Eastern Balance Oriental Medicine LLC

Promoting health through Traditional Chinese Medicine therapies & Eastern philosophy.

Patient Information Today's Date: _____

Last Name: _____ First Name: _____

Middle Name or Initial: _____ Home Phone: _____

Home Address: _____

City/State/Zip Code: _____

Cell Phone: _____ Fax: _____

Email Address: _____

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

Age: _____ Date of Birth: _____ Sex (circle one): **M** **F**

Marital Status (circle one): Married Single Divorced Widowed

Spouse's (or closest relative) Name: _____

Work Phone: _____ Cell Phone: _____

Spouse's Employer: _____

Address: _____

Emergency Contact - Name: _____

Address: _____

Relationship: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Family Physician: _____ Office Phone: _____

Whom may we thank for referring you? Name: _____

Address/Phone No.: _____

Eastern Balance Oriental Medicine LLC

1. Chief Complaint (the *main* reason for your visit today – please briefly describe the condition, how long you have had it, & the symptoms which accompany the condition):

_____

_____

_____

_____

_____

2. Factors which make this condition worse: _____

_____

3. Factors which make this condition better: _____

_____

4. Diagnosis from conventional medical doctor: _____

_____

5. Treatment you have received or are currently receiving for this condition: _____

_____

6. Have results of this treatment been helpful? _____

_____

Significant Health History Information

7. Have you ever had, or do you presently have, any of the following significant health issues?

___High Blood Pressure	___Cholesterol problems	___Bleeding Disorders
___Heart Disease	___Rheumatic Fever	___Thyroid Disease
___Diabetes	___Tuberculosis	___Hepatitis
___Cancer	___Stroke	___HIV/AIDS
___STD		

___Other(s): _____

8. List known allergies to any substances (foods, drugs, pollens, etc.): _____

_____

9. Have you suffered significant traumas/accidents, etc.: _____

10. If yes, briefly describe incident(s) and provide date(s): _____

_____

11. List major surgeries you have had, including dates (use back of page if you need more room):

Type(s) of Surgery | Date(s) of Surgery

12. List medications you are currently taking, with dosages, frequency, length of time:

Medication | Dosage/Frequency | How Long

13. Are you taking supplements or on a special diet? _____

14. (Female Only) Are you pregnant or suspect you may be pregnant? _____

15. (Female Only) How many pregnancies/miscarriages/live births? _____/_____/_____

16. (Female Only) How old were you at menarche / menopause? _____/_____

17. Other important health information you want to tell us that we did not ask about (significant family medical health history, etc.): _____

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Houston, TX 77008

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Form to be completed by patient notifying the acupuncturist as to whether he/she has been evaluated by a physician, and other information

(*Pursuant to the requirements of Rule 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) _____ am notifying the staff and acupuncturist(s) of Eastern Balance Oriental Medicine, LLC clinic of the following:

1. _____Yes _____No

I have been evaluated by a physician or dentist for the condition being treated within the twelve (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.

Initials of Patient: _____ Date: _____

or

2. _____Yes _____No

I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, I understand that the acupuncturist is required to refer me to a physician if no substantial improvement occurs in the condition being treated after 120 days or 30 treatments, whichever comes first. It is my responsibility and choice whether to follow this advice.

Initials of Patient: _____ Date: _____

Signature of Patient: _____ 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.***

INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of Traditional Chinese Medicine (TCM) treatment and other procedures within the scope of practice of TCM on me (or on the patient named below, for whom I am legally

responsible) by any licensed acupuncturist who now or in the future treat me while working or associated with Eastern Balance Oriental Medicine, LLC.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxabustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have some side effects, including: bleeding, bruising, numbness, soreness, or tingling near the needling sites that may last a few days, and dizziness and fainting. The clinic uses sterile single-use disposable needles and maintains a clean and safe environment.

Burns, blistering, and/or scarring are a potential risk of moxabustion or cupping, or when treatment involves the use of heat lamps. Bruising is also a common side effect of cupping.

I understand that herbs may need to be prepared and teas consumed according to the instructions provided orally and in writing. I further understand that these prescribed herbs may have an unpleasant smell or taste, and I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are considered safe in the practice of acupuncture, although some may be toxic in large doses. Some possible uncomfortable effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I fully acknowledge and specifically state that I understand that treatment with TCM (like treatment by other branches of health services) cannot, will not, and does not guarantee specific result or cure, and treatment with TCM, just like leaving my condition untreated, carries risk. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I understand that 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.

I understand all fees are due and payable at time treatment is given. Eastern Balance Oriental Medicine, LLC. will provide me with the appropriate receipt for filling with my insurance carrier. TCM treatment coverage by insurance varies by policy and company, and I should read my policy or check with my insurance company to determine eligibility for benefits in my case. I acknowledge that Eastern Balance Oriental Medicine, LLC. is not responsible for any denial of claim from my insurance company. TCM is a lawfully deductible medical expense for purposes of U.S. Federal Income Tax. TCM treatment is currently not covered by Medicare.

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 TCM treatment modalities, and have had an opportunity to ask questions. I acknowledge that I am legally and mentally competent to sign this authorization and that I do fully understand it, 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.

Patient signature (or patient representative) X_____
Date:_____