TIGER LILY

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:** _____ **Birthday:** ____/_____/_____ **Age:** _____
Lbs. 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.	❑	❑	❑	❑	_____
2	❑	❑	❑	❑	_____
3.	❑	❑	❑	❑	_____
4.	❑	❑	❑	❑	_____

How do these conditions impair your daily activities?
_____
_____

Other physicians/therapist seen for this condition: _____

Treatments/Medications: _____

Results: _____

Support Organs & Systems

NAME ..... DATE .....

Blood Sugar

	Never	Occasionally	Often	Regularly
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Fatigue after meals	0	1	2	3
Must have sweets after meals	0	1	2	3
Forgetful; poor memory	0	1	2	3
Feel better or calmer after eating	0	1	2	3
Prone to infections and colds	0	1	2	3
History of diabetes in your family	N	Y	(4)	
Sugar (glucose) detected in urine test?	N	Y	(4)	
Hair loss under your socks?	N	Y	(10)	

Blood Sugar Total .....

GREEN	YELLOW	RED
0-10	11-24	25-45

Stomach

	Never	Occasionally	Often	Regularly
Belching, bloating, or burping	0	1	2	3
Gas quickly following a meal	0	1	2	3
Bad breath	0	1	2	3
Feel full while eating and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Stomach pain, burning, or aching 1 to 4 hours after eating	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, or caffeine	0	1	2	3
Indigestion	0	1	2	3
Abdominal bloating	0	1	2	3
Constipation	0	1	2	3
Diminished appetite	0	1	2	3

Stomach Total .....

GREEN	YELLOW	RED
0-11	12-26	27-36

Instructions
Rate each of the following symptoms to the best of your ability based on the **last 30 days**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

SIBO (Small Intestinal Bacterial Growth)

	Never	Occasionally	Often	Regularly
Abdominal distention after consumption of fiber, starches, or sugar	0	1	2	3
Abdominal distention after taking certain probiotics or other dietary supplements	0	1	2	3
Abdominal distention, bloating or a noisy gut after eating healthy vegetables	0	1	2	3
Bloating or feeling full in upper abdominal area (*just below rib cage*)	0	1	2	3

SIBO Total .....

GREEN	YELLOW	RED
0-1	2-4	5-12

Small Intestine

	Never	Occasionally	Often	Regularly
Increased gut motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Mucus in stool	0	1	2	3
Poorly formed or loose stools	0	1	2	3
Four or more large stools daily	0	1	2	3
Stools have foul odor	0	1	2	3
Suspect nutrient malabsorption	0	1	2	3
Diagnosed with Celiac Disease, Irritable Bowel Syndrome (IBS), diverticulosis/diverticulitis	0	1	2	3
Stomach cramps	0	1	2	3
Flatulence (gas)	0	1	2	3
Fiber-rich diet doesn't stop constipation	0	1	2	3
History of pimples, skin eruptions?	N	Y	(6)	
Any known food allergies?	N	Y	(6)	

Small Intestine Total .....

GREEN	YELLOW	RED
0-10	11-24	25-45

Colon

	Never	Occasionally	Often	Regularly
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or buildup of debris on tongue	0	1	2	3
Use laxatives	0	1	2	3
History of bladder and/or kidney infection	0	1	2	3
Yeast infection (including vaginal)	0	1	2	3
Fingernail and/or toenail fungus	0	1	2	3
Use of antibiotics in past year?	N	Y	(6)	

Colon Total .....

GREEN	YELLOW	RED
0-9	10-24	25-36

Leaky Gut (Intestinal Permeability)

	Never	Occasionally	Often	Regularly
Adverse reactions to foods	0	1	3	4
Unpredictable food reactions	0	2	4	6
Aches, pains, and swelling throughout your body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Food allergies	0	2	4	5
Frequent bloating and distention after eating	0	1	2	3

Leaky Gut Total .....

