**Wisdom Acupuncture Center**
**1340 S. Main Street, Suite 210 Grapevine TX 76051.** **Phone: 469-514-8617, email: info@ewa-c.com**
**Web Address: https://ewa-c.com**

**{This is an Official Document to help us determine the best Treatment Plan for you. Have any Questions? Please do ask. }**

**Last Name:**_____________________________________ **First Name:**________________________________ **MI:**________________

**Gender: M / F Date Of Birth:**____/_____/________**Driver's ID #**_____________________**State:**_______ **Issued:**___/____/_______

**Street Address:**_________________________________________**City**______________**State:**_____________ **Zip Code:**____________

**Cell Phone#:**______________________**Email:**_____________________________________**Occupation:**_________________________

**Have You received Acupuncture Treatment before?** Yes /No. **Are you taking any Blood Thinner Medication ?** Yes / No
**Are You Pregnant?** Yes/ No. **Are You A Nursing Mother ?:** Yes/ No **Do You Have Fainting from Needle Pricks ?:** Yes / No

**Please Encircle Now If You Have Any of the Following Conditions:**

**Allergy:** Yes / No **Heart Condition:** Yes /No., **Pace Maker:** Yes / No, **Stroke:** Yes / No. **Seizures:** Yes / No. **Asthma:** Yes / No.

## Acupuncture Request And Consent

I hereby request the licensed Acupuncturist(s) of Eastern Wisdom Acupuncture Center to Treat me. I also Authorize him/her/them to perform on me the treatment, known as ACUPUNCTURE as a professional judgment may indicate, and further authorize him/her/them to use whatever therapeutic methods may seem fit, regardless of whether these methods are commonly and generally accepted and practiced in this community. I understand that Acupuncture may include:
1) The non Surgical, Non-Invasive insertion of Disposable needles in specific locations on my body.
2) The Recommendation of Herbal Dietary Supplements.
3) The Recommendation of Energy Flow Exercises or other prescribed Forms of Movements.
4) The collection of Data and information regarding the Functioning of various Physical Processes, by interrogation, Palpation, and other methods specific to the practice of Acupuncture, and
5) The use of localized Heat and / or Electrical Stimulation, whether alone or in combination with the other procedures already described above.

The Acupuncturist has Clearly explained to me the nature and purpose of treatment, the Risks involved, the Collateral hazards, and the possibilities of complications during or as a result of the treatment. I understand the meanings of the term Complication, and in giving my consent to the treatment. I have in mind the Acupuncturist's clear explanation. In the event any foreseen condition arises in the course of treatment, and in the judgment of Acupuncturist it is advisable to use procedures in addition to, or different than this now contemplated. I also request and authorize him/her/them to perform such treatments, use such procedures, or otherwise act in accordance with his/her/their professional opinion.

The Acupuncturist has made NO GUARANTEE or Representation as to the Results that may be obtained from this Treatment.

I understand that I am Fully Liable for Expanses associated with Acupuncturist's provision of Acupuncture treatment in accordance with this request, and consent, and agree to pay or cause to be paid in full, the amount billed for these service. In the event that my condition is such that treatment is beyond the normal capabilities of the Acupuncturist, I understand that I may be referred to another competent practitioner including but not limited to Medical Practitioner or other practitioners.
I also agree to give 24 hours notice if I am unable to make my scheduled appointment. I fully understand that I may be Charged part of regular treatment fee($45) if I miss my appointment without giving 24 hours notice.

**Patient's Signature:**__________________________________ **Date:**___________________

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# Notice Of Privacy Policies

Eastern Wisdom Acupuncture Center is Dedicated to provide services with respect to human Dignity. Protection of Your Privacy, and 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.
We gather Personal Information and Health care Information in Several ways:

1-Information received from you.
2-Information we receive from other health care providers.
3-Information we receive from Third party Payers.

The obtained information is used for treatment, payment, and Healthcare Operations. You should be aware that during the course of our relationship with you, we will likely use, and disclose health information about you for treatment, payment, and health care operations, You may specifically authorize us protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose to have your protected information.

