South Austin Community Acupuncture

321 W. BEN WHITE BLVD ▪ AUSTIN, TEXAS 78704 ▪ (512)707-8330

Orientation to the Clinic

Welcome!

At South Austin Community Acupuncture we offer **treatment in a group setting with an affordable sliding scale fee structure.** We do this because we want you to be able to get acupuncture as often or for as long as you need to get the best results.

Acupuncture tends to work best with some kind of course of treatment.

For acute problems, a series of back to back treatments is often best. For chronic problems, treatment over an extended period of time may be most appropriate. We are here to guide you in getting the most from the services we offer.

To help everyone have the best experience, please follow the important points below.

Consideration of others:

- Cell phones must be turned off or in airplane mode in the clinic.
- Please be clean when coming for acupuncture. You will be taking your shoes off, so please have clean feet. We're always glad to see you, but would prefer others not have to smell you!
- Do not wear lotions, oils, cologne, perfume, or other scents. Some people are sensitive to smells. Oils and lotions also make needling difficult and mess up our sheets.
- Please enter and exit the group treatment room quietly, and speak softly when talking in the group room. Acupuncture is usually very relaxing, and people often fall asleep.

Responsibility for yourself:

- On your first visit, plan to be at the clinic for about 90 minutes. Follow up treatments may not take as long. While a treatment usually lasts about an hour, we'll leave you as long as you look like you're resting soundly. Please let us know if you are ready to go, or if you want to be out by a certain time.
- Sometimes people snore in the group room. Feel free to bring earplugs or something to listen to (with earbuds) if you prefer.
- Eat a little something before your treatment. Acupuncture is not recommended on an empty stomach.
- Wear loose, comfortable clothing so we can access just above your elbows and knees easily.

I have read and understand the above:

_____

Signature Date

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Getting Acupuncture in Texas

In Texas, Licensed Acupuncturists are allowed to treat the following conditions without any prior evaluation or referral requirements. If you are coming for one of these things, indicate this with a checkmark and **skip the rest of this page.**

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

If you are coming for anything else, please fill out the following state prescribed form below:

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 22 TAC §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) _____ , am notifying South Austin Community Acupuncture 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 recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

_____ (initials of patient) Date: _____

or

___ 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 two months 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. It is my responsibility and choice whether to follow this advice.

Signature _____ Date _____

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Clinic payment policies

Community acupuncture in community *supported* acupuncture. We do not receive any grants or other funding to do what we do, and we are only able to do what we do with your support.

South Austin Community Acupuncture operates on a sliding scale. Using your income as a guide, you pick how much you pay between $20 and $40 per treatment.

We do not verify income, but do ask that you pay fairly.

Select how much you pay ----------▼

If your annual income is:	We suggest you pay:	**CHECK ONE**
< $20,000	$20	□
> $20,000 - $25,000	$25	□
> $25,000 - $30,000	$30	□
> $30,000 - $40,000	$35	□
> $40,000	$40	□

There is an additional $10 New Patient fee with your first appointment.

Payment is due at time of service.

Cancellation / No show policy:

Please be considerate. When an appointment is missed or we don't receive adequate notification that you won't be making your appointment, chances are you have kept someone else from getting acupuncture at that time.

- Appointments must be canceled the day before during our business hours.
- You will be charged **for your appointment in full** if you do not show up, or do not cancel the day before.
- Please call to cancel even if you made the appointment online. Do not email us about appointments or cancellations.

I have read and agree to the above:

_____

Signature of patient or guardian Date

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Patient Information

Date ____ / ____ / _____	Phone: _____
Name: _____	Email:_____
Address: _____	In case of emergency notify:
City / State / Zip: _____	_____
Age: _____ Date of Birth ____ / ____ / _____	Relation: _____ Phone: _____
Living situation : Live w/other(s) Live alone Single	Patient's Representative:
Married Separated Divorced Widowed	_____
Occupation:_____	(if under 18 or otherwise requiring guardianship)
Employer:_____	Relation: _____

Your doctor or other primary care provider: _____

Have you tried acupuncture before? Yes No

How did you find us?

YOUR HEALTH CONCERNS: Why are you coming for treatment?

List any hospitalizations, surgeries, major injuries, or trauma: What and when?

