Acupuncture, Reiki, Internal Herbal Medicine
8104 Nottaway Cove
Austin Texas 78745
(512) 619-5549

New Patient Health Questionnaire

Information requested below is completely confidential and will only be used to determine the best plan of treatment for you. Please fill it out as completely as you can. You are welcome to use additional sheets as needed.

Personal Information

Name:		Birth Date:	
Street Address:		Phone:	
City, State, Zip:		E-mail:	
Emergency Contact:		Emergency Contact #:	
How did you hear about us?			
Have you had acupuncture before? □ Yes □ No		If yes, what were you treated for?	
Name of your Primary Care Physician:			

Your Health

Your reason for visiting today

What is the **main** health problem for which you are seeking treatment?	
Are there any other problems you'd like to tackle?	1.
	2.
	3.

Medications

Please list all prescription or over-the-counter meds you take currently. Include herbs and supplements too. Please attach a separate sheet if you need more room or just bring a list in with you for your appointment.

Medications/Herbs/Supplements, Frequency and Dosage	Reason for Taking

Current Health Status

Please check any of the symptoms below that apply to your *current or recent* health status.

General		**Head, Eye, Ear**			Trouble concentrating	**Cardiovascular**	
	Low energy		Headaches		Mentally restless		Chest pain
	Spontaneous sweating		Migraines		Worry a lot		High blood pressure
	Feel too hot		Jaw pain/TMJ		Feel sad often		Low blood pressure
	Feel too cold		Impaired hearing		Cry uncontrollably		High cholesterol
	Excessively thirsty		Hearing loss		Terrors		Palpitations
	Chills/fever		Ear aches		Fearful often		Heart racing
	Avoid heat or cold		Ringing in ears		History of abuse		Poor circulation
	Cold hands/feet		Dizziness		Considered/attempt suicide		Irregular heartbeat
	Sweaty palms/feet		Spots in vision	**Digestive**			Fainting spells
	Hot flashes		Poor night vision		Nausea		Blood clots
	Night sweats		Double/blurred vision		Vomiting		Swelling of ankles
	Lack of sweating		Eye pain/strain		Low appetite		Varicose veins
	Weight loss		Contacts or glasses		Excessive hunger		Bleeding disorders
	Weight gain		Tearing of eye		Hypoglycemia	**Urinary tract**	
Skin and nails			Dry or burning eye		Fatigue after meals		Frequent urination
	Rashes		Itchy eye		Indigestion		Frequent night urination
	Itching		Red or inflamed eye		Bloating after meals		Poor bladder control
	Color change of skin	**Nose, Throat, Mouth**			Gas		Burning/pain on urinating
	Bruise easily		Sinus problems		Stomach ulcer		Very pale urine
	Slow wound healing		Nasal obstruction		Reflux or heartburn		Dark urine
	Acne		Runny nose		Diarrhea/loose stool		Cloudy urine
	Boils		Sneezing		Constipation		Scanty urine
	Hives		Nose bleeds		Stomach ache		Profuse urine
	Hair falling out		Loss of smell		Abdominal pain		Frequent UTI's
	Weak or brittle nails		Teeth problems		Hemorrhoids		Blood in urine
	Pitted nails		Mouth ulcers		Gallstones		Kidney or bladder stones
	Grooves in nails		Sores/ulcers on tongue		Jaundice	**Musculoskeletal**	
Respiratory System			Bad breath		Blood in stool		Pain/weakness/numbness
	Cough		Bleeding gums		Eating disorder		Joints
	Production of phlegm		Dry mouth		Less than 1 BM per day		Arms
	Wheezing		Oral thrush	**Lifestyle**			Hands
	Shortness of breath		Recurrent sore throat		Vegetarian/Vegan		Hips
	Coughing up blood		Hoarseness		Healthy diet		Legs
	Frequent colds/flus		Difficulty swallowing		Eat a lot of junk food		Feet
	Recurrent sinus infections	**Emotional/Psych/Mental**			Eat a lot of fried foods		Neck
	Chronic allergies:		Trouble falling asleep		Eat a lot of meat		Shoulders
	Mold		Trouble staying asleep		Smoke cigarettes		Upper back
	Cedar		Vivid/disturbing dreams		Drink alcohol		Lower back
	Pet fur		Anxiety		Drink coffee		Pain all over
	Dust		Depression		Use drugs		Muscle spasms/cramps
	Pollen		Mood swings		Eat a lot of sweets		Joint stiffness
	Oak		Irritability		Exercise regularly		Broken bones
	Hay fever		Often feeling angry				
	Enviro sensitivity		Poor memory				

Past History

Please check any conditions you've had in the *past*.