GREEN	YELLOW	RED
0-7	8-15	16-24

Hypothyroid

	Never	Occasionally	Often	Regularly
Tired or sluggish	0	1	2	3
Feel cold (hands, feet, or your whole body)	0	1	2	3
Require an excessive amount of sleep to function properly	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, Infrequent bowel movements	0	1	2	3
Depression or lack of motivation	0	1	2	3
Thinning or outer third of eyebrows	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dry skin and/or scalp	0	1	2	3
Slow brain processing	0	1	2	3
Lack of or diminished sex drive	0	1	2	3
Infertility or impotency	N	Y	(4)	
Heavy or profuse menstrual bleeding (women only)	0	1	2	3

Hypothyroid Total .....

GREEN	YELLOW	RED
0-11	12-22	23-40

Hyperthyroid

	Never	Occasionally	Often	Regularly
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse, even at rest	0	1	2	3
Nervous or emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Eyes appear bulging or swollen	0	1	2	3
Difficulty gaining weight	0	1	2	3

Hyperthyroid Total .....

GREEN	YELLOW	RED
0-5	6-10	11-24

Mitochondrial Dysfunction

Never Occasionally Often Regularly

History of previous infections (EBV, Lyme, etc.)	N Y (6)
Dizziness on standing up quickly	0 1 2 3
Unable to tolerate much exercise	0 1 2 3
Poor exercise or muscle stamina	0 1 2 3
Low muscle tone?	N Y (6)
Brain Fog	0 1 2 3
Difficulty focusing	0 1 2 3
Vision or hearing problems	0 1 2 3
General or chronic fatigue	0 1 2 3
Afternoon headaches	0 1 2 3
Migraines or seizures	0 1 2 3
Mood problems: anxiety, depression, or bipolar	0 1 2 3
Poor brain processing (cognition)	0 1 2 3
Blood sugar issues	0 1 2 3
Breathing problems	0 1 2 3
Overweight?	N Y (4)
Low body temperature	0 1 2 3
Intolerant to heat	0 1 2 3
Low thyroid lab numbers?	N Y (4)
Little or no skin sweating?	N Y (4)
Lack of digestive juices or undigested food	0 1 2 3
Leaky gut?	N Y (4)
Suppressed immune system?	N Y (4)
Catch colds or get sick easily?	N Y (4)
SIBO or gut dysbiosis?	N Y (4)
Reflux	0 1 2 3
Allergies	0 1 2 3
Food intolerances or sensitivities?	N Y (4)
Chronic inflammation	0 1 2 3
Cannot fall asleep	0 1 2 3
Cannot stay asleep	0 1 2 3
Slow mover in the morning (hard to get day going)	0 1 2 3
Wake up tired, even after 6 or more hours of sleep	0 1 2 3
Weak nails	0 1 2 3
Eyes sensitive to bright or direct light	0 1 2 3
Weight gain when under stress	0 1 2 3
Loss of lobido	N Y (4)

Mitochondrial Dysfunction Total .....

GREEN	YELLOW	RED
0-16	17-50	51-126

Drainage Dysfunction Susceptibility

Never Occasionally Often Regularly

Constipation (pooping one or fewer times daily)	0 1 2 3
Feel full while eating and after meals	0 1 2 3
Diminished appetite	0 1 2 3
Feeling that bowels do not empty completely	0 1 2 3
General or chronic fatigue	0 1 2 3
Mood problems:anxiety, depression, or bipolar	0 1 2 3
Poor brain processing (cognition)	0 1 2 3
Chronic inflammation	0 1 2 3
Wake up between 1 a.m. - 4 a.m.	0 1 2 3
Edema or swelling	0 1 2 3
Skin problems, rashes, itches, hives, eczema, or acne	0 1 2 3
Yellow skin, face	0 1 2 3
Suppressed immune system	0 1 2 3
Can't clear infections, despite pathogen protocols	0 1 2 3
Soreness or swollen breast tissue	0 1 2 3
Heart palpitations or irregular heartbeat	0 1 2 3
Light, sound, or EMF sensitivities	0 1 2 3
Morning stiffness	0 1 2 3
Brain fog	0 1 2 3
Swollen glands	0 1 2 3
Cellulite or flabby skin	0 1 2 3
Varicose or spider veins	0 1 2 3
Kidney problems	0 1 2 3
Breathing or lung issues	0 1 2 3
Skin doesn't sweat	0 1 2 3
Retain extra fluids	0 1 2 3

Drainage Dysfunction Total .....