**Marketing:** This Office will not use your information for Marketing communications without your written authorization. The office may send Birthday Cards, News Letters, or appointment reminders by Phones calls, Post Cards, or Letters. This office may send your information to support you health care, information about Alternative Treatments, and health related services that may be of interest to you, Please advise this office if you do not wish to receive such communications, and we will not use or disclose your information for such purposes. If you do not wish to receive such communication, you must advise our office at our contact address,

**Disclosure:** This office may use or disclose your you protected information when required by Law. Without your consent or pressurization, this office may disclose information about you only for the following purposes:
* To public health agency for the purpose such as controlling disease.
* In case of suspected child abuse, to the appropriate Governmental Authority.
* In other case of suspected abuse, neglect, or Domestic violence, to the appropriate Governmental authority, with your agreement, or if required by Law, or if you are incapacitated, or if appears necessary to prevent serious harm to you or others.
* To health oversight authorities for Regulatory, licensing, and other legal purposes.
* In Litigation Subject to subject to certain requirements controlling the terms of the disclosure .
* To Law enforcing agencies subject to applicable legal requirements, and Limitations.
* For Medical research purposes, subject to your authorization, or approval by an institutional review board.
* If you are in The United States Military, National Security, or Foreign Service, to your authorized superior, or other authorized Fedral Official.

We may not disclose information about you for any other purpose without your written authorization, provided separately from your written consent.

**Patient Rights:**
1- Upon written request you have the right toaccess, review, or receive copies of your Health care records.
2- Upon your written request you have a right to receive a list of items, this office disclosed about your health care information.
3-You have the right to request that this office place additional restrictions on disclosure of your protected health information.
4- You have the right to request that we amend your protected Health Information. The request must be in writing.
5- You have the right to receive all the notices in writing.

If have questions, complaints, or want more information, please contact the Privacy Officer at this office.
**Complaints:**
Complaints about your privacy rights, or how your privacy is handled at this office, can be directed to the privacy officer by calling this office, or directing a letter to his/her attention. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to DHHS (Office of Civil Rights), 200 independence Ave, S W, Room 509F, HHH Building, Washington, DC.20201.

**I,________________________________(Printed Name), have read, reviewed, understand, and agree to the notice of privacy policies for healthcare, and / or other services provided though this office.**
**This office has attempted to provide each patient with a notice of privacy policies.**

X__________________________________________________________________ ________________________
Patient Signatures, or Signature of Parent/Guardian if patient is under the age of 18. **Date**

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**Eastern Wisdom Acupuncture Center**
1340 S. Main St, Ste: 210, Grapevine, TX 76051

## Patient Consent
## For The Purpose Of Treatment, Payment, And Healthcare Operations

I,_________________________________(Printed Name) give consent to **Eastern Wisdom Acupuncture Center**, the use, and

disclosure of my idividual identifiable healthcare protected information for the following specific purposes:

A- Providing Treatment to me.
B- Relating to the payments this office has rendered to me.
c- The general administrative procedures this office provides to me.

**The Purpose of this consent is for:**

Protected Health Information which includes:
A- Demographic information.
B- Information gathered by this practice, as it relates to my Past, Present, or Future physical, or Mental Health condition.
C- Information gathered by this practice, as it relates to my Past, Present, or Future payments for providing the healthcare service to me.
D- Health care operations will include Quality Assessment activities, credentialing, bussiness management, conducting training programs in which students, Trainees, or practitioners in the area of Healthcare learn under supervision to practice, or improve their skills as Healthcare providers, and other General operations, procedures, or activities.

I understand that I have the right to request a restriction on the use, and disclosure of my Protected health information for the purpose of treatment, Payment, or healthcare operations of the clinic, but clinic is not required to agree to these restrictions. However, if if the clinic agree to a restriction that I request, the restriction is binding on the clinic.

