



WELLNESS & ACUPUNCTURE  
2111 Dickson Dr. Suite 26 Austin, TX. 78704  
512 899 8996

Please help us provide you with the best possible treatment plan by completing this form.  
If you have any questions, please ask. Thank you!  
*All your information is absolutely confidential*

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

Home Address: \_\_\_\_\_

City/ State/ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell/ Work:(\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

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

Sex: F M Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Lbs. Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
M D Y

Person Responsible for Your Account: \_\_\_\_\_ -If other than patient

Marital Status: S M P D W Number of Children: \_\_\_\_\_

Activities you enjoy: \_\_\_\_\_

How did you find out about our office? \_\_\_\_\_

Supplements (vitamins, herbs, minerals, etc.): \_\_\_\_\_

Have you received Acupuncture before? Yes No

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Normal	
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

How do these conditions impair your daily activities?

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

Other physicians/therapist seen for this condition: \_\_\_\_\_

Treatments/Medications: \_\_\_\_\_

Results: \_\_\_\_\_

PATIENT \_\_\_\_\_

DATE \_\_\_\_\_

**INSTRUCTIONS: Please only number the boxes which apply to you.**

**(1) for MILD symptoms (occurs once or twice a month)**

**(2) for MODERATE symptoms (occurs once a week)**

**(3) for SEVERE symptoms (you are aware of it almost constantly)**

**IF IT DOES NOT APPLY TO YOU LEAVE IT BLANK**

**GROUP ONE**

- |                            |                         |                             |                                  |                             |                        |
|----------------------------|-------------------------|-----------------------------|----------------------------------|-----------------------------|------------------------|
| 1 <input type="checkbox"/> | Acid foods upset        | 8 <input type="checkbox"/>  | Gag easily                       | 15 <input type="checkbox"/> | Appetite reduced       |
| 2 <input type="checkbox"/> | Get chilled, often      | 9 <input type="checkbox"/>  | Unable to relax; startles easily | 16 <input type="checkbox"/> | Cold sweats often      |
| 3 <input type="checkbox"/> | "Lump" in throat        | 10 <input type="checkbox"/> | Extremities cold, clammy         | 17 <input type="checkbox"/> | Fever easily raised    |
| 4 <input type="checkbox"/> | Dry mouth-eyes-nose     | 11 <input type="checkbox"/> | Strong light irritates           | 18 <input type="checkbox"/> | Neuralgia-like pains   |
| 5 <input type="checkbox"/> | Pulse speeds after meal | 12 <input type="checkbox"/> | Urine amount reduced             | 19 <input type="checkbox"/> | Staring, blinks little |
| 6 <input type="checkbox"/> | Keyed up – fail to calm | 13 <input type="checkbox"/> | Heart pounds after retiring      | 20 <input type="checkbox"/> | Sour stomach frequent  |
| 7 <input type="checkbox"/> | Cuts heal slowly        | 14 <input type="checkbox"/> | "Nervous stomach"                |                             |                        |

**GROUP TWO**

- |                             |  |                             |                                    |                             |                                      |
|-----------------------------|--|-----------------------------|------------------------------------|-----------------------------|--------------------------------------|
| 21 <input type="checkbox"/> | Joint stiffness after arising                  | 29 <input type="checkbox"/> | Digestion rapid                    | 37 <input type="checkbox"/> | "Slow starter"                       |
| 22 <input type="checkbox"/> | Muscle-leg-toe cramps at night                 | 30 <input type="checkbox"/> | Vomiting frequent                  | 38 <input type="checkbox"/> | Get "chilled" infrequently           |
| 23 <input type="checkbox"/> | "Butterfly" stomach, cramps                    | 31 <input type="checkbox"/> | Hoarseness frequent                | 39 <input type="checkbox"/> | Perspire easily                      |
| 24 <input type="checkbox"/> | Eyes or nose watery                            | 32 <input type="checkbox"/> | Breathing irregular                | 40 <input type="checkbox"/> | Circulation poor, sensitive to cold  |
| 25 <input type="checkbox"/> | Eyes blink often                               | 33 <input type="checkbox"/> | Pulse slow; feels "irregular"      | 41 <input type="checkbox"/> | Subject to colds, asthma, bronchitis |
| 26 <input type="checkbox"/> | Eyelids swollen, puffy                         | 34 <input type="checkbox"/> | Gagging reflex slow                |                             |                                      |
| 27 <input type="checkbox"/> | Indigestion soon after meals                   | 35 <input type="checkbox"/> | Difficulty swallowing              |                             |                                      |
| 28 <input type="checkbox"/> | Always seems hungry; feels "lightheaded" often | 36 <input type="checkbox"/> | Constipation, diarrhea alternating |                             |                                      |

