Welcome to Oriental Medicine 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. Yes Acupuncture & Wellness Center considers this information privileged physician/ patient communication and with holds it in confidence. If you have any question, please don't hesitate to ask for assistance. **Please Print**

Date: _____________

Name: (Last) ________________ (First) _______________ (Middle) _______________

Sex: M F Birth Date: _________ Age: ________

Home Address: ____

City __________________ State __________________ Zip _____________________

Phone: (H/C) _______________ (W) _______________ Email_____________________

Marital Status: Single Married Widowed Divorced Separated

Spouse's Name: ____________________ Phone: (W) ___________________________

Patient employed by ____

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? __________

Your medical doctor's name (Western) ____________________ Phone: _____________

Diagnosis of your problems ____

Treatment Agreement

I come here, to______________, seeking Chinese Medical treatment for my condition. I hereby authorize __________ 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 to the results.

I understand that only one-time use, pre-sterilized disposable needles are used at Yes Acupuncture & Wellness Center.

Patient's Signature: _________________________________ Date: _____________________ Please go to page 2

PATIENT HISTORY

What is your major complaint?____

How did this condition develop?____

How long has this condition persisted?____

Have you ever received any treatment for this condition? ☐Yes ☐No

If yes, where?__________________ By whom?______________ When?______________

What was the diagnosis?____

What kind of treatment(s)?____

Was the result satisfactory?____

Please list substance that you are allergic to:________________________________

(Female only) Are you pregnant or do you suspect that you may be pregnant?__________________

List medications you are currently taking:

Medications	Strength	How many per day	For how long

Have you ever received any treatment for this condition? ☐Yes ☐No

List any major surgeries you had:

Date	Problem

Significant illness (Please check):

☐High Blood Pressure ☐Rheumatic fever ☐Hepatitis ☐Diabetes
☐Thyroid disease ☐Coagulopathy ☐Seizure ☐AIDS
☐Hyperlipidemia ☐Tuberculosis ☐Cancer ☐Stroke
☐Others________________________________

Significant Trauma (auto accident, falls. etc.)

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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) ____, am 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 to 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 my 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**.

Consent to Treatment Form

I do hereby voluntarily consent to be treated with acupuncture, Chinese medicinal herbs and Oriental medicine at Hsien-Min Yeh L.Ac./

Chiung-Hui Tseng L.Ac./ Julie Chen L.Ac./ Han-Yeu Chi L.Ac./ John Fain L.Ac./ Maria Posa L.Ac.

(Initial)___________Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of sterile single use needles through the skin or by the application of heat to the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or disease, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture and Moxibustion are typically safe methods of treatment, however certain adverse side effect may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

(Initial)___________Pregnancy: I will notify the treating provider should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

(Initial)___________Chinese Herbs: I understand that Chinese medicinal herbs may be recommended to me to treat bodily dysfunction or disease, to modify or prevent pain perception, and to normalize the body's physiological function. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

(Initial)___________Acupuncture, Tui-Na Massage, Qi Gong: I understand that I may also be given acupuncture/Tui-Na massage and/ or Qi Gong as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

(Initial)___________Cupping, Gua Sha, Lance Therapy: I understand that I may also be given cupping (the application of plastic cups with vacuum to the skin), Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon), lance therapy (using a lance to remove stagnant blood) as part of my treatment to modify or prevent pain perceptions and to normalize the body's physiological functions. **I am aware that these treatments are intended to cause minor bruising, and though unsightly, are not normally painful.** However, certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at any time for any reason.

(Initial)___________Treatment by Trainees: I understand that I may have treatment performed by an acupuncture trainee supervised by Hsien-Min Yeh L.Ac. Before any treatment by trainee is performed, the patient will be verbally notified and asked by said trainee. I understand that I may refuse treatment by the trainee for any reason.

(Initial)___________ I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I do not expect Acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent (unless in and emergency or by legal demand). I give my permission and consent to treatment.

Signature: ____ **Date: _________________________**

Printed Name: ____ **Date of Birth: __________________**