3100 Richmond Ave. #390
Houston, TX 77098
281.385.8511
Jenny@NaturalPointAcu.com

WELCOME!

Please fill these forms as accurately and detailed as possible. This information is essential, so that we can offer the best diagnosis and treatment. This clinic considers this information privileged, physician/patient communication and will be protected and confidential. **Please type or write in black ink.**

Thank you!

Date:_____ Gender: _____ Age:_____ DOB:_____

First, Middle, Last Name:_____

Address:_____

City, State, Zip Code:_____

Email:_____ Phone:_____

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

Current Job Title/Employer:_____

Partner's Name:_____ Phone:_____

Guardian (if applicable):_____ Relationship:_____

In case of emergency, who should we contact?_____Phone:_____

Relationship:_____

Primary Physician:_____ Phone:_____

Who can we thank for referring you?_____

Health habits (tobacco, alcohol consumption, special diet, etc.), if yes, how much and how often?___

_____

Weight:_____Looking to lose/gain weight? If so, how much?_____Exercise:_____

Cancellation Policy:

If you need to change or cancel your appointment please do so with a **minimum of 24 hours notice**. Failure to do so will result in being charged in full for your appointment. By signing below, you agree to understanding the cancellation policy.

Signature:_____ Date:_____

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HEALTH HISTORY

Reason(s) for today's visit (include how it began):

_____

_____

_____

_____

_____

How long has this condition persisted?_____

Anything that makes it better or worse?_____

Diagnosis from medical professional (if applicable): _____

Have you tried acupuncture before?_____

If so, for what reason(s)?_____

_____

Diet: Vegetarian ☐ Vegan ☐ Gluten Free ☐ Paleo ☐ Other:_____

Are you allergic or hypersensitive to anything (food, drug, environmental)?_____

_____

Hospitalizations/Surgeries/Significant trauma (auto accident, falls, etc)

_____

_____

_____

_____

List medications you are currently taking

Medication	Dose	Frequency?	How long have you taking this?

_____

_____

_____

_____

_____

_____

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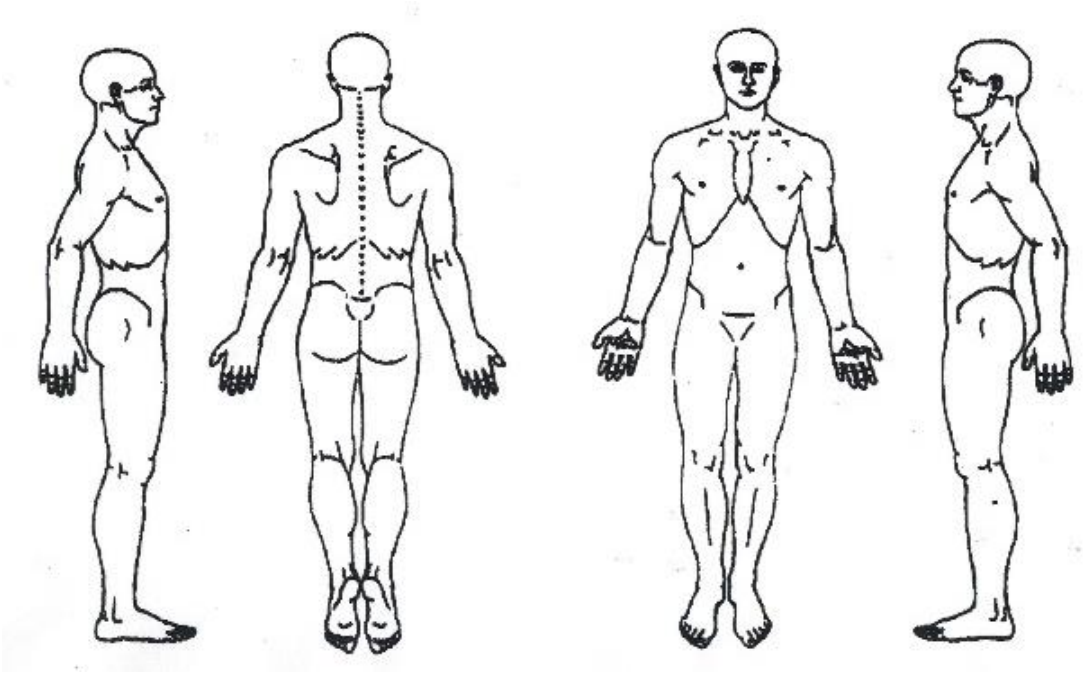
Are you experiencing pain/discomfort in any area of your body? ☐ Yes ☐ No