**I understand that I have the right to read, and discuss the notice of Privacy Policies, and Procedures from this clinic before I Sign this consent Form, regarding the use, and disclosure of my Protected Health Information.**

I have the right to revoke this consent in Writing, at any time except to the extent that the Acupuncturist, or the clinic has acted in reliance on this consent.

Signature:______________________________________________________________ ___________
(Signature of the patient / personal representative, or Signature of Parent / Guardian if under the age of 18.) Date.

______________________________________________
Description of personal representative's Authority.

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Please describe Current Health issue(s) for which you are seeking Treatment.

______________________________________________________________________________

______________________________________________________________________________

Date or Month, and year, the Problem(s) began: (mm/dd/yy). _____/_____/___________

How often are your symptoms present?
Constantly.______ Frequently._______ Intermittently.________ Occasionally._________

Please describe your current Health status:
Good._________ Fair._________ Poor.____________ Chronically ill.____________

Please Tick any significant illness(es) you have from the followings:

| Emotional Disorder | | Rheumatic Fever | | Heart Disease | | Seizure | | STD | |
|---|---|---|---|---|---|---|---|---|---|
| Hypertension | | Infectious Disease | | Hepatitis | | Diabetes | | Cancer | |

Any other health condition, you should let us Know?
______________________________________________________________________________

Please let's know what treatments have you been taking for the above conditions?
______________________________________________________________________________
______________________________________________________________________________

Please list below any Accidents, Surgeries, Hospitalizations, and any Emotional Trauma with approximate point of time in your life!
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please check below if any of your immediate family member had any of the following Ailments:

| Arthritis | | Cancer | | Hypertension | | Heart Disease | | Diabetes | | Mental Disorder | |
|---|---|---|---|---|---|---|---|---|---|---|---|

Any Other Conditions:
______________________________________________________________

Please indicate by a number per week, the frequency of your use of any of the followings:

| Tobacco | | Coffee/Tea | | Alcohol | | Rec; substances | | Exercise | |
|---|---|---|---|---|---|---|---|---|---|

Patient's Name:______________________________ Signature:_________________ Date:___/____/_______

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**Please write "C" for Current, and "P" for the Past about having an experience with any of the followings. Leave Blank if Never happened.**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Apatite increase/Low | | Poor Sleep | | Body heaviness | | Shortness of breath | | Chills / Fever | |
| Prefer Hot/Cold Drinks | | Heavy Sleep | | Cold hand/Feet | | Night Sweats | | Muscle Cramps | |
| Dream Disturbed Sleep | | Allergies | | Fatigue | | Sweat Easily | | Dizziness | |

**Head, Face, Ear, Nose, Throat:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Headache | | Eye Strain | | Glaucoma | | Tooth Grinding | | Tinnitus | |
| Migraines | | Red/Itchy Eyes | | Night Blindness | | TMJ Pain | | Dry Mouth | |
| Sinus Issues | | Eye Floaters | | Glasses / Contacts | | Bleeding Gums | | Excessive Salivation | |
| Runny Watery Nose | | Poor Vision | | Recurrent sore Throat | | Heavy / Popping Ears | | Excessive Phlegm | |
| Nasal Congestion | | Blurry Vision | | Swollen Glands | | Earache | | Facial Pain | |
| Nose Bleeding | | Cataract | | Concussion | | Poor Hearing | | Vertigo | |

**Respiratory System:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Difficulty Breathing | | Sneezing | | Cough with Phlegm | | Cough with Blood | |
| Tightness in Chest | | Dry / Hacking Cough | | Asthma / wheezing | | Pneumonia | |

**Cardiovascular System:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | | Palpitation | | Irregular Heart Beat | | Pacemaker | | Poor Clotting | |
| Low Blood Pressure | | Chest Pain | | Out of Breath on Exertion | | Fainting spells | | Easy Bruising | |