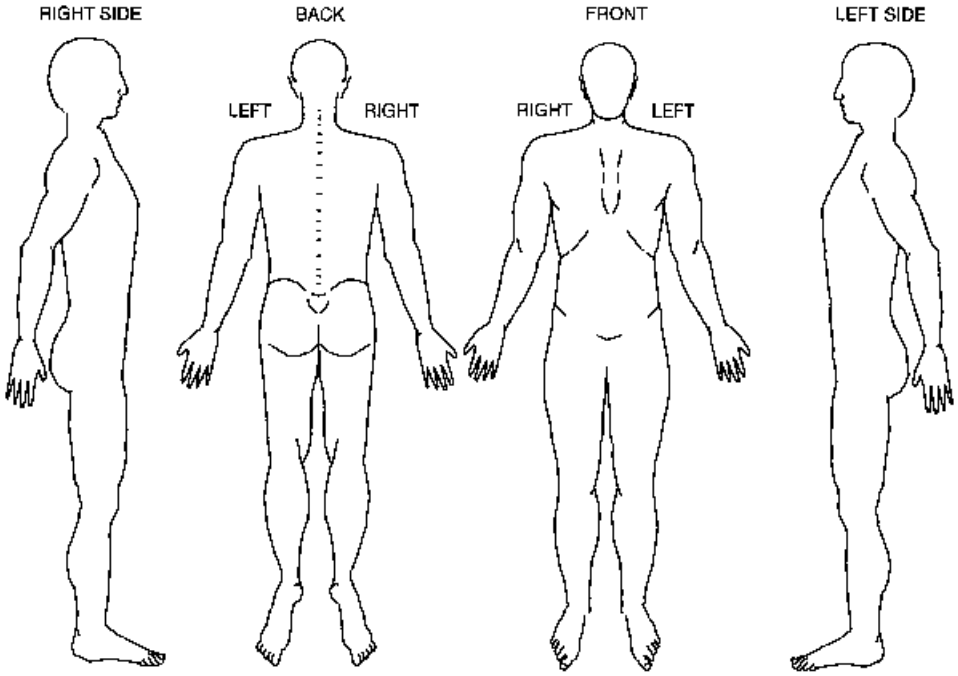
	Addictions (drugs, food, tobacco, etc.)				Hernia		Neuralgia
	AIDS				Hepatitis		Nervous disorder
	Alcoholism		Chronic bronchitis		High cholesterol		Panic attacks
	Allergies		Chronic Fatigue Syn.		Hypertension		Paralysis
	Anemia		Colitis/IBS/Crohn's		Hypotension		Pneumonia
	Anorexia		COPD		Hysterectomy		Polio or meningitis
	Anxiety		Depression		HIV positive		Prostate problems
	Appendicitis		Diabetes		Jaundice		Rheumatism
	Arteriosclerosis		Digestive Disorders		Kidney disease		Scarlet fever
	Asthma		Elevated liver enzymes		Liver disease		Small pox
	Autoimmune disorder		Emotional imbalance		Low blood pressure		Stroke
	Bladder disease		Emphysema		Malaria		Suicidal thoughts
	Blood transfusion		Epilepsy		Measles		Thyroid disorder
	Bleeding/hemorrhage		Fibromyalgia		Mental illness		Tonsillitis
	Breast lumps		Food, chemical poisoning		Migraines		Tuberculosis
	Breathing difficulties		Gallstones		Mononucleosis		Typhoid fever
	Bulemia		German measles		Multiple Sclerosis		Ulcers
	Bursitis		Glaucoma		Mumps		Vein condition
	Cancer		Goiter		Nephritis		Venereal disease
	Candida		Gout				
	Chicken pox		Heart disease				

Surgeries:	(Include dates/types/reasons)
Significant Traumas:	(Accidents, disasters, death of loved one, etc.)

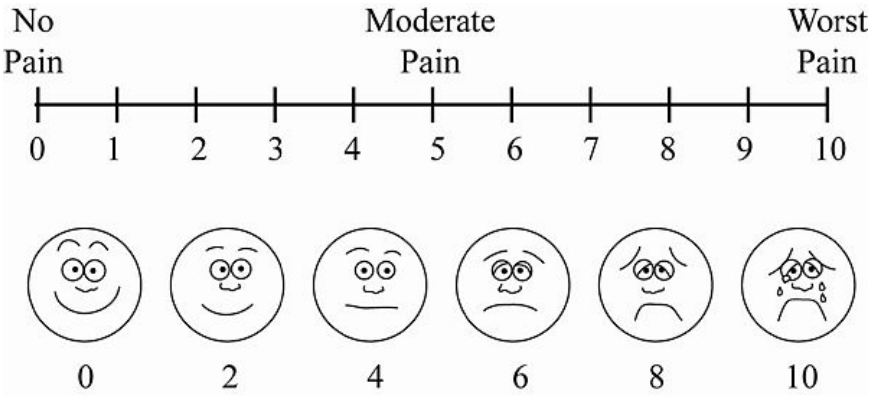
Pain and Sensory Patients

If you are coming in for physical pain and sensation issues, please fill out this portion of the paperwork. If not, you can skip this.

