Welcome to Dr. Jia / Dr. Liu's

*A*CUPUNCTURE *H*ERBAL *W*ELLNESS *C*ENTER

Would you please take a moment to provide us some information about yourself and your health conditions, so that we may do our best to treat you. AHWC clinic considers this information privileged physician/patient communication and with hold it in confidence. If you have any question, please don't hesitate to ask for assistance. **Please Print**

Date: ________________ Phones: (H) ________________ (W) ________________

Name: (Last) ________________ (First) __________________ (Middle) ____________________

Home Address: ____

City ________________ State____________________ Zip_____________________________

Sex: ☐ M ☐ F Birth date: __________ Age:_____ Social Security # ____________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse's name: ___________________________________ Phone (W) ______________________

Patient employed by____

Business address ____

Occupation ____________________________________ Business Phone ______________________

In case of emergency who should be notified? ____

Relationship _____________________________ Phone _____________________________________

Address ____

Have you received acupuncture before? _________ How did you hear about us? ______________

Whom may we thank for referring you ________________________ phone ________________

Have you consulted a Medical Doctor (Western) for your condition/complain? ________________

Your medical doctor's name (Western) ___________________________ Phone________________

Diagnosis of your problems ____

Treatment Agreement

I come here, to Dr. Jia / Dr. Liu, seeking Chinese Medical treatment for my condition. I hereby authorize Dr. Jia /Dr. Liu to perform appropriate therapy as my condition indicates or requires. I understand that these therapies may commonly accepted or known to my community or to myself. But that they are based on centuries old medical systems from around the world. I understand that Acupuncture, herbs and related treatments, as in any medical therapy, may make no guarantee as to the results.

I understand that only one-time use, pre-sterilized disposable needles are used at Acupuncture Herbal Wellness Center. Minor bruise may occasionally appear after treatment.

Patient's Signature: ______________________________________ Date: ____________________

Please go to page 2 and 3

Form to be completed by Patient, notifying the Acupuncturist of Whether He/She has been evaluated by a Physician, and other Information

(Pursuant to the requirements of '183.6(e)' of this title (relating to Denial of License; Discipline of Licensee) and Tex. Occ. Code Ann., '205.351, governing the practice of acupuncture.)

I (patient's name) ____, an notifying the acupuncturist (practitioner's name) ____ of the following:

________ Yes _______ No
I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognized 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 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 t a physician. It is my responsibility and choice whether to follow this advice.

Signature ______________________________________ Date _________________

Note:

Exemptions according to **Rule 183.6 (e) Scope of Practice**

3) …an acupuncturist holding a current and valid license may without an evaluation or a referral from a physician, dentist, or chiropractor perform acupuncture on a person for **smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse.**