You cards, appointment reminders, birthday cards, holiday cards and other correspondence may be sent to your address. By signing this form, you are giving us authorization to contact you with these reminders and information.

I authorize you to use or disclose my health information in the manner described above.

I am also acknowledging that I have the opportunity to request a copy of this authorization.

Authorization for Release of Health Information

Due to the Federal HIPAA Regulations enacted in April of 2003, your health care practitioners are not allowed to release any information concerning you or appointments without your written consent. Therefore, if you are interested in having someone other than yourself schedule or cancel appointments for you, pick up your herbal prescriptions, or be informed about any aspect of your treatment, you must list their names on the lines below giving us your authorization to communicate with a third party about your information. This written authorization is also necessary for insurance companies seeking knowledge about your treatments to reimburse a claim, or if you wish to have your case discussed with other doctors or practitioners outside my practice.

This form is included in your initial paperwork on your first visit. Please know our authorization to communicate about your treatment is limited only to those people you have listed on this form. We cannot release any information to anyone not listed on your medical records release form. If, at any time, you need to add to or amend this form please advise your practitioner.

I hereby authorize Medical Arts Acupuncture, and other associated practitioners the use or disclosure 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: (print)

____ ____

____ ____

____ ____

OFFICE POLICIES

Appointments

If you find that you need to cancel an appointment, it is important that we receive a twenty-four (24) hour notice. This enables us to adjust our schedule accordingly. **We charge the full fee for appointments canceled with less than a twenty-four hours notice or for "no show" appointments.** If you are late for more than 20 minutes past the scheduled appointment and do not inform us, the appointment is considered a “no show”.

Payment for Services Rendered

Payment is due at the time of service and may be paid in cash, credit card, or check.

Patient Name: ____________________________________ Signature: ____________________________________

Date: ____________________________________