GREEN	YELLOW	RED
0-14	15-35	36-78

Minerals & Electrolytes

	Never	Occasionally	Often	Regularly
Edema (swelling) in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Unable to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3
History of carpal tunnel syndrome	N	Y	(4)	
History of lower right abdominal pains or ileocecal valve problems	N	Y	(4)	
History of stress fracture	N	Y	(6)	
Bone loss (reduced density on bone scan)	0	1	2	3
Crave chocolate	0	1	2	3
Feet have a strong odor	0	1	2	3
History or anemia	0	1	2	3
Whites of the eyes (sclera) are blue-tinted	0	1	2	3
Hoarse voice	0	1	2	3
White spots on fingernails	0	1	2	3

Minerals & Electrolytes Total .....

GREEN	YELLOW	RED
0-19	20-35	36-59

Causes Parasite Infection

NAME ..... DATE .....

Parasite Infection

	Never	Occasionally	Often	Regularly
Restless sleep (toss, turn, or wake often)	0	1	2	3
Skin issues, rashes, itches, hives, eczema, or acne	0	1	2	3
Frequent diarrhea or loose stools	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
SIBO (small intestinal bacterial overgrowth), feel bloated or gassy	0	1	2	3
Bowel urgency, occasional accidents	0	1	2	3
Abdominal pains, cramps, or burning	0	1	2	3
Rectal, anal itch	0	2	4	6
Anal fissures (small, painful tears or cracks)	0	2	4	6
Gut ulcers, sores, or lesions	0	1	2	3
Grinding of teeth when asleep	0	2	4	6
Picking at nose, boring nose with finger	0	2	4	6
Excess boogers in nose and scab-like boogers	0	2	4	6
Fingernail Biting	0	1	2	3
Vertical wrinkles around mouth	0	1	2	3
Parallel lines (tracks) in soles of feet	0	1	2	3
Irritable (no apparent reason)	0	1	2	3
Mood disorder, depression, anxiety, or suicidal thoughts	0	1	2	3
Hyperactive tendency (nervous)	0	1	2	3
Dark circles under eyes	0	2	4	6
Need for extra sleep, wake unrefreshed	0	1	2	3
Allergies and/or food sensitivities	0	2	3	4
Fevers of unknown origin	0	1	2	3
Night sweats (not menopausal)	0	1	2	3
Kiss pets, allow pets to lick your face	0	1	2	4
Increase of symptoms around a full moon	0	2	6	8
Anemia (low iron/hemoglobin on blood test)	0	1	2	4
Iron deficiency	0	2	4	6
Vitamin B6 deficiency	0	2	4	6
Zinc deficiency and/or white spots on nails	0	2	4	6
Frequent colds, flu, sore throats	0	1	2	3

