



Acupuncture & Chinese Herb Clinic
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: _____

Person Responsible for Your Account: _____

Marital Status: M S 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/ therapists seen for this condition: _____

Treatment: _____

Results: _____

SYMPTOM SURVEY FORM

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

GROUP TWO

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

GROUP THREE

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

GROUP FOUR

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

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

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

FEMALE ONLY

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

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.

	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: _____



Acupuncture & Chinese Herbal Clinic

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. 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.

Name of Patient or Personal Representative (Print)

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 a 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 _____