**Synergy Health History**

**Today’s Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/ State/ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: (home)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we contact you by email / text/ or both? **Y / N** (email/ text will be limited to appointment reminders or changes)

Are you interested in receiving a monthly newsletter or other clinic notification via email? **Y / N**

Emergency Contact Person/Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s License # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician (PCP)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCP Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the concerns for which you are seeking care? (symptoms, diagnosis and date of onset)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other treatments have you received for any of these conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your condition better? (movement, rest, heat, cold, eating, sleeping, etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your condition worse? (fatigue, stress, certain foods or times of day, heat, cold, etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Significant Trauma, Hospitalizations, Surgery, X-Rays, Special Studies (accidents, falls, and illness)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Allergies

Are you hypersensitive or allergic to any foods, drugs, chemical or environmental substances?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications and Supplements**

Medications (prescribed or over the counter) herbs, vitamins, supplements, etc. currently taking that are not listed above? (If needed you may attach a separate list of your current medications)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Sleep

How many hours of sleep do you get? \_\_\_\_\_\_\_\_ Do you feel rested when you wake up? Yes or No

# Personal Health History

Please check any symptoms you have now or ever have had.

Cancer \_\_\_\_\_ Diabetes\_\_\_\_\_\_ Seizures\_\_\_\_\_ Heart Disease \_\_\_\_\_ High/Low Blood Pressure\_\_\_\_\_ Stroke \_\_\_\_

Anemia \_\_\_\_ Kidney Disease \_\_\_\_\_ Hepatitis \_\_\_\_\_Thyroid Imbalance\_\_\_\_\_ Asthma \_\_\_\_\_ Arthritis \_\_\_\_\_ Ulcer \_\_\_\_

Auto Immune \_\_\_\_\_\_ Alcohol/Drug Overuse\_\_\_\_\_\_ Blood Clotting Disorder\_\_\_\_\_ HIV \_\_\_\_\_ Pacemaker\_\_\_\_\_\_

Any other serious health conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

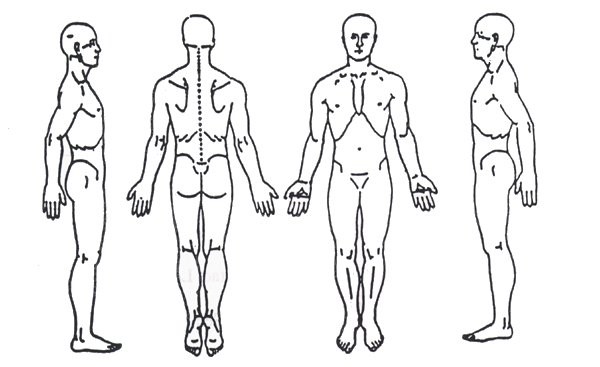
**Immunizations**

Scarlet Fever \_\_\_\_ Diptheria \_\_\_\_ Rheumatic Fever \_\_\_\_ Mumps \_\_\_\_\_Measles \_\_\_\_ German Measles \_\_\_\_\_

# Family Medical History

List the health conditions that run in your family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Mark the areas where you feel pain or discomfort: A= aching B= burning N=numbness P= pins and needles S= stabbing pain O= other type of sensation



**HIPPA Notice**

**Privacy Disclosure and Policies**

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the 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.

**Safeguards in place include:**

•Limited access to facilities where information is stored.

•Policies and procedures for handling information.

•Requirements for third parties to contractually comply with privacy laws.

•All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

## Public Interaction

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health in the office setting only to protect your privacy and ensure that important information is kept in your chart.

## Consultations

We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, we may gather and maintain information that may include these examples of non-public personal information

•From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.

