Align Health Austin

Acupuncture & Herbal Medicine
1001 Cypress Creek Road Suite 103,
Cedar Park, TX 78613

Today's Date: ____ / ____ / _____

Patient Personal Information – *Please Print*

Thank you for choosing Align Health Austin. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be used for your treatment and care. If you have questions, please ask. Thank you.

First Name: _____ Middle Initial:_____ Last Name: _____

Street Address: _____ Suite/Apt.#_____

City: _____ State: _____ Zip Code: _____

Sex: ☐ F ☐ M ☐ Other: _____ Date of Birth ____ / ____ / _____ Age: _____

Occupation: _____ Employer: _____

Employer Phone: _____ Employer City/State: _____

Do you have any children? ☐ Yes ☐ No Number of children: _____

Living situation: ☐ Live w/other(s) ☐ Live alone ☐ Frequent Travel ☐ Other: _____

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

Patient Contact Information:

Please note, the contact information you provide will be used to contact you for administrative purposes and other health or treatment related items. Please review privacy policy and consent forms for more details on how Align Health Austin may use this information.

May we contact you via phone, text and/or email provided? ☐ Yes ☐ No

Patient Primary Phone: _____ Patient Mobile Phone: _____

Patient Primary Email: _____ Patient Secondary Email: _____

Emergency Contact Information (EC):

Please indicate primary person to contact and notify in case of an emergency. In case of emergency notify:

May we share your personal and medical information with this person? ☐ Yes ☐ No

EC First / Last Name: _____ Relationship to patient: _____

EC Primary Phone: _____ EC Mobile Phone: _____

EC Primary Email: _____ EC Secondary Email: _____

Primary care provider or doctor: _____ Phone: _____

Practice or clinic name: _____ City/Location: _____

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Becoming a new patient at Align Health Austin:

Primary reason(s) for your visit: _____ any other reason(s) you would like to address: _____ When did this begin (month/year)?: _____

Were you referred to us for treatment? ☐ Yes ☐ No Referred by: _____

What diagnosis, if any, have you received for this?_____

When did this begin? _____ List known causes of this problem? _____

Does this problem interfere with your daily activities (work, sleep, sex, etc.)?_____

What kind of treatment have you tried? _____

What makes this problem worse? _____

What makes this problem better? _____

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

How did you find out about our clinic? ☐ *Friends/Relatives (name):* _____

☐ *Referred by alternative care provider:* _____

☐ *Website* ☐ *Other:* _____

Work, Social and Health History:

Occupation: _____ How long have you done this? _____

Do you usually work: ☐ indoors ☐ outdoors ☐ sitting #of hours: _____ ☐ on feet #of hours: _____

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

Height_____ Weight now_____ Weight one year ago_____

Weight maximum: _____@Year _____ Weight minimum _____@Year _____

Do you smoke ? ☐ Yes ☐ No How old when first started? _____ How long have you smoked? _____

What do you smoke? _____ #per day? _____ Purpose: _____

Have you tried to quit? ☐ Yes ☐ No How many times: _____ Longest you were able to quit: _____

Other drug(s) use (legal or illegal) or history of drug(s) use: _____ Date of last use: _____ Frequency of Use: _____ Purposes:_____

Do you exercise regularly or are physically active ☐ Yes ☐ No How many times a week? _____

Please describe your physical routine or exercise program: _____

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

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Diet:

Are you on a diet or do you follow a special diet? ☐ Yes ☐ No ☐ if Yes, which: _____

Are you a vegetarian? ☐ Yes ☐ No ☐ Yes, but not so strict

Do you eat a lot of spicy food? ☐ Yes ☐ No

How much do you drink?

Water _____ cups/day **Coffee** _____ cups/day **Sodas** _____ number/day **Tea** _____cups/day

What kind of alcoholic beverages do you usually drink, if any? _____

Average # alcoholic drinks/week/day? _____

Remarks and additional information (e.g. diet): _____

Health & Medical History:
List all surgical interventions and/or hospitalizations you may recall from childhood to recent year

Surgeries & Hospitalizations:

1. _____ For: _____ Year: _____
2. _____ For: _____ Year: _____
3. _____ For: _____ Year: _____
4. _____ For: _____ Year: _____

Significant traumas: Auto Accidents, Sports Injuries, Other, etc…

1. _____ Type: _____ Year: _____
2. _____ Type: _____ Year: _____
3. _____ Type: _____ Year: _____
4. _____ Type: _____ Year: _____

List All Allergies: Drugs, Food, Chemical, Environmental, etc…

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____
10. _____ 11. _____ 12. _____

Family & Self Medical History:

Diagnosis	Self	Family	Diagnosis	Self	Family		Self	Family
Cancer			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other:		

Patient Prescriptions(s) and Over-the Counter Medication:
Please list all prescriptions drugs and medications, over-the counter drugs prescribed or recommended by a physician to take

Name of Drug/Rx	Diagnosis / Reason for Taking	Dose & Frequency	How long have you taken this?

