Welcome to Dr. Yang

CINCO RANCH ACUPUNCTURE CLINIC

Would you please take a moment to provide us some information about yourself and your health conditions, so that we may do our best to treat you. CR Acupuncture clinic considers this information privileged physician/patient communication and with hold it in confidence. If you have any question, please don't hesitate to ask for assistance.

Please Print

Date: _____ Phones: (H) _____ (W) _____

Name: (Last) _____ (First) _____ (Middle) _____

Home Address: _____

City _____ State_____ Zip_____

Sex: ☐ M ☐ F Birth date: _____ Age:_____ Email _____

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

Spouse's name: _____ Phone (W) _____

Patient employed by_____

Business address _____

Occupation _____ Business Phone _____

In case of emergency who should be notified? _____

Relationship _____ Phone _____

Address _____

Have you received acupuncture before? _____ How did you hear about us? _____

Whom may we thank for referring you _____ phone _____

Have you consulted a Medical Doctor (Western) for your condition/complain? _____

Your medical doctor's name (Western) _____ Phone_____

Diagnosis of your problems _____

Treatment Agreement

I come here, to Dr. Yang, seeking Chinese Medical treatment for my condition. I hereby authorize Dr. Yang to perform appropriate therapy as my condition indicates or requires. I understand that these therapies may commonly accepted or known to my community or to myself. But that they are based on centuries old medical systems from around the world. I understand that Acupuncture, herbs and related treatments, as in any medical therapy, may make no guarantee as to the results.

I understand that only one-time use, pre-sterilized disposable needles are used at Cinco Ranch Acupuncture Clinic. Minor bruise may occasionally appear after treatment.

Patient's Signature: _____ Date: _____

Please go to page 2 and 3

Form to be completed by Patient, notifying the Acupuncturist of Whether He/She has been evaluated by a Physician, and other Information

(Pursuant to the requirements of '183.6(e)' of this title (relating to Denial of License; Discipline of Licensee) and Tex. Occ. Code Ann., '205.351, governing the practice of acupuncture.)

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

_____ 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 recognized that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

_____ (initials of patient) 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 t a physician. It is my responsibility and choice whether to follow this advice.

Signature _____ Date _____

Note:

Exemptions according to **Rule 183.6 (e) Scope of Practice**

3) …an acupuncturist holding a current and valid license may without an evaluation or a referral from a physician, dentist, or chiropractor perform acupuncture on a person for **smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse.**

PATIENT HISTORY

1. What is your major complaint and how long has this condition persisted? _____

_____

2. Have you ever received any treatment for this condition? □ Yes □ No

If yes, where ? When ? and By whom?_____

What was the diagnosis? _____

What kind(s) of treatment(s)? _____

What were the results of treatment? _____

3. List medications you are currently taking.

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

4. Please list substances that you are allergic to: _____

5. List any major surgeries and significant trauma you have had.

Date	Problem
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

6. Significant illness: (please check)

□ Rheumatic Fever □ Heart Disease □ Diabetes □ Hypothyroid □ Hyperthyroid
□ Hypertension □ Hepatitis □ Seizures □ Cancer □ HIV Positive
□ Tuberculosis ` Others_____

7. Does any of your relatives have the following diseases:

Rheumatic Fever _____ Heart Disease _____ Diabetes _____ Cancer _____
Hypothyroid _____ Hyperthyroid _____ Hypertension ____ Hepatitis _____
Seizures _____ HIV Positive _____ Tuberculosis ____ Others _____

8. Have you tried acupuncture or Chinese medicine before?
9. (Female only) Are you pregnant or do you suspect that you may be pregnant? Yes or No
How many children _____ Last period _____ Last pap-smear _____