Eastern Balance Oriental Medicine LLC

Promoting health through Traditional Chinese Medicine therapies & Eastern philosophy.

Patient Information

Today's Date: _____

Last Name: _____ First Name: _____

Middle Name or Initial: _____ Home Phone: _____

Home Address: _____

City/State/Zip Code: _____

Cell Phone: _____ Fax: _____

Email Address: _____

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

Age: _____ Date of Birth: _____ Sex (circle one): M F

Marital Status (circle one): Married Single Divorced Widowed

Spouse's (or closest relative) Name: _____

Work Phone: _____ Cell Phone: _____

Spouse's Employer: _____

Address: _____

Emergency Contact - Name: _____

Address: _____

Relationship: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Family Physician: _____ Office Phone: _____

Whom may we thank for referring you? Name: _____

Address/Phone No.: _____

Eastern Balance Oriental Medicine LLC

1. Chief Complaint (the main reason for your visit today – please briefly describe the condition, how long you have had it, & the symptoms which accompany the condition):

2. Factors which make this condition worse: _____

3. Factors which make this condition better: _____

4. Diagnosis from conventional medical doctor: _____

5. Treatment you have received or are currently receiving for this condition: _____

6. Have results of this treatment been helpful? _____

Significant Health History Information

7. Have you ever had, or do you presently have, any of the following significant health issues?

____High Blood Pressure	____Cholesterol problems	____Bleeding Disorders
____Heart Disease	____Rheumatic Fever	____Thyroid Disease
____Diabetes	____Tuberculosis	____Hepatitis
____Cancer	____Stroke	____HIV/AIDS
____STD		

____Other(s): _____

8. List known allergies to any substances (foods, drugs, pollens, etc.): _____

9. Have you suffered significant traumas/accidents, etc.: _____

10. If yes, briefly describe incident(s) and provide date(s): _____

11. List major surgeries you have had, including dates (use back of page if you need more room):

Type(s) of Surgery	Date(s) of Surgery

12. List medications you are currently taking, with dosages, frequency, length of time:

Medication	Dosage/Frequency	How Long

13. Are you taking supplements or on a special diet? _____

14. (Female Only) Are you pregnant or suspect you may be pregnant? _____

15. (Female Only) How many pregnancies/miscarriages/live births? _____ / _____ / _____

16. (Female Only) How old were you at menarche / menopause? _____ / _____

17. Other important health information you want to tell us that we did not ask about (significant family medical health history, etc.): _____

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Form to be completed by patient notifying the acupuncturist as to whether he/she has been evaluated by a physician, and other information

(*Pursuant to the requirements of Rule 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) _____ am notifying the staff and acupuncturist(s) of Eastern Balance Oriental Medicine, LLC clinic of the following:

1. _____Yes _____No

I have been evaluated by a physician or dentist for the condition being treated within the twelve (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.

Initials of Patient: _____ Date: _____

or

2. _____Yes _____No

I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, I understand that the acupuncturist is required to refer me to a physician if no substantial improvement occurs in the condition being treated after 120 days or 30 treatments, whichever comes first. It is my responsibility and choice whether to follow this advice.

Initials of Patient: _____ Date: _____

Signature of Patient: _____ 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.***