Patient Supplement(s) and/or dietary aides:
Please list all supplements and dietary aides taken an any form (oral, topical, diffused/neb, etc.) suggested by a provider or self-recommended that you take daily or have taken in the last 2 weeks:

Name of Supplement	Reason For Taking	Dose & Frequency	How long have you taken this?

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General Patient Information:
Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General:
☐ Poor appetite ☐ Poor sleep ☐ Fatigue ☐ Fevers ☐ Chills
☐ Night sweats ☐ Sweat easily ☐ Tremors ☐ Cravings ☐ Change in appetite
☐ Poor balance ☐ Bleed or bruise easily ☐ Localized weakness ☐ Weight loss
☐ Weight gain ☐ Peculiar/loss of tastes ☐ Desire hot (spicy)food ☐ Desire cold food (salad)
☐ Strong thirst ☐ Desire hot/warm drink ☐ Desire for cold (ice) drinks
☐ Sudden energy drop (What time of day) _____
Favorite time of year _____ Worst time of year _____

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

Musculoskeletal:
☐ Joint disorders ☐ Muscle weakness ☐ Pain/soreness in the muscles ☐ Tremors
☐ Cold hands/feet ☐ Difficulty walking ☐ Swelling of hands/feet ☐ Spinal curvature
☐ Back pain ☐ Hernia ☐ Numbness ☐ Tingling
☐ Paralysis ☐ Neck tightness ☐ Neck pain ☐ Shoulder pain
☐ Hand/wrist pain ☐ Hip pain ☐ Knee pain ☐ Joint sprain

Head, eyes, ears, nose, & throat:
☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses/lens ☐ Eye strain/pain
☐ Color blindness ☐ Night blindness ☐ Poor vision ☐ Cataracts ☐ Blurry vision
☐ Floaters in vision ☐ Earaches ☐ Ringing in ears ☐ Poor hearing ☐ Sinus problems ☐ Nose bleeding ☐ Sore throat ☐ Grinding teeth ☐ Teeth problems ☐ Jaw Pain/TMJ
☐ Sores on lips/tongue ☐ Difficulty swallowing ☐ Other? _____

Cardiovascular:
☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Palpitation ☐ Fainting
☐ Phlebitis ☐ Irregular heartbeat ☐ Rapid heartbeat ☐ Varicose veins ☐ Poor Circulation

Respiratory:
☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty breathing
☐ Bronchitis ☐ Pneumonia ☐ Chest pain ☐ Snoring at night
☐ Shallow Breathing ☐ Allergies ☐ Production of phlegm – color:_____

Gastrointestinal:
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas
☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath
☐ Acid Reflux ☐ Rectal pain ☐ Hemorrhoids ☐ Parasites ☐ Abdominal pain/cramps

Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____

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Neuro-psychological:

☐ Loss of balance ☐ Lack of coordination ☐ Concussion ☐ Depression
☐ Anxiety ☐ Stress ☐ Bad temper ☐ Bi-polar
☐ Mood swings ☐ Adrenal fatigue ☐ Forgetfulness

Genito-urinary:

☐ Painful urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate
☐ Kidney stones ☐ Unable to hold urine ☐ Dribbling ☐ Pause of flow
☐ Genital pain ☐ Genital itching ☐ Genital rashes ☐ STD
☐ Frequent urinary tract infection ☐ Other?