Current medications and supplements:

Health questionnaire Name: _____

Check all that apply:	
□ epilepsy/seizures □ Hepatitis A/B/C □ HIV+ □ bleeding disorder or hemorrhage □ taking blood thinners	□ pacemaker □ fainting □ diabetes □ mental illness □ addiction □ other _____

LIFESTYLE:
□ Exercise regularly
□ Eat much fried food
□ Eat much meat
□ Eat a lot of sweets / carbs
□ Vegetarian / vegan
□ Drink alcohol
□ Drink coffee
□ Smoke cigarettes
□ Use drugs

SLEEP:
□ Not rested upon waking
□ Trouble falling / staying asleep
□ Less than 6 – 8 hours
□ Insomnia

GASTRO-INTESTINAL:
□ Excessive / low appetite
□ Fatigued after meals
□ Hypoglycemic
□ Indigestion / reflux / heartburn
□ Nausea / vomiting
□ Gas / bloating
□ Stomach ache / abdominal pain
□ Constipation
□ Diarrhea / loose stools
□ Hemorrhoids
□ Gallstones

CARDIO-VASCULAR:
□ High / low blood pressure
□ High cholesterol
□ Palpitations
□ Poor circulation
□ Rapid / irregular heartbeat

HEAD / FACE:
□ Headaches / migraines
□ TMJ / jaw pain

TEMPERATURE / PERSPIRATION:
□ Hot / Cold body sensation overall
□ Aversion to heat or cold
□ Cold hands / feet
□ Hot flashes / night sweats
□ Spontaneous sweating
□ Sweaty palms / feet

EYES / ENT / RESPIRATORY:
□ Frequent colds / sinus infections
□ Sinus problems
□ Chronic / seasonal allergies
□ Environmental sensitivity
□ Cough
□ Asthma / wheezing
□ Difficulty breathing
□ Sore throat
□ Enlarged glands
□ Ear ache
□ Impaired hearing / hearing loss
□ Ringing in ears
□ Dizziness
□ Red / inflamed / itchy eyes
□ Teary / dry eyes
□ Gum problems
□ Nose bleeds

DERMATOLOGICAL:
□ Rash / itching / hives
□ Acne / boils
□ Hair falling out
□ Weak / brittle nails
□ Slow wound healing

GENITO-URINARY:
□ Frequent urination
□ Poor bladder control
□ Burning / pain on urination
□ Frequent urinary tract infections
□ Kidney stones

EMOTIONAL / PSYCHOLOGICAL:
□ Anxiety
□ Depression
□ Mood swings
□ Irritability
□ Difficulty concentrating
□ Worry
□ Feel sad a lot
□ Cry uncontrollably
□ Much fear / terrors
□ History of abuse
□ Considered or attempted suicide

FEMALE ONLY:
□ May be pregnant
□ Irregular cycle
□ Painful periods
□ Heavy / scant periods
□ Chronic vaginal infections
□ Abnormal pap
□ Endometriosis
□ Ovarian cysts
□ Uterine fibroids
□ Partial / Total Hysterectomy
Number of:
Pregnancies -
Abortions -
Miscarriages -
Number of Births:
Vaginal -
Cesarean -

Cycle is ____ days.
Period lasts _____ days.

MALE ONLY:
□ Erection difficulties
□ Premature ejaculation
□ Penis discharge
□ Prostate problems

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INFORMED CONSENT TO TREATMENT

At South Austin Community Acupuncture we principally practice acupuncture (sometimes with electrical stimulation), cupping, and Chinese herbal medicine. We may also recommend dietary supplements or make dietary recommendations, suggest exercises, or do minimal bodywork. We generally don't do gua sha (scraping) or moxabustion, although we may provide moxabustion and instructions for home use.

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of acupuncture. I am hereby informed that the treatment methods are all generally safe but that there may be some side effects or risks, as follows:

Acupuncture may potentially cause temporary bruising, swelling, bleeding, numbness and tingling, or soreness at the site of needling. Highly unlikely risks of acupuncture include lung puncture (pneumothorax), nerve damage, organ puncture, and infection - although South Austin Community Acupuncture uses only sterile, disposable needles and maintains a clean and safe environment. Acupuncture can cause aggravation of symptoms existing prior to treatment and appearance of new symptoms.

Common side effect of cupping and gua sha are temporary bruising and redness lasting a few days. Cupping can also cause blistering of the skin in some instances.

The herbal and nutritional supplements (which may be from plant, animal, or mineral sources) recommended to me by my practitioner are generally safe in the traditionally recommended doses. Possible side effects of herbs include nausea, gas, stomach ache, diarrhea, and headache. Unusual side effects of plant herbs include vomiting, rashes, hives, and tingling of the tongue. I understand I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reaction.

I understand that I have the right to refuse any part of the treatment. I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I intend this form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with South Austin Community Acupuncture.

I will notify my acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs may be contraindicated during pregnancy.

Signature of patient or guardian Date