	Never	Occasionally	Often	Regularly
Go barefoot in garden or parks	0	1	2	4
Travel in developing nations	0	2	4	6
Eat pork products	0	1	2	3
Eat sushi, raw fish	0	2	4	6
Sleep with pets on bed	0	1	2	3
Bed-wetting	0	1	2	3
Sexual dysfunction	0	1	2	3
Forgetfulness	0	1	2	3
Slow reflexes	0	1	2	3
Loss of appetite	0	1	2	6
Hungry all the time, bottomless pit, hungry after meals	0	2	4	6
Strong sugar and processed food cravings	0	1	2	3
Yellowish skin, face	0	1	2	3
Rapid heartbeat	0	1	2	3
Heart, chest pain	0	1	2	3
Breathing problems, asthma	0	2	4	6
Pain in belly button area (umbilicus)	0	1	2	4
Blurry, unclear vision	0	1	2	3
Eye floaters	0	2	4	6
Back, thigh, or shoulder pain	0	1	2	3
Lethargy, apathy (disinterest)	0	1	2	3
Numbness, tingling in hands, feet	0	1	2	3
Menstrual problems	0	1	2	3
Dry lips	0	1	2	3
Drooling while asleep	0	1	2	3
Occult blood in stool (from lab test)	0	1	2	3
Swim in creeks, rivers, lakes	0	2	4	6
History of *Giardia*, pin worms, worms, parasites?	N	Y	6	
Do you work in childcare?	N	Y	6	
History of or currently have cancer?	N	Y	20	

Parasite Infection Total .....

GREEN	YELLOW	RED
0-46	47-96	97-264

Causes Radioactive Elements

NAME ..... DATE .....

Radioactive Elements

	Never	Occasionally	Often	Regularly
History of or currently have cancer?	N	Y	20	
Suppressed immune system?	N	Y	6	
Osteoporosis or osteopenia diagnosis?	N	Y	6	
Can't clear infections, despite following pathogen protocols?	N	Y	6	
Chronic *Candida* infection	0	2	4	6
Fatigue	0	2	4	6
Anemia	0	2	4	6
Skin (red, dry, itchy, color changes)	0	1	2	3
Hair loss	0	2	4	6
Loss of appetite	0	1	2	3
Nausea and vomiting	0	1	2	3
Low blood cell count	0	1	2	3
Seizures	0	2	4	6
Earaches or difficulty hearing	0	1	2	3
Headaches	0	1	2	3
Memory or speech problems	0	1	2	3
Cranial nerve dysfunction	0	1	2	3
Hormone problems	0	1	2	3
Sore or dry mouth	0	1	2	3
Taste changes	0	1	2	3
Difficulty swallowing	0	2	4	6
Voice changes, hoarseness	0	1	2	3
Dry eyes	0	1	2	3
Stiff jaw	0	1	2	3
Tooth decay	0	1	2	3
Heartburn or indigestion	0	1	2	3
Chronic cough	0	1	2	3
Soreness or swelling of the breast	0	1	2	3
Heart palpitations	0	2	4	6

Instructions

Rate each of the following symptoms to the best of your ability based on the **last 6 months**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

	Never	Occasionally	Often	Regularly
Irregular heartbeat	0	1	2	3
Bloating or gas	0	1	2	3
Diarrhea	0	1	2	3
Stomach ulcers	0	2	4	6
Kidney problems	0	1	2	3
Pain with bowel movements	0	1	2	3
Loss of bowel control	0	1	2	3
Bladder infection (cystitis)	0	2	4	6
Burning or pain during urination	0	1	2	3
Loss of bladder control	0	1	2	3
Fertility problems	0	1	2	3
Sexual problems (male & female)	0	1	2	3
Mental or emotional issues	0	1	2	3

Radioactive Elements Total .....

GREEN	YELLOW	RED
0-16	17-40	41-176

Causes Heavy Metal Toxicity

NAME ..... DATE .....

Instructions
Rate each of the following symptoms to the best of your ability based on the **last 6 months**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