Female:

☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis ☐ Vaginal discharge
☐ Fibroids ☐ Ovarian cysts ☐ Irregular periods ☐ Clots
☐ Breast tenderness ☐ Breast Lumps ☐ Fertility Problems ☐ Hot flashes
☐ Moodiness related to periods ☐ Pain/cramps prior/during periods

Age of first period: _____ First date of last period _____
How many days does your periods last _____days How long are your cycles: _____
Do you take any form birth control ? ☐ Yes ☐ No
If yes, what type and for how long?_____
Number of children: _____ Number of pregnancies: _____ Number of births: _____
Number of Miscarriages: ____ Number of Miscarriages: _____ Number of Abortions: _____
Number of premature births:_____ Number of C-sections: _____

Male:

☐ Prostate problems ☐ Abnormal Genital Discharge ☐ Erectile dysfunction
☐ Ejaculation problems ☐ Frequent seminal emission ☐ Painful/swollen testicles
☐ Sperm & Fertility problems: _____ ☐ Other _____

I the undersigned have completed this form accurately and correctly to the best of my knowledge.

_____ _____
Patient First Name (print) **Patient Last Name (print):**

_____ _____
Patient Signature: **Date:**

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Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, Align Health Austin (Katherine Webster) is required to have you respond affirmatively to the following statements before you may be treated. Please be advised that at least one (1) of these statements must be verifiably true AND we will NOT be permitted to treat you with acupuncture if your response to ALL of these statements is no.

(Pursuant to the requirements of section 183.10(a)(11) of this title and section 205.302 V.A.C>S article 4495b, governing the practice of acupuncture)

I (**print first/last name print**), _____ am notifying the Align Health Austin (Katherine Webster) of the following (please check YES OR NO to each statement):

___ **Yes** ___ **No** I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within 12 months before the acupuncture was performed. I recognize that I and understand that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

__ **Yes** ___ **No** I have received a referral from my chiropractor (**first/last name of chiropractor**): _____ within the last 30 days for acupuncture. The date of the referral is, and the most recent date of treatment prior to acupuncture treatment is 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 should I not improve for this or any other condition being treated. It is my responsibility and choice whether to follow this advice or referral.

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 symptoms related to one or more of the following conditions:

___ Chronic Pain	___ Smoking/Nicotine Cessation	___ Weight loss
___ Alcoholism	___ Substance abuse	___ Herbal/Supplement

Should I, the named patient return for treatment for any condition(s) other than the reason(s) for visit listed on (page 2) or the original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture. I understand that it is my responsibility and/or choice to follow the acupuncturist advice if I am referred to a physician or to seek other medical opinion / treatment (s).

_____ _____

Patient First Name (print) **Patient Last Name (print):**

_____ _____

Patient Signature: **Date:**

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Permission To Contact, Release And Share Protected Health Information

Private Medical Information About Health, Treatment and Medical History
Align Health Austin (Katherine Webster) has permission to discuss the any and all information regarding my health care, treatment, history, etc… with the following family, friends and other people listed below. This form does not authorize releasing copies of my records.

Scheduling/Appointment/ Payment Information
I give permission for Align Health Austin (Katherine Webster) to contact me via all modes of contact provided and share this information with family or others that I have identified below as being involved in my health care, care coordination, scheduling or payment.
that I have the right to revoke my permission at any time except where HealthPartners has already made disclosures in reliance upon this request. I understand this permission remains in effect until the time I revoke it in writing.

I understand that in certain situations the Align Health Austin (Katherine Webster) may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

First & Last Name	Relationship	Phone Number	E-mail Address

Patient First Name (print) _____

Patient Last Name (print): _____

Patient Signature: _____

Date: _____

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PAYMENT AND CANCELATION POLICIES

Payment Policy:
Align Health Austin requires payment at the time of scheduling your appointment. We also accept HSAs and some FSAs (check with your employer). Align Health Austin does not take any form of insurance and requires payment directly from patient. A receipt from the our payment software will be provided at the time of payment. In some cases and at your request Align Health Austin may be able to provide you with a receipt and/or super bill to submit to your insurance***. Align Health Austin does NOT guarantee and is NOT responsible for submitting claim, denial of claim or reimbursement for your insurance provider.

*** There is a level of acceptable detail required to provide an appropriate office visit receipts and/or superbills for submission for reimbursement to insurance carriers. As such, please allow 30/45 days to process your request request(s).

Cancelation Policy:
Please be considerate. When an appointment is missed or we do NOT receive adequate notification that you won't be making your appointment, chances are you have kept someone else from being treated at that time. Appointments must be canceled within 24 hours of your scheduled appointment. You will be charged for your appointment in full if you do not show up, or do not cancel the day before. Please call, email or text to reschedule your appointment and if you made the appointment online. I have read and agree to the above:

_____ _____

Patient First Name (print) **Patient Last Name (print):**

_____ _____

Patient Signature: **Date:**