**Gastrointestinal System:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Bad Breath | | Acid Re-flux | | Mucous in Stools | | Constipation | | Gas | |
| Nausea | | Hiccups | | Hemorrhoids | | Rectal Pain | | Abdominal Pain/Cramps | |
| Vomiting | | Bloody Stools | | Diarrhea | | Bloating | | Sleepy after Meals | |

**Musculoskeletal System:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| General Muscle Pains | | Low Back | | Shoulder Pain/Limited Mobility | | Hip Pain | | Sciatic Nerve Pain | |
| Upper/Mid Back Pain | | Neck Pain | | Rib Pain/(With Breathing) | | Knee Pain | | Wrist / Finger Pain | |

**Genitourinary System:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Painful Urination | | Incomplete Urination | | Blood in Urine | | Prostate Problems | | Nocturnal Emissions | |
| Weak urine Stream | | Can't Hold Back Urine | | Frequent Urge to Urinate | | Decreased Libido | | Premature Ejaculation | |
| Burning urination | | Waking up to Urinate | | Bed Wetting | | Increased Libido | | Impotence | |

**Parapsychological System:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Seizures | | Tremors | | Poor Memory/ Brain Fog | | Anxiety / Depression | | Irritability | |
| Numbness | | Ticks / Twitching | | Easily Stressed/Stress | | Short Tempered | | Indecisiveness | |

**Skin, And Hair, Nails:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Rashes / Ulcerations | | Itching | | Acne | | Dandruff | | Dry Skin | |
| Hives | | Psoriasis | | Fungal Infections | | Hair Loss | | Brittle Nails | |

**Gynecological System: (** For Females Only)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Irregular /Regular Cycle | | Number of Miscarriages | | Menopause | | Total Pregnancies | |
| PMS irritability, Tender Breasts Backache, Food Cravings, Mood Swings | | Clots in Menstrual Blood | | Vaginal Discharge | | Breast Lumps | |

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**For Clinic Use Only**

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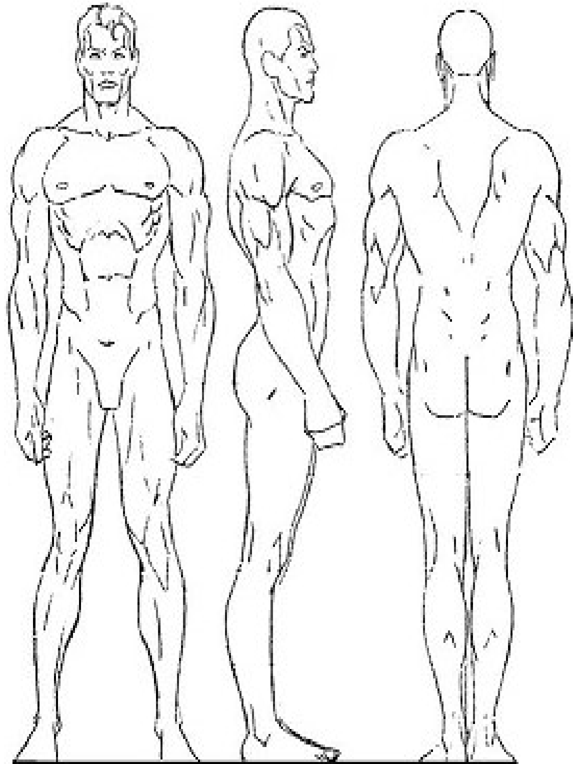
**Initial Visit Detailed Intake**

Patient's Name:______________________________________DOB:_______________ Date:___________________

Chief Complaint:________________________________________________________________________________

Pain Location:_______________________ Pain Character:_________________________

Pain Frequency:_________________________ Pain Times of Day:_______________________



Pulse:

Pulse Rt:___________________________

___________________________

Pulse Lt:___________________________

___________________________

Tongue Diagnosis:

___________________________________

___________________________________

Blood Pressure:

