ACUPUNCTURE & HERBS

Full name: _____ Date: _____
Date of Birth: _____ Age: _____
Phone: _____
Address: _____ City: _____ State: ____ Zip: _____
Occupation: _____ E-mail: _____
In Emergency notify: _____ Phone # _____ Relationship: _____
Family physician: _____ Phone # _____
Have you been treated by acupuncture before? Y N
How did you hear about us? _____

Main Concerns (include duration):

Have you been given a diagnosis? If so what?

What kind of treatments have you tried?

What do you think may be the cause of your health concerns?

What alleviates your symptoms?

What aggravates your symptoms?

Is there anyone in your family with the same/similar problems?

Past Medical History:
Significant Illness: ☐ Cancer ☐ Arthritis ☐ Anemia ☐ Thyroid Disease
☐ Emotional Imbalance ☐ Fibromyalgia ☐ Heart Disease ☐ Venereal Disease
☐ Seizures ☐ Diabetes ☐ Hepatitis ☐ Tuberculosis ☐ Hypertension
☐ Digestive Disorders ☐ Breathing Problems ☐ COVID
☐ Other: _____

Family Medical History (Please write in family member):

☐ Cancer _____ ☐ Diabetes _____ ☐ Hepatitis _____

☐ Hypertension_____ ☐ Heart Disease _____ ☐ Stroke _____

☐ Asthma _____ ☐ Alcoholism _____ ☐ Miscarriage_____

☐ Other: _____

Hospitalizations / Surgeries: _____

_____

_____

Significant trauma (auto accidents, sports injuries, etc): _____

_____

_____

Allergies (drugs, foods, chemicals): _____

_____

_____

Medicines taken in the past 3 months (include vitamins, OTC drugs, herbs etc...):

Medicine:	Reason for taking:	Dose:

Occupational stress (chemical, physical, psychological, etc): _____

Personal: Height_____ Weight now_____ One year ago_____ Max Weight_____

Habits: Do you smoke? ☐ Y ☐ N What? _____ How much/day? _____ Since_____

Do you take recreational drugs? ☐ Y ☐ N What? _____

Do you exercise regularly? ☐ Y ☐ N Please describe: _____

How many hours do you sleep in general? _____ When do you go to bed? _____

Diet: How much caffeine do you drink/day? (Include: coffee, tea, colas etc...): _____

Kind of alcohol you usually drink, if any? _____ Avg. # of drinks/week_____

How much water do you drink per day? _____

Areyouavegetarian? ☐ Y ☐ N Do you eat alot of spicy food? ☐ Y ☐ N

Please describe your average daily diet (be as specific as possible):

- Morning:
- Afternoon:
- Evening:
- Snacks:

Rate your relationship with the following by indicating either: poor (P), fair (F), well (W), or great (G):
Health _____ Work _____ Yourself _____ Others _____

Contributing factors to lack of personal optimum health (check all that apply):
☐ Lack of motivation ☐ Lack of information ☐ Lack of time
☐ Contradictory information ☐ Inability to follow through ☐ Circumstance
Areas that you feel could be improved in your life (check all that apply):
☐ Diet ☐ Physical activity ☐ Time management ☐ Priorities ☐ Outlook
☐ Other: _____

Please check if you have or have had any of the following conditions within the past 3 months:
General: ☐ Poor sleeping ☐ Fatigue ☐ Fevers ☐ Chills ☐ Night sweats
☐ Sweat easily ☐ Tremors ☐ Cravings ☐ Poor appetite ☐ Change in appetite ☐ Poor balance
☐ Localized weakness ☐ Bleed or bruise easily ☐ Weight Loss ☐ Weight Gain
☐ Peculiar taste ☐ Desire hot food ☐ Desire cold food ☐ Strong thirst (cold or hot)
☐ Sudden energy drop - time of day _____

Skin & hair: ☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema ☐ Acne
☐ Dandruff ☐ Dry Skin ☐ Recent Moles ☐ Loss of hair ☐ Purpura ☐ Change in hair or skin texture
Other: _____

Musculoskeletal: ☐ Joint disorders ☐ Weakness in muscles ☐ Pain/Soreness in muscles ☐ Tremors
☐ Difficulty walking ☐ Cold hands/feet ☐ Swelling of hands/feet ☐ Back Pain
☐ Spinal Curvature ☐ Hernia ☐ Numbness ☐ Tingling ☐ Paralysis ☐ Neck Tightness
☐ Shoulder pain ☐ Neck pain ☐ Hand/wrist pain ☐ Hip pain ☐ Knee pain ☐ Sprain of joint
☐ Other: _____

Head, Eyes, Ears, Nose, and Throat: ☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses/lens
☐ Eye Strain ☐ Eye Pain ☐ Color Blindness ☐ Night Blindness ☐ Poor vision
☐ Blurry vision ☐ Cataracts ☐ Earaches ☐ Ringing in ears ☐ Poor hearing
☐ Sinus problems ☐ Nose bleeding ☐ Sore throat ☐ Facial pain ☐ Jaw clicks
☐ Sores on lips/tongue ☐ Spots in front of the eyes ☐ Grinding teeth ☐ Difficulty swallowing
☐ Teeth problems ☐ Other: _____

