TxHarmony Acupuncture & Herbal Medicine
Kevin (Wen-Chiang) Luo, L.Ac.
512.795.8021
www.txharmony.com
13740 Research Blvd. , Suite B-1
Austin, TX 78750

New Patient Information Form

Patient Information

Name: _____ Today's Date: _____/_____/_____

Address: _____

City _____ State _____ ZIP _____

Home phone: _____ Office phone: _____

Cell phone: _____ Fax: _____

E-mail address: _____

Birthdate: _____/_____/_____ Age: _____ SSN: _____

Gender: Female Male Height: _____ Weight: _____ lbs

Marital status: Married Single Divorced Widowed Other _____

Emergency contact: _____ Relationship: _____

Emergency contact phone: _____

Referred by: _____

Employment Status

☐ Full time ☐ Part time ☐ Retired ☐ Unemployed ☐ Student

Occupation: _____

Employer: _____ Phone: _____

Employer's address: _____

Primary Healthcare

Family Physician: _____ Phone: _____

Address: _____

Date of last visit: _____

Health Insurance Information

Primary insurance: _____ Phone: _____

Policy No.: _____ Group No.: _____

Billing address: _____

Policy holder: _____ Relationship: _____

Insured's Date of birth: _____ Insured's SSN: _____

Insured's Employer: _____

Do you have a secondary insurance? ☐ Yes ☐ No

Family Medical History

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Asthma / wheezing							
Tuberculosis							
Heart disease							
Digestive tract disorder							
Kidney or bladder disorder							
Blood disorder / anemia							
Diabetes							
Tumor or cancer							
Seizures							
Hypertension							
Drug abuse							
Stroke							
Depression / mental illness							
Other							
Age at death							

Major Hospitalization

Year	Operation of Illness	Name of Hospital	City & State

Previous Pregnancies

Total Pregnancy	Living	Ectopic	Miscarriage	Induced Abortions

Current Medications, Supplements & Habits

☐ aspirin	☐ ibuprofen	☐ acetaminophen (Tylenol)	☐ others
☐ antacids	☐ laxatives	☐ cold tablets	_____
☐ oral contraceptives	☐ diet pills	☐ tranquilizers	_____
☐ fiber supplements	☐ sleeping pills	☐ hay fever tablets	_____
☐ blood pressure pills	☐ blood thinning pills	☐ insulin, diabetic pills	_____

Vitamins: _____

Herbs: _____

Drug allergies: _____

Coffee: _____ cups per day/week, started at _ years old, quit at _____ years old

Tobacco: _____ cigarettes per day, started at __ years old, quit at _____ years old

Alcohol: use per day/week, started at _____ years old, quit at _____ years old

Recreational drug: _____ use per day/week, started at _____ years old, quit at . years old

Please specify the type of recreational drug(s): _____

Treatment History

Have you ever had an acupuncture treatment? When and for what condition?

_____

Are you presently being treated for a medical condition? Please describe.

_____

Please briefly describe any chronic or acute pain you have:

_____

What health issues do you want treated? Please describe as detailed as possible.

_____

_____

What treatments have you tried for relieving this issue?

_____

Do you have other health concerns?

_____

Are you on a special diet? If so, please describe: _____

Do you exercise regularly? If so, what type of exercise and frequency: _____

_____

Detailed Medical Conditions

GENERAL
- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Insomnia
- ☐ Fatigue
- ☐ Fevers
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Chills
- ☐ Localized weakness
- ☐ Poor coordination
- ☐ Strong thirst
- ☐ Other _____

SKIN AND HAIR
- ☐ Rashes
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dryness
- ☐ Tumor, Lumps
- ☐ Other _____

HEAD AND NECK
- ☐ Dizziness
- ☐ Fainting
- ☐ Neck stiffness
- ☐ Enlarged lymph nodes
- ☐ Headaches
- ☐ Concussions
- ☐ Other _____

