PINE MOUNTAIN
CHINESE ACUPUNCTURE & HERB CLINIC

The purpose of this questionnaire is to help us determine the best treatment plan for you and will be held in complete confidence. If you have any questions, please do not hesitate to ask. Thank you.

Personal Information: ***Date:*** _____

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

Home Address: _____

City/State/Zip Code: _____

Telephone Numbers: _____ _____
(Home) *(Work/Office)*

_____
(Cell)

E-mail Address: _____

Occupation: _____

Sex: Male ____ Female ____ Date of Birth:_____ **Age:** _____

Marital Status: M S D W Number of Children: _____

Driver's License Number: _____

Health Insurance Carrier: _____

How did you find Pine Mountain Clinic?

- **Friend/Relative:** _____
  (Please give us the name of the person(s) who referred you to us so we can thank them)
- **AT&T Yellow Pages:** _____ **Provider Directory:** _____
- **Website:** _____ **Other:** _____

Have you received Acupuncture therapy before? _____

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REQUEST, CONSENT, AND PRIVACY POLICY

I hereby request Ziyang Zhou, L.Ac. to treat me. I authorize him to perform on me the treatment known as acupuncture as his judgment may indicate, and authorize him to use whatever therapeutic methods he may see fit, whether or not such methods are commonly and generally accepted and practiced in this community.

Ziyang Zhou, L.Ac. has frankly and fully explained to me the nature and purpose of the treatment and the risks involved, including, but not limited to, mild bruises from needling and burns from moxibustion. In giving my consent to the treatment, I have in mind his full and frank explanation. If any unforeseen condition arises in the course of the treatment, and in the judgment of the acupuncturist if it is advisable to use procedures in addition to or different from those now contemplated, I also request and authorize him to do whatever he deems advisable.

If I am suffering from any of the following diseases, I will give notification:

1. ***Heart condition***
2. ***Stroke***
3. ***Diabetes***
4. ***Fainting from needles***
5. ***Bruising easily***

(Please circle "yes" to confirm that the acupuncturist has shown you the disposable needles.) **Yes**

In the event my condition is such that treatment is beyond the normal capabilities of the acupuncturist, I understand I may be referred to other competent practitioners, including but not limited to medical physicians or other acupuncturists.

By signing this consent form, I understand and agree to give 24 hours advance notice if I am going to be unable to make/keep my scheduled appointment. I understand I will be charged a fee if I miss an appointment without giving 24 hour notice in advance.

I understand that Pine Mountain Clinic maintains the privacy of my records as governed by law. A copy of the privacy policies has been made available to me, and I understand that I may request a written copy of the policies.

I have been given no guarantee as to the results that may be obtained.

_____

(Patient Signature) *(Date)*

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To comply with TEXAS CIVIL STATUTES GOVERNING THE PRACTICE OF ACUPUNCTURE
Article 4495, Subchapter F. Sec. 6.11, subsection (b) through (d)

Please read and check the appropriate answers:

I, _____, am notifying the acupuncturist,
(Patient Name, please print)
Ziyang Zhou, L.Ac. of the following:

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

OR

I have received a referral from my chiropractor in the last 30 days for acupuncture. After being referred by a chiropractor, if after 60 days or 20 treatments, whichever come first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician.
YES _____ No ____

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 one of the following conditions:

Chronic Pain _____
Weight Loss _____
Smoking Cessation _____

Signature: _____
(Date)

THE ACUPUNCTURIST HAS REFERRED ME TO SEE A PHYSICIAN. IT IS MY RESPONSIBILITY AND CHOICE TO FOLLOW HIS ADVICE.

_____ _____
(Patient's Signature) *(Date)*

_____ _____
(Acupuncturist's Signature) *(Date)*

Pine Mountain Chinese Acupuncture and Herb Clinic is not responsible for untrue statements made by patients.

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Please assist us in the assessment of your condition by answering the following questions as thoroughly as you can.

What is the main health problem for which you are seeking treatment for today?

_____

_____

What other health problems do you have?

_____

_____

Please list any accidents, surgeries or other periods of hospitalization.

_____

_____

Please list the medications and/or supplements you are currently taking, *i.e., prescription or over-the-counter medications.*

_____

_____

_____

(Please circle any that apply:)

Tobacco Coffee Tea Alcohol Soft Drinks

How often? _____

Any additional information that you feel is important:

_____

_____

_____

Family Medical History: *(please specify family member next to the condition listed below)*

- HeartDisease_____
- Alcoholism _____
- Diabetes _____
- Cancer _____
- Stroke _____
- Seizures _____
- Asthma _____
- High Blood Pressure _____
- Other _____