**GROUP THREE**

- |                             |                                |                             |  |                             |   |
|-----------------------------|--------------------------------|-----------------------------|--|-----------------------------|---|
| 42 <input type="checkbox"/> | Eat when nervous               | 49 <input type="checkbox"/> | Heart palpitates if meals missed or delayed              | 53 <input type="checkbox"/> | Crave candy or coffee in afternoons         |
| 43 <input type="checkbox"/> | Excessive appetite             | 50 <input type="checkbox"/> | Afternoon headaches                                      | 54 <input type="checkbox"/> | Moods of depression – "blues" or melancholy |
| 44 <input type="checkbox"/> | Hungry between meals           | 51 <input type="checkbox"/> | Overeating sweets upsets                                 | 55 <input type="checkbox"/> | Abnormal craving for sweets or snacks       |
| 45 <input type="checkbox"/> | Irritable before meals         | 52 <input type="checkbox"/> | Awaken after few hours sleep – hard to get back to sleep |                             |   |
| 46 <input type="checkbox"/> | Get "shaky" if hungry          |                             |  |                             |   |
| 47 <input type="checkbox"/> | Fatigue, eating relieves       |                             |  |                             |   |
| 48 <input type="checkbox"/> | "Lightheaded" if meals delayed |                             |  |                             |   |

**GROUP FOUR**

- |                             |   |                             |   |                             |  |
|-----------------------------|---|-----------------------------|---|-----------------------------|--|
| 56 <input type="checkbox"/> | Hands and feet go to sleep easily, numbness | 63 <input type="checkbox"/> | Get "drowsy" often  | 68 <input type="checkbox"/> | Bruise easily, "black and blue" spots                                  |
| 57 <input type="checkbox"/> | Sigh frequently, "air hunger"               | 64 <input type="checkbox"/> | Swollen ankles worse at night                                     | 69 <input type="checkbox"/> | Tendency to anemia   |
| 58 <input type="checkbox"/> | Aware of "breathing heavily"                | 65 <input type="checkbox"/> | Muscle cramps, worse during exercise; get "charley horses"        | 70 <input type="checkbox"/> | "Nose bleeds" frequent   |
| 59 <input type="checkbox"/> | High altitude discomfort                    | 66 <input type="checkbox"/> | Shortness of breath on exertion                                   | 71 <input type="checkbox"/> | Noises in head, or "ringing in ears"                                   |
| 60 <input type="checkbox"/> | Opens windows in closed room                | 67 <input type="checkbox"/> | Dull pain in chest or radiating into left arm, worse on exertion. | 72 <input type="checkbox"/> | Tension under the breast-bone, or feeling of tightness" worse on exert |
| 61 <input type="checkbox"/> | Susceptible to colds and fevers             |                             |   |                             |  |
| 62 <input type="checkbox"/> | Afternoon "yawner"                          |                             |   |                             |  |

- 73  Dizziness
- 74  Dry Skin
- 75  Burning feet
- 76  Blurred vision
- 77  Itching skin and feet
- 78  Excessive falling hair
- 79  Frequent skin rashes
- 80  Bitter, metallic taste in mouth in mornings
- 81  Bowel movements painful or difficult
- 82  Worrier, feels insecure

**GROUP FIVE**

- 83  Feeling queasy; headache over eyes
- 84  Greasy foods upset
- 85  Stools light-colored
- 86  Skin peels on foot soles
- 87  Pain between shoulder blades
- 88  Use laxatives
- 89  Stools alternate from soft to watery
- 90  History of gallbladder attacks or gallstones

- 91  Sneezing attacks
- 92  Dreaming, nightmare type bad dreams
- 93  Bad breath (halitosis)
- 94  Milk products cause distress
- 95  Sensitive to hot weather
- 96  Burning or itching anus
- 97  Crave sweets

- 98  Loss of taste for meat
- 99  Lower bowel gas several hours after eating
- 100  Burning stomach sensations, eating relieves

**GROUP SIX**

- 101  Coated tongue
- 102  Pass large amounts of foul-smelling gas

- 103  Indigestion 1/2 - 1 hour after eating; may be up to 3 - 4 hrs.
- 104  Mucous colitis or "irritable bowel"
- 105  Gas shortly after eating
- 106  Stomach "bloating" after eating