Sys:________ Diast:________ HR:_____

Temperature: _______

**Lung, and Large intestine Meridian Organ System:**

| | | | | | |
|---|---|---|---|---|---|
| Frontal Sinus/ HA | | Wheezing/ SOB | | Smell Problems | |
| Arm/Wrist/Elbow | | Grief/ Sadness | | Stiff Joint/ Neck | |
| Asthma/ Bronchitis | | Lethargy/ Fatigue | | Allergies | |
| Constipation | | Sweating Problems | | Weak Voice | |
| Cough/ Sneeze/ Phlegm | | Mucus in Stool | | Loose Stools | |
| Eczema/Rash/Psoriasis | | Nasal Problems | | | |
| Flatulence | | Shoulder Pain | | | |
| Recurrent Colds | | Sinusitis | | | |

**Kidney, and Bladder Meridian Organ System:**

| | | | | | |
|---|---|---|---|---|---|
| Adrenal Weakness | | Sore Throat in am | | Poor Memory | |
| Back/Hip/Knee Pain | | Impotence / Libido | | Hot Flashes | |
| Bladder infec;/ Control | | Tight Hamstrings | | Brittle Bones | |
| Premature Graying Hair | | Lethargy / Fatigue | | Tinnitus | |
| Cold Hands/ Feet | | Hair Loss/ Thinning | | Urine Problems | |
| Dark Puffy around Eyes | | Night Sweats | | Brittle Bones | |
| Infertility / Sterility | | Depression /Fear | | | |
| Edema / Water Retention | | Sciatica / Back Pain | | | |

**Liver, and Gallbladder Meridian /Organ System**

| | | | | | |
|---|---|---|---|---|---|
| Anger (sudden)/Irritability | | Nausea / Vomiting | | | |
| Breast Tenderness | | Hemorrhoids | | PMS | |
| Brittle/ Coarse Nail, Hair | | Indigestion | | Depression | |
| Neck / Shoulder Stiffness | | Flatulence | | Headache | |
| Irritable Bowel Syndrome | | IT Band Tightness | | Tinnitus | |
| Distension / Bloating | | Lack of Flexibility | | Vertigo | |
| Eye /Vision Problems | | Tension / Cramps | | Insomnia | |
| Irregular Menstruation | | Migraines | | Bruising | |

**Heart, and Small Intestine Meridian/ Organ System:**

| | | | | | |
|---|---|---|---|---|---|
| Abdominal Pain | | Hot Flashes | | Sleep Problems | |
| Hearing Problems | | Cardiac Problems | | Tongue / Speech | |
| Anxiety / Dread | | Anemia | | Upper Back Pain | |
| Digestive Issues | | Mouth Sores | | Urine Problems | |
| Dream Disturbed Sleep | | Neck Pain | | Wrist pain | |
| Elbow/ Shoulder Pain | | Palpitation | | | |
| Lack of Joy / Humor | | Poor Circulation | | | |
| Hot Painful Joints | | Restlessness | | | |

**Spleen, and Stomach Meridian /Organ System:**

| | | | | | |
|---|---|---|---|---|---|
| Distension/ Bloating | | Abdominal Pain | | Muscle Weakness | |
| Aching Heavy Limbs | | Headache | | Nausea / Vomiting | |
| Anemia | | Head Heaviness | | Poor Memory | |
| Appetite / Digestive Issues | | Hemorrhoids | | Prolapse | |
| Belching | | Hiccups | | Easy Bruising | |
| Worries, overthinking | | Irritable Bowel | | | |
| Colic / indigestion | | Lethargy / Fatigue | | | |
| Difficulty Focusing | | Loose Muscles | | | |

*Please Confirm that Acupuncturist has Shown You the Pre-sterilized Disposable needles to be used for your treatment.*

Patient's Name:_____________________________________ Signature:__________________Date:___________________

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**Patient Name:**___________________________________

**Diagnosis & Differentiation:**

______________________________________________________________________________

______________________________________________________________________________

**Treatment Principles:** ________________________________________________________________

______________________________________________________________________________

**Date / Codes** **Treatment:**

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**Patient Name:**___________________________________

**Date / Codes** **Treatment:**