Guided Hand Acupuncture & Chinese Herbs
Jane Yu, L.Ac.

Full name		Sex □ F □ M	
Date of birth	Age	Occupation	
Main phone #	Text ok?	Other phone #	Text ok?
E-mail address		Allow email contact □ Yes □ No	
Emergency contact name & phone			
Address Street		City	State Zip
Physician		Chiropractor	
Do you have health insurance? □ Yes □ No Does it cover acupuncture? □ Yes □ No □ I don't know			
How did you find out about our clinic? □ Location or walk by □ Website □ Referred by_____ □ Other (please specify)			

HIPAA Acknowledgement Form

I acknowledge that I have been provided access to the "HIPAA Notice of Privacy Policies". I understand that I have the right to review the "HIPAA Notice of Privacy Policies" prior to signing this document. I hereby give my consent for Jane Yu to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations.

_____

Patient Name (print) Date

_____

Patient Signature

Guided Hand Office Policies

In order to make your experience here as enjoyable and easy as possible, Jane Yu, L.Ac. has implemented the following policies:

Payment for Clinic Services Rendered – Payment is due at the time of service and may be paid in cash, by check, medical savings account card, flexible spending account card, health savings accounts card, and all major credit cards. Upon request, we will provide you with a printed receipt containing the necessary information enabling you to file an insurance claim.

Cancellation Policy – Treatments are by appointment. Should the clinic need to close due to inclement weather or other severe circumstances, the information will be posted on the website at http://janeyu.com and on the telephone voice message. If you find that you need to cancel an appointment, it is important that we receive 24-hour notice. We reserve the right to charge a $25.00 fee for an appointment canceled with less than 24-hour notice or for a "no show" appointment.

Herbal Refills – Please call no less than 24 hours before you wish to pick up herbal refills to allow time to process the request. Herbal formula refills are available at the clinic or can be called into AOMA Herbal Medicine.

Communication – This office may call, mail or e-mail your home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice such as appointment reminders, insurance items and any calls pertaining to your clinical care. Appointment reminder cards and patient statements will be marked "Personal and Confidential." You have the right to request Jane Yu to restrict how your protected health information (PHI) is used or disclosed. The practice is not required to agree to your requested restrictions, but if it does, it is bound by this agreement.

I would prefer my primary means of communication to be conducted via:

_____ Telephone/Text (please circle a preference)

_____ Mailing Address

_____ E-mail

Patient Signature Date

INFORMED CONSENT TO ACUPUNCTURE & CHINESE 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 Jane Yu, L.Ac: acupuncture and other Chinese 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 body work, 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 recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with the practitioner the nature and purpose of acupuncture and Chinese medical procedures. Although I am aware that acupuncture and the other procedures used in Chinese 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 conventional Western medicine, in the practice of Chinese 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: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from that location; nerve pain, 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 understand that acupuncture and Chinese medicine treatments may not have the desired therapeutic affect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is reasonable cause to believe that treatment is not appropriate for a patient who is under the influence of illegal drugs, alcohol, or appears to be overly medicated, then a treatment may not be performed at that time. The patient will be informed that they may not be treated at that time and will be requested to reschedule their appointment.

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 and conditions of treatment. 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 from Jane Yu L.Ac.

Patient's or Patient's Representative's Name (please print) Date Signed

Signature of Patient's or Patient's Representative Relationship of Representative (if applicable)

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, Jane Yu, L.Ac is required to have you respond affirmatively to the following statements before you may be treated. Please be advised that she will not be permitted to treat you with acupuncture if your response to all 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 (patient's name) _____ am notifying the practitioner, Jane Yu, of the following:

___ 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 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 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 to follow this advice.

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 am seeking treatment for symptoms related to one or more of the following conditions:

___ Chronic pain

___ Alcoholism

___ Smoking addiction

___ Substance abuse

___ Weight loss

Should I return for treatment for any condition other than my original condition(s) treated by the acupuncturist, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

_____

Patient Signature Date

Jane Yu L.Ac is not responsible for untrue statements made by patients.

CASE REVIEW QUESTIONNAIRE

Please use blue or black pen

Name:_____

Date:_____

	Onset	Major Complaint(s): list in order of significance to you:	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
1								
2								
3								
4								
5								

✖	For the list below please place an ✖ mark in the grey column to the left for all the symptoms that apply to you:
	Please indicate the specific frequency of each symptom in terms of how many times per day (D), week (W), month (M), or year (Y)
	Note: organs in parenthesis are the Chinese medical system/channel which includes the organ as well as associated tissues.