- (A)**
- 107  Insomnia
  - 108  Nervousness
  - 109  Can't gain weight
  - 110  Intolerance to heat
  - 111  Highly emotional
  - 112  Flush easily
  - 113  Night sweats
  - 114  Thin, moist skin
  - 115  Inward trembling
  - 116  Heart palpitates
  - 117  Increased appetite without weight gain
  - 118  Pulse fast at rest
  - 119  Eyelids and face twitch
  - 120  Irritable and restless
  - 121  Can't work under pressure

**GROUP SEVEN**

- (C)**
- 137  Failing memory
  - 138  Low blood pressure
  - 139  Increased sex drive
  - 140  Headaches, "splitting or rending" type
  - 141  Decreased sugar tolerance

- (E)**
- 150  Dizziness
  - 151  Headaches
  - 152  Hot flashes
  - 153  Increased blood pressure
  - 154  Hair growth on face or body (female)
  - 155  Sugar in urine (not diabetes)
  - 156  Masculine tendencies (female)

- (B)**
- 122  Increase in weight
  - 123  Decrease in appetite
  - 124  Fatigue easily
  - 125  Ringing in ears
  - 126  Sleepy during day
  - 127  Sensitive to cold
  - 128  Dry or scaly skin
  - 129  Constipation
  - 130  Mental sluggishness
  - 131  Hair coarse, falls out
  - 132  Headaches upon arising wear off during day
  - 133  Slow pulse, below 65
  - 134  Frequency of urination
  - 135  Impaired hearing
  - 136  Reduced initiative

- (D)**
- 142  Abnormal thirst
  - 143  Bloating of abdomen
  - 144  Weight gain around hips or waist
  - 145  Sex drive reduced or lacking
  - 146  Tendency to ulcers, colitis
  - 147  Increased sugar tolerance
  - 148  Women: menstrual disorders
  - 149  Young girls: lack of menstrual function

- (F)**
- 157  Weakness, dizziness
  - 158  Chronic fatigue
  - 159  Low blood pressure
  - 160  Nails weak, ridged
  - 161  Tendency to hives
  - 162  Arthritic tendencies
  - 163  Perspiration increase
  - 164  Bowel disorders
  - 165  Poor circulation
  - 166  Swollen ankles
  - 167  Crave salt
  - 168  Brown spots or bronzing of skin
  - 169  Allergies - tendency to asthma
  - 170  Weakness after colds, influenza
  - 171  Exhaustion - muscular and nervous
  - 172  Respiratory disorders

**GROUP 8**

173  Apprehension  
 174  Irritability  
 175  Morbid fears  
 176  Never seems to get well  
 177  Forgetfulness  
 178  Indigestion  
 179  Poor appetite  
 180  Craving for sweets  
 181  Muscular soreness  
 182  Depression/Feeling something dreadful  
 183  Noise sensitivity  
 184  Acoustic hallucinations  
 185  Tendency to cry without reason

186  Hair is Coarse and/or thinning  
 187  Weakness  
 188  Fatigue  
 189  Skin sensitive to touch  
 190  Tendency towards hives  
 191  Nervousness  
 192  Headache  
 193  Insomnia  
 194  Anxiety  
 195  Anorexia  
 196  Inability to concentrate or Confusion  
 197  Frequent stuffy nose / sinus infection  
 198  Allergy to some foods  
 199  Loose Joints

**FEMALE ONLY**

200  Very easily fatigued  
 201  Premenstrual tension  
 202  Painful menses  
 203  Depressed feelings before menstruation  
 204  Menstruation excessive  
 205  Painful breasts  
 206  Menstruate too frequently  
 207  Vaginal discharge  
 208  Hysterectomy/ ovaries removed  
 209  Menopausal hot flashes  
 210  Menses scanty or missed  
 211  Acne, worse at menses  
 212  Depression of long standing

**Women Only:**

Regular menstrual cycle?  Y  N      Pregnant?  Y  N  
 Number of Children: \_\_\_\_\_      Number of pregnancies: \_\_\_\_\_  
 Age of first menstruation: \_\_\_\_\_      Age of menopause(if applicable) \_\_\_\_\_  
 Average number of days of flow: \_\_\_\_\_      Average number of days of entire cycle: \_\_\_\_\_

	Severe	Moderate	Slight	Normal
Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Between periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you experience any of the following?

Nausea    Food Craving    Depression    Vomiting    Headaches    Irritability

Water retention    Migraines    Anxiety    Breast tenderness

Other emotions: \_\_\_\_\_       Dull Pain, Where? \_\_\_\_\_

Sharp Pain, Where? \_\_\_\_\_

Other: \_\_\_\_\_

Please fill in the following menstrual chart: If you do not have a cycle please write N/A on the chart below.