If yes, using the models below, please indicate the location of the discomfort by using the symbol that best describes the feeling:

XXX – Sharp/Stabbing PPP – Pins/Needles DDD – Dull/Aching NNN - Numbness



Significant family medical history (ex: cancer, cardiovascular(stroke, heart attack), eye disorders, high blood pressure, liver disease, etc.)_____

_____

_____

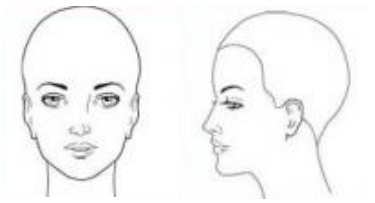
How would you describe your emotional well being?_____

Have you ever had a seizure? If so, when?_____

Do you suffer from headaches? IF yes, please describe:_____

_____

Please indicate below location of headache.



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Please check if symptom is in the past or present and rate if applicable.

Rate on scale of 1(mild/rare) – 5 (severe/often)			
Symptoms	**Present**	**Past**	**Rate**
General			
Sweat easily			
Difficult to sweat			
Night sweating			
Spontaneous sweating			
Bleed or bruise easily			
Dizziness/ vertigo			
Fatigue			
Fever			
Chills			
Insomnia			
Cardiovascular/Circulatory			
Rapid pulse			
Slow pulse			
Irregular pulse			
Palpitations			
Chest pain			
Fainting			
Lightheadedness			
Cold hands/ feet			
Swelling/ edema			
High blood pressure			
Low blood pressure			
Shortness of breath			
Anemia			
High cholesterol			
Other:			
Skin/ Hair			
Eczema			
Acne			
Skin rashes/ hives			
Dermatitis			
Warts			
Psoriasis			
Loss or thinning of hair			
Other:			

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Rate on scale of 1(mild/rare) – 5 (severe/often)			
Symptoms	**Present**	**Past**	**Rate**
Ringing in the ears (L or R, High or Low)			
Hearing loss			
Ear infections			
Migraines (list location)			
Sinus pressure			
Excessive wax			
Eye floaters			
Itchy eyes			
Red eyes			
Blurry vision			
Nose bleeds			
Stuffy nose			
Post nasal drip			
Teeth/ jaw clenching			
Dry throat			
Itchy throat			
Sore throat			
Other:			
Gastrointestinal			
Excessive appetite			
Low appetite			
Abdominal pain/ discomfort			
Gastritis/ heartburn			
Gas			
Belching			
Ulcer			
Nausea			
Vomiting			
Bad breath			
Sores on lips/ tongue/ gums			
Constipation			
Diarrhea			
Mucus in stool			
Blood in stool			
Hemorrhoids			
Stones			
Other:			

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Rate on scale of 1(mild/rare) – 5 (severe/often)			
Symptoms	**Present**	**Past**	**Rate**
Bronchitis			
Emphysema			
Cough			
Wheeze			
Pneumonia			
Painful breathing			
Chest tightness			
Sneezing			
Allergies			
Phlegm (color?)			
Other:			
Genito-Urinary			
Difficulty urinating			
Blood in urine			
Painful urination			
Urgent/ frequent urination			
Sores on genitals			
Hormonal Imbalance			
Hypothyroid			
Hyperthyroid			
Diabetes I or II			
Blood sugar			
Other:			
Autoimmune/ Inflammatory Conditions			
Rheumatism			
Lupus			
Colitis			
Chron's			
Alopecia			
Cellulitis			
Low immunity			
Other:			
Musculoskeletal			
Fibromyalgia			
Neck pain			
Shoulder pain			
Back pain (upper, middle, low)			
Hip pain			
Knee pain			
Foot/ankle pain			

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Rate on scale of 1(mild/rare) – 5 (severe/often)			
Symptoms	**Present**	**Past**	**Rate**
Muscle weakness			
Muscle cramping			
Restless leg syndrome			
Other:			
Neurological/ Psychological			
Anxiety			
Depression			
Easily angered			
Poor memory			
High stress			
Worry			
Other:			
Venereal Diseases			

