



Najar Acupuncture & Oriental Medicine

Patient Information

Date:

Name:	Occupation:
Address:	Employer:
City:	Phone:
State:	Email:
Zip:	Emergency contact:
Age:	Relation:
Date of Birth:	Phone:
Relationship status: Single Married Divorced Widowed	Patient's Representative: (If under 18 or otherwise requiring guardianship)
Number of cohabitants:	Relation:

Your doctor or primary care provider: _____

Have you tried acupuncture before? Yes No

How did you find us? _____

Are you currently taking any blood thinners (Coumadin, Aspirin, Etc.)? _____

What is the main condition you would like to address today?
Are there any secondary conditions you would like to address today or in the future?
List any hospitalizations, surgeries, major injuries, or trauma (what and when):
List current medications and supplements:

Check all that apply: <input type="checkbox"/> epilepsy/seizures <input type="checkbox"/> Hepatitis A/B/C <input type="checkbox"/> HIV+ <input type="checkbox"/> bleeding disorder or hemorrhage <input type="checkbox"/> taking blood thinners		<input type="checkbox"/> pacemaker <input type="checkbox"/> fainting <input type="checkbox"/> diabetes <input type="checkbox"/> mental illness <input type="checkbox"/> addiction <input type="checkbox"/> other _____
LIFESTYLE: <input type="checkbox"/> Exercise regularly <input type="checkbox"/> Eat much fried food <input type="checkbox"/> Eat much meat <input type="checkbox"/> Eat a lot of sweets / carbs <input type="checkbox"/> Vegetarian / vegan <input type="checkbox"/> Drink alcohol <input type="checkbox"/> Drink coffee <input type="checkbox"/> Smoke cigarettes <input type="checkbox"/> Use drugs SLEEP: <input type="checkbox"/> Not rested upon waking <input type="checkbox"/> Trouble falling / staying asleep <input type="checkbox"/> Less than 6 – 8 hours <input type="checkbox"/> Insomnia GASTRO-INTESTINAL: <input type="checkbox"/> Excessive / low appetite <input type="checkbox"/> Fatigued after meals <input type="checkbox"/> Hypoglycemic <input type="checkbox"/> Indigestion / reflux / heartburn <input type="checkbox"/> Nausea / vomiting <input type="checkbox"/> Gas / bloating <input type="checkbox"/> Stomach ache / abdominal pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea / loose stools <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Gallstones CARDIO-VASCULAR: <input type="checkbox"/> High / low blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Palpitations <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid / irregular heartbeat HEAD / FACE: <input type="checkbox"/> Headaches / migraines <input type="checkbox"/> TMJ / jaw pain	TEMPERATURE / PERSPIRATION: <input type="checkbox"/> Hot / Cold body sensation overall <input type="checkbox"/> Aversion to heat or cold <input type="checkbox"/> Cold hands / feet <input type="checkbox"/> Hot flashes / night sweats <input type="checkbox"/> Spontaneous sweating <input type="checkbox"/> Sweaty palms / feet EYES / ENT / RESPIRATORY: <input type="checkbox"/> Frequent colds / sinus infections <input type="checkbox"/> Sinus problems <input type="checkbox"/> Chronic / seasonal allergies <input type="checkbox"/> Environmental sensitivity <input type="checkbox"/> Cough <input type="checkbox"/> Asthma / wheezing <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Sore throat <input type="checkbox"/> Enlarged glands <input type="checkbox"/> Ear ache <input type="checkbox"/> Impaired hearing / hearing loss <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Dizziness <input type="checkbox"/> Red / inflamed / itchy eyes <input type="checkbox"/> Teary / dry eyes <input type="checkbox"/> Gum problems <input type="checkbox"/> Nose bleeds DERMATOLOGICAL: <input type="checkbox"/> Rash / itching / hives <input type="checkbox"/> Acne / boils <input type="checkbox"/> Hair falling out <input type="checkbox"/> Weak / brittle nails <input type="checkbox"/> Slow wound healing GENITO-URINARY: <input type="checkbox"/> Frequent urination <input type="checkbox"/> Poor bladder control <input type="checkbox"/> Burning / pain on urination <input type="checkbox"/> Frequent urinary tract infections <input type="checkbox"/> Kidney stones	EMOTIONAL / PSYCHOLOGICAL: <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Mood swings <input type="checkbox"/> Irritability <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Worry <input type="checkbox"/> Feel sad a lot <input type="checkbox"/> Cry uncontrollably <input type="checkbox"/> Much fear / terrors <input type="checkbox"/> History of abuse <input type="checkbox"/> Considered or attempted suicide FEMALE ONLY: <input type="checkbox"/> May be pregnant <input type="checkbox"/> Irregular cycle <input type="checkbox"/> Painful periods <input type="checkbox"/> Heavy / scant periods <input type="checkbox"/> Chronic vaginal infections <input type="checkbox"/> Abnormal pap <input type="checkbox"/> Endometriosis <input type="checkbox"/> Ovarian cysts <input type="checkbox"/> Uterine fibroids <input type="checkbox"/> Partial / Total Hysterectomy Number of: Pregnancies - Abortions - Miscarriages - Number of Births: Vaginal - Cesarean - Cycle is ____ days. Period lasts ____ days. MALE ONLY: <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Premature ejaculation <input type="checkbox"/> Penis discharge <input type="checkbox"/> Prostate problems

Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, Thomas Najar, L.Ac., is required to have you respond affirmatively to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no.

(Pursuant to the requirements of section 183.10(a)(11) of this title and section 205.302 V.A.C>S article 4495b, governing the practice of acupuncture)

I (patient's name) _____

am notifying Thomas Najar, L.Ac. and Najar Acupuncture and Oriental Medicine, PLLC of the following:

___ Yes ___ No I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within 12 months before the acupuncture was performed. I recognize that a physician or dentist for the condition being treated by the acupuncturist should evaluate me.

OR

___ Yes ___ No I have received a referral from my chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of treatment prior to acupuncture treatment is _____. 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 to a physician. It is my responsibility and choice whether to follow this advice.

OR

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 seek treatment for symptoms related to one or more of the following conditions:

OR

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

Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

Patient Signature Required

Date

The acupuncturist has referred me to a physician. It is my responsibility and choice to follow his/her advice.

Patient Signature Required

Date

Acupuncturist's Signature

Date

INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by Thomas Najar, L.Ac. and Najar Acupuncture and Oriental Medicine, PLLC who now or in the future treat me while employed by, working or associated with Najar Acupuncture and Oriental Medicine, PLLC: acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with Thomas Najar, L.Ac. and/or with other clinic personnel the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from those locations; nerve pain, burns, infection of insertion site, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I understand that acupuncture and Oriental medicine treatments may not have the desired therapeutic affect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is reasonable cause to believe that treatment is not appropriate for a patient who is under the influence of illegal drugs, alcohol, or appears to be overly medicated, then a treatment may not be performed at that time. The patient will be informed that they may not be treated at that time and will be requested to reschedule their appointment

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures and conditions of treatment. 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 at Najar Acupuncture and Oriental Medicine, PLLC.

Patient's name (please print)

Patient's signature

Print Name of Patient's Representative (if applicable)

Relationship or Authority of Patient's Rep.

Signature of Patient's Representative (if applicable)

Date Signed

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to Thomas Najar, L.Ac. and Najar Acupuncture and Oriental Medicine, PLLC "Notice of Privacy Practices". I understand that I have the right to review Thomas Najar, L.Ac. and Najar Acupuncture and Oriental Medicine, PLLC "Notice of Privacy Practices" prior to signing this document.

I understand that Thomas Najar, L.Ac. and Najar Acupuncture and Oriental Medicine, PLLC members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

I also understand that my clinical information may be used for educational and/or research purposes by Thomas Najar, L.Ac. and Najar Acupuncture and Oriental Medicine, PLLC or individuals authorized by Thomas Najar, L.Ac. and Najar Acupuncture and Oriental Medicine, PLLC. All information that can identify me personally will be removed.

By signing this form, I am giving Thomas Najar, L.Ac. and Najar Acupuncture and Oriental Medicine, PLLC authorization to contact me and am giving my informed consent to utilize my information for research and educational purposes. I acknowledge that all information discussed during the assessment and treatment at Thomas Najar, L.Ac. and Najar Acupuncture and Oriental Medicine, PLLC Clinic will be held confidential except in the instance where my safety or the safety of others may be at risk.

_____	_____
Patient Name (print)	Date
_____	_____
Patient Signature	Date

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize the Thomas Najar, L.Ac. and Najar Acupuncture and Oriental Medicine, PLLC the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____	_____
_____	_____
_____	_____

Patient's Signature

Date