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color: (normal, pale, bright red, rust, dark, other)							
Amount of flow: (normal, heavy, light)							
Pain/Cramps: (location, dull, sharp, other)							
Clots: ( large, small, black, purple, red, other)							
Nausea							
Vomiting							
Other							

**MALE ONLY:**

- 186  Prostate trouble
- 187  Urination difficulty or dribbling
- 188  Night urination frequent
- 189  Depression
- 190  Pain on inside of legs or heels
- 191  Feeling of incomplete bowel evacuation
- 192  Lack of energy
- 193  Migrating aches and pains
- 194  Tire too easily
- 195  Avoids activity
- 196  Leg nervousness at night
- 197  Diminished sex drive

	Severe	Moderate	Slight	Normal
<input type="checkbox"/> Swollen Testes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Testicular Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Impotence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Premature ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Feeling of coldness or numbness in external genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other comments: \_\_\_\_\_

**Patient signature:** \_\_\_\_\_

**Acupuncturist Signature:** \_\_\_\_\_



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## Acknowledgement Form

### Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that TigerLily Acupuncture and Chinese Herbal Clinic's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review TigerLily Acupuncture and Chinese Herbal Clinic's "Notice of Privacy Practices" prior to signing this document. TigerLily Acupuncture and Chinese Herbal Clinic's "Notice of Privacy Practices" has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information that will occur in my treatment, payment of my bills or in the performance of health care operations of TigerLily Acupuncture and Chinese Herbal Clinic. The Notice of Privacy Practices for TigerLily Acupuncture and Chinese Herbal Clinic is also provided on request at the front desk of this practice and on TigerLily Acupuncture and Chinese Herbal Clinic's website at [www.tigerlilyacupuncture.com](http://www.tigerlilyacupuncture.com). This Notice of Privacy Practices also describes my rights and TigerLily Acupuncture's duties with respect to my Protected Health Information.

TigerLily Acupuncture and Chinese Herbal Clinic reserve the right to change the privacy practices that are described in the "Notice of Privacy Practices". I may obtain a revised notice of privacy practices by calling TigerLily Acupuncture and Chinese Herbal Clinic's office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

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**Name of Patient or Personal Representative (Print)**

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**Signature of Patient or Personal Representative**

**Date**

---

**Description of Personal Representative's Authority**

Douglas Rutkowski, LAc.

April 14, 2005

**Name of Privacy Officer**



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**Notification Form Regarding Evaluation of Patient by Physician**

**(Pursuant to the requirement of section 183.6(e) of the title and section 6.11, Subsection (d) V. A. C. article 44956b, governing the practice of acupuncture)**

I (patient's name), \_\_\_\_\_ am notifying TigerLily  
Acupuncture and Chinese Herbal Clinic of the following:

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

**AND**

Yes\_\_ No\_\_ I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is \_\_\_\_\_, and the most recent date of chiropractic 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 to follow his advice.

---

**Patients Signature (required)**

Date

---

**If the Acupuncturist refers me to a physician, it is my responsibility and choice to follow her/his advice.**

---

**Patients Signature (required)**

Date

---

Acupuncturist's Signature

Date



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## **PATIENT INFORMATION**

### **Appointments:**

Treatments are by appointment only. If you find that you need to cancel an appointment, it is important that we receive twenty-four (24) hour notice. This enables us to fill the time slot. We reserve the right to charge a \$75.00 fee for appointments canceled with less than twenty-four hour notice or for “no show” appointments.

### **Payment for Services Rendered**

Payment is due at time of service and may be paid in *cash, check, MasterCard or Visa.*

### **Herbal Refills**

If you require a refill on an herbal formula prescribed during a previous treatment, we encourage you to make a follow-up appointment to determine if the formula is still appropriate for your current needs.

### **Insurance**

We would be happy to file your claims for you. Please indicate if you have insurance before your appointment begins so that we can copy your insurance card and check your benefits. If you have benefits for acupuncture, we will give you a clear explanation of your benefits, including number of visits/year, co-pay & deductible. If your insurance company fails to issue a payment for a treatment, you will be responsible for the prompt pay cash discount price for the visit of \$75 or \$120.

Please sign and date on the line provided below. Thank you for allowing us to provide you with a quality, low-cost alternative to traditional health care.

---

**Patient's Signature**

**Date**





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### ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of the acupuncture on me (or on the patient named below, for whom I am legally responsible) by Douglas Rutkowski and/or Vanessa Rutkowski, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (chinese massage), Chinese herbal medicine, nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax), infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns, and/or scarring are potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. 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, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effect of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of the treatment which the clinical staff thinks at the time, based upon the facts known to my best interest. I understand the results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and I have had an opportunity to ask questions. 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 SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_