www.birdsnestacupuncture.com
512.761.6719

birds nest
acupuncture & herbs

4101 Medical Parkway Suite 113
Austin, Texas 78756

Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name _____ Sex ☐ F ☐ M Date _____

Date of birth _____ Age _____ Occupation _____

Address _____ City _____ State _____ ZIP _____

Main phone number _____ Other phone number _____

E-mail address _____ Allow email contact ☐ Yes ☐ No

Relationship status _____ Children _____ Family physician _____ Chiropractor _____

Do you have health insurance? ☐ Yes ☐ No If yes, name insurance company _____

Does your health insurance cover acupuncture? ☐ Yes ☐ No Who is your employer? _____

Emergency contact name _____ Phone number _____

How did you find out about us? ☐ Friends/relatives (Name) _____

☐ Direct mail ☐ Location ☐ Website ☐ Yellow pages ☐ Periodicals ☐ Other _____

Main problem(s)

What is/are your main problem(s)? _____

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

When did this problem begin? _____ What are the causes of this problem? _____

To what extent 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? _____

Remarks and additional information: _____

Medical History (Please include the month/year when the event occurred or when the diagnosis was made)

Surgeries: _____ Hospitalization: _____

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

Allergies: (drugs, chemicals, foods, environmental): _____

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type?)			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		

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

_____

Occupation: _____ Do you usually work ☐ indoors ☐ outdoors?

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

Personal Data

Height _____ Weight now _____ Weight one year ago _____ Weight maximum _____ @Year _____

Do you smoke? ☐ Yes ☐ No What? _____ How many per day? _____ Since when? _____

Please describe any use of drugs for non-medical purposes: _____

Do you exercise regularly? ☐ Yes ☐ No Please describe your exercise program: _____

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

Diet

How much coffee do you drink? _____ cups/day Colas? _____ number/day Tea? _____ cups/day Water? ____ glasses/day

What kind of alcoholic beverages do you drink, if any? _____ Average number of drinks/week? _____

Are you a vegetarian? ☐ Yes ☐ No ☐ Yes, but not so strict Do you eat a lot of spicy food? ☐ Yes ☐ No

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

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

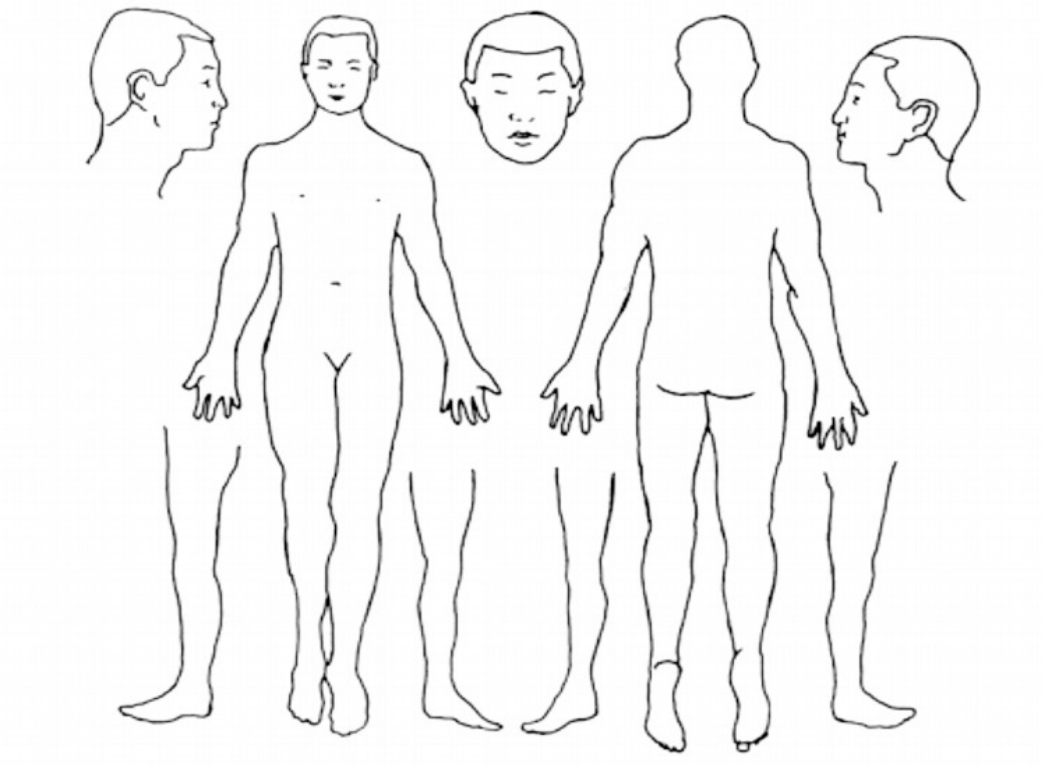
Morning _____

Afternoon _____

Evening _____

Snacks _____

Indicate painful or distressed areas:



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 ☐ Change in appetite ☐ Cravings

☐ Poor balance ☐ Bleed or bruise easily ☐ Localized weakness ☐ Weight loss ☐ Weight gain

