www.qiflowacu.com

Phone: (832) 441 5823

# NEW PATIENT REGISTRATION INFORMATION

**PATIENT INFORMATION**

Last Name: ______________________________ First Name: __________________________ Middle Initial: _____

Address: ___________________________________________ City: ___________ State: ______ Zip: ___________

Home Ph: ____________________ Cell: __________________ Email: ___________________________________

Age: _____ DOB: _____________ Sex: ____ Primary language: ________________________________________

Driver's License or other ID: _______________________ Occupation: _________________________________

How did you hear about us? _________________________

**RESPONSIBLE PARTY (Please complete if patient is under 18 years old)**

Last Name: ______________________________ First Name: __________________________ Middle Initial: _____

Address: ___________________________________________ City: ___________ State: ______ Zip: ___________

Home Ph: ____________________ Cell: __________________ Email: ___________________________________

Driver's License or other ID: _________________________Relationship to patient: ___________________________

**EMERGENCY CONTACT**

Last Name: _________________________ First Name: _______________________ Relationship: _______________

Phone: ___________________________ Alt Phone: __________________________

**CASE HISTORY**

Your chief complaint today: ____________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Have you ever received treatment for this condition? Y / N

If yes, what? __________________________________________________________________________

______________________________________________________________________________________

**CURRENT MEDICATIONS** (List medications, vitamins & herbs that you are currently taking)

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

**ALLERGIES** (List any medications or foods you are allergic to)

______________________________________________________________________________________

**INJURIES/SURGERIES** (List any injuries or surgeries that you have had in the past)

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

## MEDICAL HISTORY

### PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Hyperthyroidism
- ❑ Cancer (type) ________________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

**Women Only:** **When?**

- ❑ Abnormal Pap smear __________
- ❑ Irregular periods __________
- ❑ Bleeding between periods __________
- ❑ Menopause __________

Age of first period ______
# Pregnancies ______
# Miscarriages ______
# Abortions ______ Year of last abortion ____________
Contraceptives ______ How long? __________________

Other medical conditions (please list):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

### SYSTEMS REVIEW

**In the past 6 months, have you had any of the following problems?**

**GENERAL**
- ❑ Weight gain; _______ lbs.
- ❑ Weight loss: _______ lbs.
- ❑ Weakness
- ❑ Headache

**MUSCLE/JOINTS/BONES**
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

**EYES**
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

**EARS**
- ❑ Ringing in ears
- ❑ Loss of hearing

**THROAT**
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

**HEART AND LUNGS**
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting

**BLOOD**
- ❑ Anemia
- ❑ Clots

**NERVOUS SYSTEM**
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

**SKIN**
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

**PSYCHIATRIC**
- ❑ Depression
- ❑ Stress
- ❑ Irritability
- ❑ Anxiety

Have you ever had acupuncture? ___Yes ___No

**Signature:** ________________________________ **Date :** ____________________

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**Notification Form Regarding Evaluation of Patient by Physician**

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, Qi Flow Acupuncture 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 all of these statements is no. (Pursuant to the requirement of section 183.6 (e) of this title and section 6.11, Subsection (d) V.A.C.S. article 4495b, governing the practice of acupuncture)

I (patient name), _________________________________________________ am notifying Qi Flow Acupuncture that:

__ Yes __ No I have been evaluated by a physician or dentist for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that a physician should evaluate me for the condition being treated by the acupuncturist.

**OR**

__ Yes __ No I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _______________, and the most recent date of chiropractic treatment prior to acupuncture treatment is ________________. After being referred by a chiropractor, if after 60 days 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 to follow this advice.

**OR**

__ Yes __ No 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 one of the following conditions:

- ☐ Chronic Pain
- ☐ Weight Loss
- ☐ Smoking Cessation
- ☐ Alcoholism
- ☐ Substance Abuse

____________________________________ ____________ _______________________________

Patient Signature (or Patient Representative) Date (Indicate relationship if signing for patient)

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**PATIENT ACKNOWLEDGEMENT OF PRIVACY POLICES**

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to receive our notice before signing the consent. The terms of our notice may change. If we change notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclose for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for your treatment, payment, and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I hereby give my consent for Qi Flow Acupuncture to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Qi Flow Acupuncture describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Qi Flow Acupuncture reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Mrs. Merryl Fernandes.

With this consent, Qi Flow Acupuncture may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, Qi Flow Acupuncture may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Qi Flow Acupuncture may e-mail to the email address I have provided or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Qi Flow Acupuncture restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Qi Flow Acupuncture to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Qi Flow Acupuncture may decline to provide treatment to me.

**This Consent was signed by:**

___________________________________
**Printed Named-Patient or Representatives**

___________________________________
**Patient or Representatives Signature**

_____/_____/_________
**Date**

**Signing of Consent was witnessed by:**

_____________________________________
**Acupuncturist**

______________________________________
**Signature of Acupuncturist**

_____/_____/_________
**Date**