EARS
- ☐ Infection
- ☐ Ringing
- ☐ Decreased hearing
- ☐ Other _____

EYES
- ☐ Blurred vision
- ☐ Visual changes
- ☐ Poor night vision
- ☐ Spots
- ☐ Cataracts
- ☐ Glass/contacts
- ☐ Eye inflammation
- ☐ Other _____

NOSE, THROAT, MOUTH
- ☐ Nose bleeds
- ☐ Sinus infection
- ☐ Hay fever / allergies
- ☐ Recurring sore throat
- ☐ Grinding teeth
- ☐ Difficulty swallowing
- ☐ Other _____

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Blood clots
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Cold hands / feet
- ☐ Swelling of hands / feet
- ☐ Other _____

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Frequent colds
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Pneumonia
- ☐ Cough
- ☐ Coughing blood
- ☐ Production of phlegm
- ☐ Other _____

GASTRO-INTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Belching
- ☐ Bad breath
- ☐ Indigestion
- ☐ Pain or cramps
- ☐ Gallbladder disorder
- ☐ Gas
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Other _____

GENITO-URINARY
- ☐ Kidney stones
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgent urination
- ☐ Unable to hold urine
- ☐ Pain / itchiness of genitalia
- ☐ Genital lesions / discharge
- ☐ Other _____

MALE
- ☐ Impotence
- ☐ Weak urinary stream
- ☐ Lumps in testicles
- ☐ Other _____

FEMALE
- ☐ Frequent urinary tract infections
- ☐ Frequent vaginal infections
- ☐ Pelvic inflammatory disease
- ☐ Abnormal Pap Smear
- ☐ Irregular periods
- ☐ Painful menstruation
- ☐ Abnormal bleeding
- ☐ Premenstrual syndrome
- ☐ Menopausal syndrome
- ☐ Breast lumps
- ☐ Other _____

NEUROLOGICAL
- ☐ Seizures
- ☐ Tremors
- ☐ Numbness or tingling of limbs
- ☐ Pain
- ☐ Paralysis
- ☐ Other _____

PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety / stress
- ☐ Irritability
- ☐ Treated for emotional / psychological problems
- ☐ Other _____

POSITIVE SCREENING
- ☐ HIV
- ☐ TB
- ☐ Hepatitis
- ☐ Herpes: oral / genital
- ☐ Syphilis
- ☐ Other _____

TxHarmony Acupuncture & Herbal Medicine
Notice of Privacy Policy

TxHarmony Acupuncture & Herbal Medicine (hereinafter, "TxHarmony") is dedicated to providing services with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

You should be aware that during the course of our relationship, we will likely gather personal and health information from you, other healthcare providers and third party payers as well as use and disclose health information about you for the purpose of treatment, payment and healthcare operations.

You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosure will be made to any personal representation you choose to have your protected health information.

Marketing

TxHarmony will not use your health information for marketing communications without your written authorization. However, we may send birthday cards, newsletters and appointment reminders by telephone call, mails or e-mails.

Disclosure

TxHarmony Acupuncture & Herbal Medicine may use or disclose your protected health information when required by law.

Patient Rights

- Upon written request, you have the right to access, review or receive copies of your healthcare records. There is a copy fee of $15 and 10-day processing period.
- Upon written request, you have the right to receive a list of items this office disclosed about your healthcare information.
- You can request, in writing, that TxHarmony place additional restrictions on disclosure of your protected health information.
- You have the right to request, in writing, that your protected health information be amended.

If you have any questions or complaints, please contact TxHarmony, (512) 795-8021, 13740 Research Blvd., Suite B-1, Austin, TX 78750. Written complaints can be sent to Texas Medical Board.

By signing below, I show that I have read, reviewed, understood and agreed to the statement of the Privacy Policy for healthcare services in TxHarmony.

_____ _____

Patient Signature Date

Notice to Acupuncturist

(Pursuant to the requirements of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I _____ (patient's name), am notifying the acupuncturist Kevin (Wen-Chiang) Luo, L.Ac., of the following:

☐ Yes ☐ No I have been evaluated by a physician or dentist for the condition being treated within 6 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: _____

☐ 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 two months or 20 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 _____