		Overall Temperature (Kidney function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
6		Cold Hands						
7		Cold Feet						
8		Heat in hands						
9		Heat in feet						
10		Heat in chest						
11		Afternoon flushes						
12		Night sweats						
13		Take water to bed						
14		Hot flashes any time of the day…. Average times per day _____						
15		Sweaty feet						
16		Sweaty hands						
17		Thirsty						
18		Perspire easily						
19		Lack of perspiration						
20		Hot body temperature (sensation)						
21		Cold body temperature (sensation)						

		Overall Energy (Lung, Kidney Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
22		Shortness of breath						
23		Difficulty keeping eyes open in the daytime						
24		General weakness						
25		Easily catch colds						
26		Low energy						
27		Feel worse after exercise						

		Overall Blood (Liver, Spleen, Heart Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
28		See floating black spots						
29		Birth marks? If yes: how many:_____ and the location (s):_____						
30		Pale lips or gums						
31		Dry or brittle hair						
32		Dry or brittle nails						
33		Dry scalp						

		(Heart Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
34		Palpitations						
35		Chest pain traveling to shoulder						
36		Anxiety						
37		Frequent dreams						
38		Sores on the tip of the tongue						
39		Restlessness						
40		Easily Startled						
41		Mental sluggishness						

		(Lung Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
42		Nasal Discharge (circle color: white - yellow - green)						
43		Sneezing						
44		Cough						
45		Nose Bleeds						
46		Sinus Congestion						
47		Headache (circle one: forehead - top of head - temple - base of skull)						
48		Overall achy feeling the body						
49		Sadness						
50		Alternating fever and chills						
51		Sore throat						
52		Difficulty breathing						
53		Dry mouth						
54		Dry throat						
55		Dry Nose						
56		Dry Skin						
57		Smoke cigarettes (# of cigarettes per day: _____)						
58		**Allergies:** To what? 1. _____ 2. _____						
		3._____ 4. _____						
59		**Allergies:** Runny Nose						
60		Itchy Eyes						
61		Fatigue						
62		Congestion						
63		Sneezing						
64		Seasonal? What Season(s)? _____						

		(Spleen Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
65		Low appetite						
66		Abrupt weight gain						
67		Abrupt weight loss						
68		Abdominal bloating						
69		Abdominal gas						
70		Gurgling noise in the stomach						
71		Easily bruised						
72		Hemorrhoids						
73		Worry						
74		Fatigue after eating						
75		Prolapsed organs (previously diagnosed which organ? _____)						
76		Circular Thoughts						
77		Athlete's foot						
78		Fungal infection						

		(Spleen, Stomach, Large Intestine, Small Intestine Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
79		Loose stools						
80		Constipated						
81		Incomplete stools						
82		Diarrhea						
83		Blood in stools						
84		Mucous in stools						
85		Mental confusion / fogginess						
86		Undigested food in stools						

		Dampness Trapped in the Body:	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
87		General sensation of heaviness in the body						
88		Swollen joints Location:						
89		Swollen feet						
90		Swollen hands						
91		Snoring						
92		Chest congestion						
93		Nausea						

		(Stomach Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
94		Burning sensation after eating						
95		Heartburn / acid regurgitation						
96		Belching						
97		Stomach pain						
98		Bad breath						
99		Mouth (canker) sores						
100		Bleeding, swollen or painful gums						
101		Vomiting						

		(Liver, Gall Bladder Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
102		Alternating diarrhea and constipation						
103		Chest pain						
104		Tight sensation in the chest						
105		Skin rashes						
106		Tingling sensation Location:_____						
107		Numbness Location:_____						
108		Muscle spasms/cramping Location:_____						
109		Muscle twitching Location:_____						
110		Bitter taste in the mouth						
111		Seizures						
112		Convulsions						
113		Neck tension						
114		Shoulder tension						
115		Limited Range-of-Motion, Neck						
116		Limited Range-of-Motion, Shoulder						
117		High-pitched ringing in the ears						
118		Gall stones (history or current)						
119		Anger easily						
120		Lump in the throat						
121		Frustration						
122		Sexually transmitted disease (Which? _____)						
123		Recreational drugs (Which? _____, How much per week? _____)						
124		Depression						
125		Difficulty falling asleep						
126		Wake in the night between 12-3am						
127		Skin Tags (small growths on the skin)						
128		Frequently unable to adapt to stress (What causes the stress? _____						

		Eyes (Liver Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
129		Itchy						
130		Bloodshot						
131		Hot						
132		Dry						
133		Watery						
134		Gritty						
135		Blurry vision						
136		Near-sighted						
137		Far-sighted						

		Sleep (Kidney, Bladder Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
138		Average number of hours of sleep per night?_____						
139		Wakes in middle of night (times? _____)						
140		Wake in middle of night sweaty						
141		Wakes in middle of night hot						
142		Wake unrefreshed						
143		Light sleeper / wakes easily						

		(Kidney, Urinary, Bladder Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
144		Frequent cavities						
145		Past/ Present Concussions If yes, how many?_____						
146		Easily broken bones						
147		Sore knees						
148		Weak knees						
149		Cold sensation in the knees						
150		Low back pain						
151		Excessive hair loss						
152		Low-pitched ringing in the ears						
153		Kidney stones						
154		Bladder infections						
155		Wake during the night to urinate						
156		Lack of bladder control						
157		Fear						
158		Memory problems						

