Hawken Acupuncture 6510 Abrams Rd, Suite 401, Dallas, Texas 75231
972.804.9113

Personal Information

Name _____ Nickname _____ Date _____

Home Address _____ City _____

State _____ Zip _____ Home Phone _____ Cell _____

Email _____ Ok to leave message on phones? Yes No

Occupation _____ Person responsible for account _____

Emergency Contact _____ Relationship _____ Phone _____

How you heard of us _____ Previous Acupuncture? Yes No When? _____

Height _____ Weight _____ Birth date _____ Age _____ Number of children _____

Sex Assigned at Birth _____ Gender _____ Sexual Orientation _____

Living Arrangement: Alone Spouse/Partner(s) Child(ren) Sibling(s) Parent(s)/ Guardian(s) Group setting

Personal care attendant Other _____

Please indicate any significant illnesses you or a blood relative (grandparent, parent, or sibling) have had:

Illness	You	Relative	When?	Illness	You	Relative	When?
Cancer	□	□		Rheumatic Fever	□	□	
Diabetes	□	□		Emotional Disorders	□	□	
Hepatitis	□	□		Infectious Diseases	□	□	
Heart Disease	□	□		Tuberculosis	□	□	
High Blood Pressure	□	□		Seizures	□	□	

Other diseases (you): □ Gonorrhea □ Syphilis □ HIV □ HPV □ Chlamydia □ Herpes Date of Diagnoses_____

Please indicate use and frequency of the following:

	Yes	No	Amount		Yes	No	Amount
Coffee/black tea				Alcohol			
Recreational Drugs				Tobacco			
Water				Soda Pop			

Please check √ the box if any of the following statements are true:

I have known allergies □ Yes □ No I am taking Coumadin/Warfarin/Plavix or other blood thinners □ Yes □ No

I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs) □ Yes □ No

I have a pacemaker □ Yes □ No I have other electrical implants □ Yes □ No If yes, please describe:

_____

_____

Physician History

Have you seen a physician in the past year? □ Yes □ No

If yes: Physicians name: _____ Phone: _____

Approximate date of most recent examination/visit: _____

What is the chief health complaint for which you are seeking treatment? _____

What forms of treatment have you sought? _____

_____

Do you have any additional health concerns or diagnoses? _____

_____

List any allergies, food sensitivities, or food cravings that you have: _____

_____

List any accidents, surgeries, or hospitalizations (include date): _____

_____

Medications: Please list any prescription or over the counter medications, supplements or herbs you are taking:

Rx/Supplement/Herb	Dosage	Reason for taking	How Long?	Prescribed by?	Date last checkup?

General Health

What sort of diet do you have? (check one) □ Standard American □ Fast Food □ Balanced Food Groups
□ Muscle Building □ Vegetarian □ Vegan □ Low Fat □ Low Carb □ Other: _____

Activity Level (check one: □ Sedentary Job WITHOUT exercise □ Sedentary Job with SOME exercise
□ Sedentary Job with MUCH exercise □ Active Job WITHOUT exercise
□ Active Job with SOME exercise □ Active Job with MUCH exercise
What type of exercise do you do? _____
How frequently? _____
How long (time or mileage)? _____