☐ Peculiar tastes ☐ Desire hot food ☐ Desire cold food ☐ Strong thirst (cold or hot 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 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 ☐ Other _____

Head, eyes, ears, nose, and throat

☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses/lens ☐ Eye strain

☐ Eye pain ☐ Color blindness ☐ Night blindness ☐ Poor vision ☐ Cataracts

☐ Blurry vision ☐ Earaches ☐ Ringing in ears ☐ Poor hearing ☐ Sore throat

☐ Spots in front of eyes ☐ Sinus problems ☐ Nose bleeding ☐ Grinding teeth ☐ Teeth problems

☐ Facial pain ☐ Jaw clicks ☐ 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 ☐ Other _____

Respiratory

☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty breathing ☐ Bronchitis

☐ Pneumonia ☐ Chest pain ☐ Production of phlegm (what color) _____

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas

☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath

☐ Rectal pain ☐ Hemorrhoids ☐ Abdominal pain/cramps ☐ Gallbladder problems ☐ Parasites

☐ Chronic laxative use

Bowel movements: Frequency _____ Color _____ Odor _____ Texture _____

Neuro-psychological

☐ Loss of balance ☐ Lack of coordination ☐ Concussion ☐ Depression ☐ Anxiety

☐ Stress ☐ Bad temper ☐ Bi-polar

Genital-urinary

☐ Painful urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate ☐ Kidney stones

☐ Unable to hold urine ☐ Dribbling ☐ Pause of flow ☐ Frequent urinary tract infection

☐ Genital pain ☐ Genital itching ☐ Genital rashes ☐ STD ☐ Other _____

Female

☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis ☐ Fibroids

☐ Vaginal/genital discharge ☐ Ovarian cysts ☐ Irregular periods ☐ Clots

☐ Pain/cramps prior to/during periods ☐ Breast tenderness ☐ Breast lumps ☐ Hot flashes

☐ Moodiness related to periods ☐ Fertility problems

____ Number of pregnancies ____ Number of births ____ Miscarriages ____ Abortions

____ Premature births ____ C-sections ____ Difficult delivery

First date of last period _____ Age of first period _____ Duration of periods _____ days, cycle _____ days

Do you practice birth control? ☐ Yes ☐ No If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long? _____

Male

☐ Prostate problems ☐ Fertility problems ☐ Erectile dysfunction ☐ Ejaculation problems ☐ Discharge

☐ Frequent seminal emission ☐ Painful/swollen testicles ☐ Other _____

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

Signature: _____ ☐ Adult patient ☐ Parent or Guardian ☐ Spouse

Are there any other health issues you want to discuss with us?

Cancellation Policy

Because our practice is by appointment only, your appointment time is reserved exclusively for you. If you need to reschedule or cancel an appointment, we require a minimum of 24 hours notice. Full visit fees will be charged for missed visits and late cancellations.

Signature _____ Date _____

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HIPAA Acknowledgement and Appointment Reminders Form

I am aware that treatment with Birds Nest Acupuncture involves complete privacy and will not be discussed with out permission. Your privacy is respected at all times. Contact may need to be made with appointment reminders or information related to your treatment. If this contact is made by phone, and you are not home, a message will be left on your answering machine or with whoever answers the phone. By signing this form you are giving us authorization to contact you with these reminders and information.

I also understand that my clinical information may be used for educational and/or research purposes by Birds Nest Acupuncture. All information that can identify me personally will be removed.

_____
Patient Name (Printed)

_____
Patient Signature Date

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Leah Shadwick the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive my information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. Persons/Organizations authorized to receive information (please print):

_____

_____

_____

_____

_____

_____
Patient Signature Date

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Informed Consent to Oriental Medical Health Care

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by Leah Shadwick to treat me while employed by, working or associated with, or including those working at this clinic or any other associated clinic: acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as bodywork, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation, cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendation; exercise advice and healthy lifestyle counseling.

I understand I have an opportunity to discuss with Leah Shadwick the nature and purpose of acupuncture and oriental medical procedures. Although I am aware that acupuncture and the other procedures used in oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: slight bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, minor burns, aggravation of current symptoms, appearance of new symptoms, and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. 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 at Birds Nest Acupuncture.

_____	_____
Patient's name (please print)	Patient's signature/ Date
_____	_____
Name of Patient's Representative (if applicable)	Relationship or Authority of Representative
_____	_____
Signature of Patient's Representative (if applicable)	Date Signed

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Notification Form Regarding Evaluation of Patient by Physician

(Pursuant to the requirement of section 183.7 (e) of this title and section 6.11, Subsection (d) V.A.C.S. article 4495b, governing the practice of acupuncture)

I (patient's name), _____, am notifying Leah Shadwick, L.Ac. of the following:

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

OR

Yes ____ No ____ I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of chiropractic 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. It is my responsibility and choice to follow this advice.

_____ _____
Patient Signature (required) Date

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/Alcoholism/Substance Abuse

_____ _____
Patient Signature (required) Date

Leah Shadwick, L.Ac., is not responsible for untrue statements made by patients.