Please list any other relevant information or issues you would like to discuss:_____

_____

_____

_____

Male Only

_____ Erectile Dysfunction

_____ BPH

_____ Premature ejaculation

_____low sperm count

_____ low motility

_____ testicular pain/injury

Any other issues?_____

_____

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Female Only

Are you pregnant or do you think you may be pregnant?_____

Are you trying to become pregnant?_____

Age of first menses?_____

Age of menopause (if applicable)?_____

Have you taken birth control pills? When and for how long?_____

Premenstrual and menstrual symptoms_____

How many? Please fill in or check if applicable

_____ pregnancies

_____ miscarriages

_____ children born

_____ abortions

_____ last menses

_____ duration of typical menses

_____ time between menses

_____ menstrual flow (heavy, moderate, light)

_____ color (dark red, red, purple, brown)

_____ last pap

_____ abnormal pap (when) _____

_____ vaginal discharge

_____ bleeding or spotting between periods

_____ breast lump, please specify which side

_____ contraceptive, which kind?_____

_____ irregular periods

_____ clots (size) _____

_____ painful periods

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Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by Jennifer Vargas Lic. Ac.

I understand that methods or treatment may include, but are not limited to: acupuncture, moxibustion, cupping, moving cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine, supplement recommendations, and nutritional and lifestyle counseling.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

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. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

By signing below, I agree to the above- named procedures. 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's Name _____

Patient's/Patient Representative's Signature _____

Today's Date _____/_____/_____

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Notice of Privacy Policies

This notice describes our policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways; Information we receive, information we receive from other healthcare providers, and information we receive from third party payers.

This 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 the treatment, payment, and healthcare operations.

You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

This office may use or disclose your Protected Health Information when required by law.

Upon written request, you have the right to access, review or receive copies of your healthcare records. Upon written request, you have the right to receive a list of items this office disclosed about your healthcare information. Upon written request, you have the right to request that this office place additional restrictions on disclosure of your Protected Health Information. Upon written request, you have the right to request that we amend your Protected Health Information. You have a right to receive all notices in writing.

If you have questions, complaints or want more information, please contact Jennifer Vargas Lic. Ac. at 281.948.2951.

You may also send a written complaint to the U.S. Department of Health and Human Services:

DHHS (Office of Civil Rights)

200 Independence Ave S.W. Room 509 F HHH Building

Washington, DC 20201

_____ _____

Signature Date

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Informed Consent for use of Essential Oils

Essential oils may be used during your treatment. Your practitioner will determine and discuss the use of essential oils during your treatment. If you are not comfortable with the use of oils please consult with your practitioner before the treatment begins.

These are some of the guidelines for safe use:

Essential oils are never to be used in the eyes or ears.

If you have sensitive skin or have never used essential oils before, use a diluting carrier oil. Examples of common carrier oils are: vegetable oil, olive oil, coconut oil, almond oil, avocado oil, and grape seed oil.

Start using oils gradually and find what works best for you and your family. You may want to begin with using the oil on the inside of the upper arm and wait at least 30 minutes before applying to another part of the body.

Keep bottles tightly closed, away from sunlight and away from children and animals.

If you think you may be pregnant, are pregnant or are thinking about becoming pregnant please talk to your medical provider first and let The Natural Point know this beforehand.

Epileptics and people with low or high blood pressure should consult with your medical provider first. Use caution with high ketone oils such as basil, rosemary, sage and tansy oils.

While primarily safe, there can be potential side effects, such as, chemically induced skin irritation or phototoxicity, also known as an exaggerated sunburn. You can also develop a rash or dark pigmentation on skin after being exposed to direct sunlight or UV rays. It usually occurs within 24 hours of sun exposure. The primary essential oils that cause this are of the citrus family. These include: angelica, bergamot, grapefruit, lemon, lime, orange, wild orange or tangerine.

Inhalation can be intense, so do not inhale more than 10-15 times in a day without consulting a health professional

You may also purchase essential oils from The Natural Point for your use at home. Statements made by The Natural Point in regard to essential oils, have not been evaluated by the Food and Drug Administration. Essential oils are not intended to diagnose, treat, cure, mitigate or prevent disease.

_____ _____

Signature Date

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

.

Thank you for taking the time to fill out these forms.