How would you describe your stress level? □ Low □ Medium □ High □ Very High

Please write your answers or circle Y/N as appropriate:
How would you describe your energy level on a 1-10 scale, with 0 being asleep and 10 a good consistent energy (not manic and hyper)? _____
Is there a time of day when your energy is highest? What time? _____
Is there a time of day when your energy is lowest? What time? _____
Do you fall asleep quickly after going to bed? Y/N
Do you wake to urinate? Y/N If Yes, how many times during the night? _____
If no, do you sleep through the night? Y/N
If no, how long does it take you to fall back to sleep (give range of time) _____
Are you rested when you wake? Y/N
Regarding your body temperature (NOT measured with a thermometer, but how you FEEL), do you run:
□ Hot □ Cold □ Even temperature
Do you have any unexpected sweating (not under exertion)? Y/N
How hungry are you? (meaning an actual feeling of hunger in the stomach, NOT a desire to eat for other reasons)
□ Low □ Average □ High
How thirsty are you? □ Not thirsty □ Average □ Excessively thirsty
Do you experience bloating after eating? Y/N
How often, in a day, do you have a bowel movement (number) _____ (give range, if number varies - for example, 1-4. If you have one, and then soon have another, this still counts as 2)
What is the typical consistency of the stool? (Check all that apply) □ watery diarrhea □ loose, no form
□ soft, broken tubes □ one single, easy to pass tube □ knobby □ hard □ small pellets
Do you have urgency with bowel movements? Y/N
Do you have to strain to pass stool? Y/N
Does it seem like you are urinating the same amount (volume) that you are drinking? Y/N
Do you have frequent urination? Y/N
If you could name one emotion that you feel is dominant for you – one that you feel more than any other, what would that be? _____
If applicable: what was the first day of your last menstrual period? _____

Please fill out the information that applies to you, and the Symptom Survey below

Are you pregnant? □ Yes □ No
Date of last Pap smear _____ Date of last Mammogram _____ Date of last Bone Density Scan _____
Results: Pap _____ Mammogram _____ Bone Density _____
Are you using contraception? □Yes □ No If Yes, what type? _____
Age of 1st period (menarche) _____Age of last period (menopause) ____Number of days between periods _____
Number of days of bleeding _____ How heavy is the bleeding? □ light □ average □ heavy
Color of blood: □ light red □ red □ dark red □ purple □ brown □ black Is there clotting? □Yes □ No
Average number pads/tampons used: 1st day ____ 2nd day ____ 3rd day ____ 4th day ____ +days _____
Have you been diagnosed with: □Fibroids □Fibrocystic Breasts □Endometriosis □Ovarian Cysts □PID □Other
Do you have chronic vaginal discharge? □Yes □No Are your periods painful? □Yes □No
Location of menstrual pain: □ Lower abdomen □ Lower back □ Thighs □ Other_____
Nature of menstrual pain (please indicate before (B), during (D), or after (A) menses)
Cramping _____ Stabbing _____ Burning _____ Aching _____ Dull _____ Bloating _____
Consistent _____ Intermittent _____ Bearing down sensation _____
Other symptoms related to menses: □ Discharge □ Vaginal dryness □ Headache □ Nausea □ Constipation
□ Swollen breasts □ Diarrhea □ Mood swings □ Ravenous appetite □ Poor appetite □ Hot flashes
□ Night sweats □ Insomnia □ Decreased libido □ Increased libido

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Date of last prostate check up _____ PSA results_____ Manual prostate exam results _____
Frequency of urination: Daytime_____ Nighttime _____ Color of urine: □ Clear □ Murky
Symptoms related to prostate: □ Rectal dysfunction □ Increased libido □ Decreased libido
□ Premature ejaculation □ Impotence □ Prostate problems □ Delayed stream □ Dribbling □ Incontinence
□ Retention of urine □ Back pain □ Groin pain □Testicular pain Other _____

Symptom Survey (for everyone)

Please check √ if you experience or have experienced

□ lack of appetite
□ excessive appetite
□ loose stool or diarrhea
□ digestive problems/ indigestion
□ vomiting
□ belching/burping
□ heartburn/reflux
□ feeling the retention of food in the stomach
□ tendency to become obsessive in work, relationships, etc.
□ insomnia, difficulty sleeping
□ heart palpitations
□ nightmares
□ mentally restless
□ laughing for no apparent reason
□ colitis
□ diverticulitis
□ cough
□ shortness of breath
□ decreased sense of smell
□ nasal problems
□ skin problems
□ claustrophobia
□ bronchitis
□ asthma
□ tendency to catch colds easily
□ allergies
□ hay fever
□ jaundice (yellowish eyes or skin)
□ eye problems
□ difficulty digesting oily food
□ gall stones
□ light colored stool
□ soft or brittle nails
□ easily angered or agitated
□ difficulty in making plans or decisions
□ spasms or twitching of muscles
□ pain or coldness in the genital area
□ cold hands and feet
□ intolerance to weather changes
□ low back pain
□ knee problems
□ hearing impairment
□ ear ringing
□ kidney stones
□ decreased sex drive
□ hair loss
□ urinary problems
□ fatigue
□ edema
□ blood in stool
□ black tarry stool
□ difficulty stopping bleeding
□ recent use of antibiotics
□ abdominal pain
□ chest pain
□ sciatic pain
□ headaches
□ dizziness
□ fainting easily
□ high cholesterol
□ sudden weight loss