Cardiovascular: ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Chest pain
☐ Palpitation ☐ Fainting ☐ Phlebitis ☐ Irregular heartbeat ☐ Rapid heartbeat
☐ Varicose Veins ☐ Other: _____

Respiratory: ☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty in breathing
☐ Pneumonia ☐ Bronchitis ☐ Chest pain ☐ Production of phlegm - What color? _____
☐ Other: _____

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas ☐ Belching
☐ Black Stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath ☐ Rectal Pain
☐ Hemorrhoid ☐ Abdominal cramps/pain ☐ Gallbladder problem ☐ Parasites ☐ Chronic laxative use
Bowel movements: Frequency_____ Color_____ Odor_____ Texture/ Form_____
☐ Other: _____

Neuro-psychological: ☐ Loss of Balance ☐ Lack of Coordination ☐ Concussion ☐ Depression
☐ Anxiety ☐ Stress ☐ Bad temper ☐ Bi-polar ☐ Other: _____

Genito-urinary: ☐ Kidney Stones ☐ Pain in genital ☐ Pain on urination
☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate ☐ Unable to hold urine ☐ Dribbling
☐ Pause in flow ☐ Frequent urinary tract infection ☐ Itching of genital
☐ Other: _____

Female: ☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis
☐ Vaginal discharge ☐ Fibroids ☐ Ovarian cysts ☐ Irregular periods ☐ Clots
☐ Pain/cramps prior/during periods ☐ Breast tenderness ☐ Breast lumps ☐ Fertility Problems
☐ Moodiness related to periods ☐ Low libido ☐ Hot Flashes ☐ Vaginal dryness
☐ Other: _____
_____ #of pregnancies _____ #of births _____ Miscarriages _____ Abortions _____ Premature Births

Male: ☐ Prostate problems ☐ Impotence ☐ Frequent seminal emission ☐ Painful/swollen testicles
☐ Fertility problems ☐ Discharge ☐ Ejaculation problems ☐ Other: _____

☐ I understand the above information and have completed this form to the best of my knowledge.

Signature: _____

☐ Adult patient
☐ Parent or guardian

PRIVACY PRACTICES

This notice describes how Peggy Ghorbani L.Ac., protects your health information and what rights you have regarding it. We are obligated by law to give you notice of our privacy practices. Please review it carefully.

Right to Notice
As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPPA), Peggy Ghorbani L.Ac. can use your protected health information for treatment, payment, and health care operations.

a) Treatment - We may use or disclose your health information to a physician or other health care provider providing treatment to you.
b) Payment – We may use and disclose your health information to obtain payment for services that we provide to you.
c) Health care operations – We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of health care professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization
Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations
In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or other person responsible for your care, using our professional judgment. We will only disclose health care information that is directly relevant to the person's involvement in your health care.

Marketing
We will not use your health information for marketing communications without your written authorization.

Required by Law
We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health and safety.

National Security
We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders
We may use or disclose your health information to provide you with appointment reminders via phone, e- mail or letter.

Your Rights as a Patient

- You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment, or health care operations.
- You have the right to receive confidential communications regarding your protected health care information.
- You have the right to inspect and copy your protected health information (PHI). Requests for copies of PHI must be made in writing to our office and will be available for review within 30 days of the date of the request.
- You have the right to amend/update your protected health information. To provide the best health care possible, it is always recommended that you keep us up-to-date on ALL of your health information/conditions.
- You have the right to receive an account of disclosures of your protected health information. Our office will provide within 30 days of a written request.
- You have the right to a paper copy of this notice of privacy practices.

Legal Requirements

Peggy Ghorbani L.Ac. is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted within our office.

Complaints

It is always our utmost goal to treat our patients with care and respect. If, however, you have complaints regarding the way that your protected health information is handled, you may submit a complaint to our office. We hope that you always let us know what we may do to improve your patient care.

Contact Information

For further information about our privacy policies, please contact Peggy Ghorbani L.Ac. at 801 W. 34th Street, Austin, TX 78705.

Payment policy

- Payment is due at the time of service. We accept cash, checks, and most major credit cards.
- A $30 fee will be charged for returned checks.
- We reserve the right to change our fee scale without notice.

Cancellation Policy

Because our practice is by appointment only, your appointment is time reserved exclusively for you. If you need to reschedule or cancel an appointment, we require a minimum of 24 hours notice. Please call (512) 294-6895 to cancel or reschedule.

- More than 24 hours notice: session will be cancelled at no charge.
- Less than 24 hours notice: 50% of session price will be charged.
- Failure to show without notice: 100% of session price will be charged. A credit card will be required to secure future appointments.

Please acknowledge your understanding and acceptance of these practices and policies by signing below.

Patients Name: _____ Date: _____

Signature: _____

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Signature: _____