		Urination (Kidney, Bladder Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
159		Dark yellow						
160		Clear						
161		Strong odor						
162		Reddish color						
163		Difficult						
164		Frequent						
165		Burning						
166		Discharge						
167		Cloudy						

		Libido (Kidney Function):	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
168		High						
169		Low						

		Women Only: Menses	Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
170		Irregular menstrual cycle						
171		Bleeding between periods						
172		vaginal discharge						
173		Number of children? _____						
174		Number of pregnancies? _____						
175		How many days to date has it been since your 1st day of bleeding with your last cycle?						
176		Average number of days of flow? _____						
177		Age of first menstruation? _____						
178		Are you currently pregnant? _____						

Pre-menstrual symptoms (Liver Function):			Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
179		Nausea						
180		Food cravings						
181		Depression						
182		Vomiting						
183		Headaches						
184		Irritability						
185		Water retention						
186		Migraines						
187		Anxiety						
188		Breast swelling						
189		Breast tenderness						
190		Dull pain (where?_____)						
191		Sharp pain (where?_____)						
192		Other emotions (Which? _____)						

Please fill in the following menstrual chart:

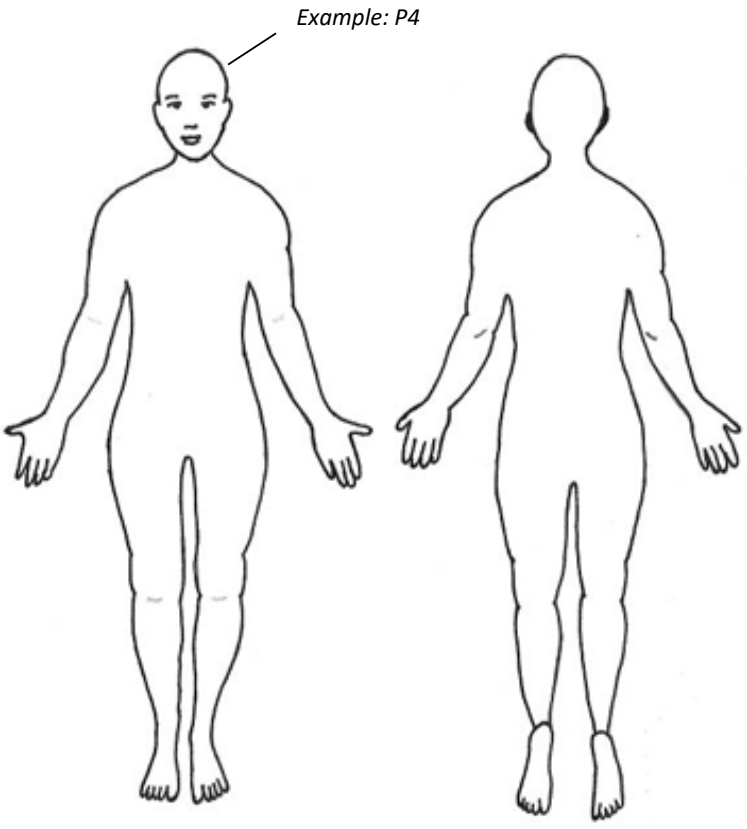
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Date Resolved (Office Use Only)			
Color (normal, bright red, pale, brown, rust, dark, purple, other)											
Amount of flow (normal, heavy, light)											
Pain/cramps (location, dull, sharp, other)											
Clots (large, small, black, purple, red, other)											
Vomiting (check if yes)											
Nausea (check if yes)											

Men Only:			Frequency	D/W/M/Y	Date Resolved (Office Use Only)			
193		Swollen testes						
194		Testicular pain						
195		Impotence						
196		Premature ejaculation						
197		Feeling of coldness or numbness in external genitalia						
198		Enlarged prostate						
Other :_____								

Indicate the area of pain/discomfort on the body image below by selecting the quality of the pain and the appropriate number.

(Example See Below: P4 indicating Pressure at a level 4 of pain)

Aching
Burning
Cramping
Dull
Fixed
Moving
Numbness
Pressure
Tingling
Sharp
Tight
Weak
Tremors



0	No pain or discomfort
2	Mild, annoying
4	Nagging, troublesome
6	Miserable, distressing
8	Intense, horrible
10	Worst, unbearable

Do the following reduce pain?
☐ Pressure ☐ Cold ☐ Heat ☐ Exercise ☐Other:_____
Do the following worsen pain?
☐ Pressure ☐ Cold ☐ Heat ☐ Exercise ☐Other:_____

Other comments :_____

_____

_____

_____

PATIENT SIGNATURE: _____ Date:_____

II. Patient Medical History

Hospital visits/stay:

Date	Reason	Outcome

Western Medical Diagnosis:

Current Medications:

Name of Medication	Dosage	Reason

Physician / Health Care Providers:

Type	Name	Phone #
Primary Physician:		
Cardiologist:		
Oncologist:		
Chiropractor:		
Naturopath:		
Physical Therapist:		
Other:		