Please complete this section if you are seeking treatment for pain

Describe location of pain: _____

Describe the onset of the pain: _____

Circle the words that best describe your pain:

dull sharp stabbing achy sore sudden cramping throbbing burning constant

comes & goes radiating electric fixed moves about severe moderate chronic other: _____

Circle if any help your pain:

ice heat rest movement other: _____

Weather: hot cold dry humid windy rainy stormy

Circle if any make your pain worse:

ice heat rest movement other: _____

Weather: hot cold dry humid windy rainy stormy

Are there movements that aggravate the pain? _____

_____

How does exercise affect your pain? _____

_____

Do any medications help your pain? If yes, list them: _____

_____

List other treatments you've had for the pain: _____

_____

Evaluation Request Form

Please circle the appropriate answers (if answer is "No," please circle "No" – do not leave blank), initial, sign, and date.

I have been evaluated by a physician (MD/DO) or dentist for the condition being treated within 12 months before receiving acupuncture treatment.

Yes No

Patient's signature _____ Date _____

I recognize that I should be evaluated by a physician (MD/DO) or dentist for the condition being treated by the acupuncturist. This serves as a referral by the acupuncturist for me to see a physician. It is my responsibility and choice whether or not to follow this advice.

Patient's signature_____ Date_____

I have received a referral from my chiropractor within the last 30 days for acupuncture.

Yes No

After being referred by a chiropractor, if after 60 days 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, and consider this written notice a referral in advance. It is my responsibility and choice whether or not to follow this advice. This does not apply to the following conditions: chronic pain, alcoholism and substance abuse, smoking cessation, or weight loss.

Patient's Signature _____ Date_____

Our Office Policy

We do not bill insurance directly. Patients are expected to take care of their fees as services are rendered. You may request a detailed receipt to submit to your insurance company.

Our policy is to charge the full appointment fee for a missed appointment. If you need to cancel your appointment, please inform us at least 24 hours prior to your appointment to avoid being charged.

I have read and agree to the terms above.

Patient's Signature _____ Date _____

Payment and Appointment Cancellation Policies

Payment is expected at the time of service.

At Hawken Acupuncture, PLLC, we require a 24-hour notice for cancellation of an appointment, emergencies excepted. It is the policy of our clinic to hold a credit card number on file in order to reserve all of your appointments.

Please note that the held credit card will not be charged unless you miss an appointment or do not give our office 24-hours notice that you need to change your scheduled appointment. _____ (initial)

If you do not show for your appointment, or cancel your appointment giving us less than 24-hours notice, you will be charged the usual fee for your missed appointment. _____ (initial)

We appreciate your understanding and consideration.

Patient Credit Card Information:

Name on Card: _____

MC/Visa/Discover # _____ Exp _____

I, (print name) _____ understand and agree to the payment and cancellation policies for Hawken Acupuncture, PLLC as part of my healthcare treatment.

Patient Signature: _____

Today's Date: _____

Notice of Privacy Practices Patient Acknowledgement

Patient Name _____ Date of Birth _____

I have received and understood this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosure of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This includes, but is not limited to:

* A statement that this practice is required by law to maintain the privacy of protected health information.

* A statement that this practice is required to abide by the terms of the notice currently in effect.

* Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.

* A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.

* A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.

* My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

    * The right to complain to this practice, and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.

    * The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.

    * The right to receive confidential communications of protected health information.

    * The right to inspect and copy protected health information.

    * The right to amend protected health information.

    * The right to request an accounting of disclosures of protected health information.

    * The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, the practice will provide me a revised Notice of Privacy Practices upon request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____