Where is the pain for which we will be treating you located? Please circle or mark the areas. You are welcome to briefly describe what it feels in the margins if you like. Words that people use about pain are deep ache, tight, pinching, sharp, burning, constant, or pinpricks. For odd sensations other than pain, you might note numbness, tingling, electrical sensations, pins and needles, etc.



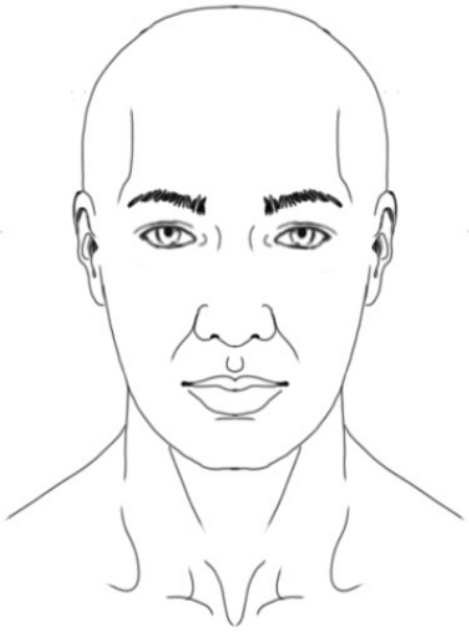
Rate your pain level on a scale of 1-10.



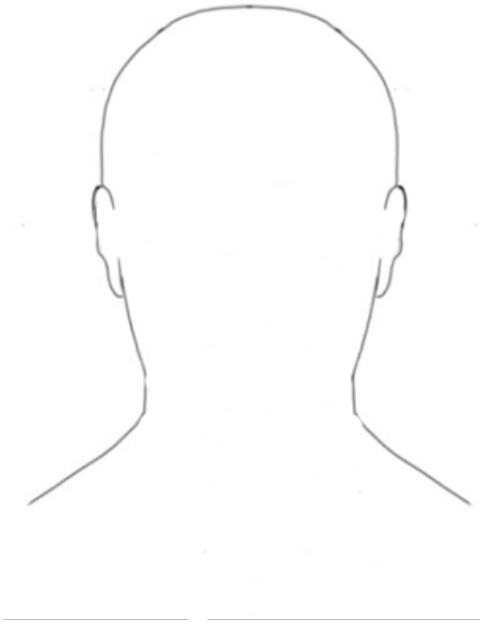
Headache and Facial Pain Patients

Headache and facial pain patients, please indicate your pain areas here.