•From health care providers, insurance companies, workman’s comp and your employer, and other third-party administrators (e.g.

requests for medical records, claim payment information)

## Records Release

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

## Definition and Penalties to Comply

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

**I have read and understand my right to privacy, as stated above, and agree to have Tracee Beaumont, Licensed Acupuncturist maintain my records confidentially in accordance with the law. I agree to inform Tracee Beaumont, Licensed Acupuncturist if I need any special arrangements pertaining to this issue.**

|  |  |
| --- | --- |
| Print | Date |
| Signature |  |

## Informed Consent to Receive Treatment

By signing below, I do hereby request and voluntarily consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Tracee Beaumont, LAc or another practitioner serving as back-up for Tracee Beaumont, L.Ac. I understand that methods of treatment may include, but are not limited to, acupuncture/ acupressure, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine , nutritional counseling and lifestyle coaching.

**Acupuncture:** This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatments can occasionally produce a mild but temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will rarely leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

**Traditional Chinese Herbal Medicine Treatments:** Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated.

**Heat Treatments with Moxa or a TDP Lamp:** These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

**Cupping:** This technique involves a localized suction produced by heating a small glass cup. There is a possibility of a local non-painful bruising from this suction. Very rarely a slight burn or blister may appear due to heat.

**Gua-Sha**: Gua Sha is a light scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising of the treated area. The bruising, which is not painful usually resolves in 3-7 days.

**Electro-Acupuncture:** A mild electric micro-current similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for a few days after the treatment. I understand that I must inform my practitioner if I am using a pace maker or have any heart or neurological condition prior to having this treatment.

By voluntarily signing below, I show that I read, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend for this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, as Tracee Beaumont, LAc is not primary care physicians.

I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treat:

Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, we are required to have you respond to the following statements before you may be treated with acupuncture. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no, unless your condition being treated is smoking cessation, alcoholism, substance abuse (Narcotics or Prescription drugs), weight loss, or chronic pain (continuous pain for more than 2 months or pain that occurs off and on over a one year period).

*(Pursuant to the requirement of 22 T.A.C. ∫183.7 of the Texas State Board of Acupuncture Examiners’ rules*

*(relating to Scope of Practice) and Texas. Occ. Code Ann., ∫205.351, governing the practice of acupuncture.)*

I (patient’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am notifying Tracee Beaumont, L.Ac of the following:

■ 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. ( )Yes ( )No

■ I have received a referral from my chiropractor within the last 30 days for acupuncture.

( ) Yes ( )No

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you answered no to both questions above**, I Tracee Beaumont, L.Ac am requesting that you see a physician for your condition being treated by me. It is your responsibility and your choice whether to follow this advice.

*(Pursuant to the requirement of 22 T.A.C. ∫183.7 of the Texas State Board of Acupuncture Examiners’ rules*

*(relating to Scope of Practice) and Texas. Occ. Code Ann., ∫205.351, governing the practice of acupuncture.)*

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

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acupuncturists Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SAW Clinic Policies**

**Payments**

Payments are due for your treatment at the time of service. Cash, check, credit cards, and HSA/ FSA are accepted forms of payment. If your check is returned for insufficient funds, there will be a $35.00 Returned Check fee added to your account, in addition to the amount the check was for. **Initial\_\_\_\_\_**

**Late Arrival Policy**

We strive to see every patient as close to their appointment time as possible if we are running more than 15 minutes late efforts will be made to notify you before your arrival time.

If you know you will be late to your appointment, please call or text the office to let the practitioner know. If you will be more than 15 minutes late and have not notified the office you may be asked to reschedule. If you’re asked to reschedule due to lack of late arrival notification the late cancellation fee of $30.00 will be charged.

**Initial\_\_\_\_\_**

**Late Cancellation and No-show Policy**

SAW is committed to providing all of our patients with exceptional care. When patient’s cancel without giving enough notice, they prevent another patient from being seen that day.

Please call/text **(346) 208-8764** or email **acupuncture.tracee@gmail.com** 24 hours prior to your scheduled appointment to notify us of any changes or cancellations. *To cancel a Monday appointment, please contact our office by 5:00 p.m. on Friday.* If prior notification is not given, you will be charged $30.00 for the missed appointment.

**Initial\_\_\_\_\_**

Thank you for understanding our policies,

Synergy Acupuncture & Wellness