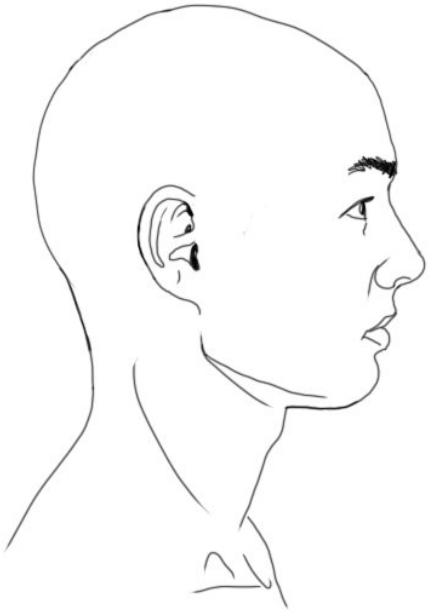
Front



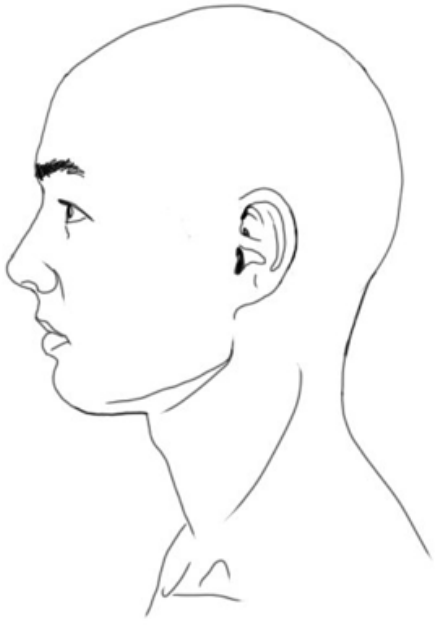
Back



Right side



Left side



Acupuncture Consent to Treat

I, _____, hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the named patient below, for whom I am legally responsible) by **Catherine D. (Cat) Calhoun** and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as backup for the **Catherine D. (Cat) Calhoun**, including those working at the clinic or office operated by Whole Human PLLC, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Reiki, Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and/or in writing. The herbs may have an unpleasant taste or smell. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites which may last a few days, and/or dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including pneumothorax (lung puncture). Infection is another possible risk, although the clinic uses single-use, sterile, disposable needles and maintains a clean, safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements, which are from plant, animal, and mineral sources, that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or if I become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my ***written*** consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment and have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

Patient signature	Date
Patient's printed name	
Patient Representative's signature (if patient is a minor)	Date
Patient representative's printed name	
Representative's relationship to patient/Authorization to act for patient	

Acupuncturist: Catherine D. (Cat) Calhoun Texas License: AC01317

Notification Regarding Evaluation of Patient by Physician

According to Texas law (pursuant to the requirements of Section 183.10(a)(11) and Section 205.302, Article 4495b governing the practice of acupuncture) I am required to inform you that in the State of Texas, acupuncture and Oriental medicine is not considered "primary health care." As a result, you must respond in the affirmative to *at least one* of the following three statements. Please be advised that per the law, I will not be permitted to treat you unless *at least one* of the 3 statements below is answered in the affirmative.

I, _____, am notifying Whole Human PLLC of *at least **one** of the following*:

1. I have been evaluated by a physician, dentist, or nurse practitioner for the condition for which I am requesting treatment within the 12 months prior to being treated by Whole Human PLLC.

   _____ Yes _____ No

   -OR-

2. I have received a referral from my chiropractor within the last 30 days for acupuncture. The date of this referral is _____. After being referred by a chiropractor if no substantial improvement occurs within 120 days or 30 treatments (whichever comes first), I understand that Whole Human PLLC is required by Texas law to refer me to a physician. It is my responsibility and choice as to whether to follow this advice.

   _____ Yes _____ No

   -OR-

3. 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 of more of the following conditions:

   ___ Chronic Pain
   ___ Weight loss
   ___ Smoking addiction
   ___ Alcoholism
   ___ Substance abuse

Patient signature (required) _____ Date _____

Patient's printed name _____

Patient Representative's signature (if patient is a minor) _____ Date _____

Patient representative's printed name _____ Relationship to patient _____

Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important.

Legal Responsibilities of Cat Calhoun, L.Ac: As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

Protected Health Information Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provided providing treatment to you. However, this information will *not* be provided unless you have authorized it in writing.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be use and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but *only with your authorization*.

Person Involved In Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information maybe used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

Required By Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters. We may also write a thank you card to whomever referred you to our practice. We will only do this with your written authorization. There is a form in your initial paperwork authorizing this. If you change your mind at any time, you may withdraw this authorization, but you must do so in writing.

Patient Rights Access: At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you $0.83 per page for the first 30 pages and $0.63 for every page after that plus $19.00 for staff time to locate and copy you protected health information. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associated disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

Questions and Complaints
If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in any way. We are available to assist you with any questions, concerns, or complaints.

Contact Person's Name:	Cat Calhoun, L.Ac.
Telephone:	512-619-5549
Address:	2111 Dickson Drive, Suite 24
City, State, Zip:	Austin TX 78704

I have read and understood the HIPAA privacy policies of Whole Human PLLC.

_____	_____	_____
Name	Date	Relationship to patient (if applicable)

Authorization to Contact

Appointment Reminders and Health Care Information Authorization

Cat Calhoun, L.Ac, or affiliated staff members may use your name, address, phone number, email and clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone, a message will be left on your voicemail. Thank you cards, appointment reminders, holiday cards, and other correspondence may be sent to your mailing or e-mail address.

Please be aware that you have a right to refuse or limit this contact. You may restrict the individuals or organizations to which your health care information is released. You may also revoke this authorization with us at any time as long as your revocation is in writing and is delivered to Whole Human PLLC. You should also know that if you were required to give your authorization to release health care information as a condition of obtaining insurance, the insurance company may have a right to your health information should they decide to contest any of your claims.

I, _____, authorize you to use or disclose my health information in the manner described above and I am giving authorization for Whole Human PLLC to contact me with the types of information described above.

Patient signature	Date
Patient's printed name	
Patient Representative's signature (if patient is a minor)	Date
Patient representative's printed name	
Representative's relationship to patient/Authorization to act for patient	