Mercury Toxicity

	Never	Occasionally	Often	Regularly
Do you have amalgam (silver) fillings in your teeth?	N	Y		(20)
Have you ever had an amalgam removed?	N	Y		(12)
If you had amalgams removed, was it done by a biological dentist using a safe protocol?	(20)	N	Y	(4)
Were there amalgam fillings in your mother's mouth while she was pregnant with you?	(0)	N	Y	(3)
Worked in a dental office?	0	1	2	3
Did you wear contact lenses during the 1980s or early 1990s?	0	1	2	3
Did you take oral contraceptives during the 1980s or early 1990s?	0	1	2	3
Have you had flu shots?	0	1	2	3
Have you had allergy shots?	0	1	2	3
Eat tuna, shark, swordfish or Atlantic Salmon more than twice per week	0	1	2	3
Urinate frequently (during the day, night, or both)	0	1	2	3
Sleep issues	0	1	2	3
Do you have compact flourescent (CFL) bulbs in your home?	N	Y		(6)
Have you broken any CFL bulbs?	N	Y		(12)
Anxiety	0	1	2	3
Mood swings	0	1	2	3
Anger for no apparent reason	0	1	2	3
Excessive shyness, timidity, social phobia (not typical to your personality)	0	1	2	3
Irritability (not typical to your personality)	0	1	2	3
Dizzy or balance issues	0	1	2	3
Insomnia (can't get to sleep or return to sleep)	0	1	2	3
Low body temperature (below 97.5 degrees Fahrenheit or 36.4 degrees Celsius)	0	1	2	3
Sound in ears (ringing or hearing heart beat)	0	1	2	3
Psychological symptoms, even thoughts of suicide	0	1	2	3
Sound sensitivities	0	1	2	3

Mercury Toxicity Total .....

GREEN	YELLOW	RED
0-30	31-64	65-130

Lead Toxicity

	Never	Occasionally	Often	Regularly
Have lived in a home built 1978 using lead-based paint	0	2	4	6
Do home renovation, including sandblasting or moving walls	0	2	4	6
Currently live or previously lived in a mining community or area	0	2	4	6
Involved in construction, soldering, metal salvage, or stained glass	0	2	4	6
Are an electrician, handle electrical devices, electrical wiring, ballards, or TV glass	0	2	4	6
Paint or handle/make ceramics, brass, bronze, or crytal	0	2	4	6
Handle and/or reload ammunition	0	2	4	6
Read the newspaper regularly before 1985	0	2	4	6
Previously or currently consume coral calcium supplement	0	2	4	6
Wear lipstick	0	2	4	6
Previously or currently wear cosmetics containing kohl (a dark pigment that is not FDA-approved for makeup)	0	2	4	6
Are around or have a lot of fake leather or vinyl	0	2	4	6
Get your hair colored	0	2	4	6
Get stomachaches in the morning?	0	2	4	6
Eyelid swelling	0	1	2	3
Eyelid twitching	0	1	2	3
Chest or heart pain	0	1	2	3
Metallic taste in mouth	0	1	2	3
Teeth sensitivity	0	1	2	3
Bleeding gums	0	1	2	3
Bad breath	0	1	2	3
Inability to decide/indecisiveness	0	1	2	3
Overwhelmed or fearful feeling	0	1	2	3
Anemia (low iron/hemoglobin on blood test	0	1	2	3
Peeling of top layer of skin (hands, feet)	0	1	2	3
Dry skin	0	1	2	3
Depression	0	1	2	3
Dyslexia or loss of your place while reading, even as a child	0	1	2	3
Gout (arthritic pain, especially in big toes)	0	1	2	3
Pain in shoulders or upper back	0	1	2	3
Wrist or ankle drop, weak extensor muscles	N	Y	(6)	
Hair falls out (not normal male pattern baldness)	N	Y	(12)	

Mercury Toxicity Total .....

GREEN	YELLOW	RED
0-37	38-70	71-150

NAME ..... DATE .....

Biotoxin Illness

	Never	Occasionally	Often	Regularly
Shortness of breath with minimal activity	0	1	2	3
Excessive exhaustion after exercising	0	1	2	3
Excessive thirst	0	1	2	3
Morning stiffness	0	1	2	3
Irritated or red eyes	0	1	2	3
Non-restful sleep	0	1	2	3
Sensitive to light	0	1	2	3
Bad night vision or seeing halos around lights	0	1	2	3
Vision blurry	0	1	2	3
Sensitive to smells	0	1	2	3
Chronic fatigue or weakness	0	1	2	3

Biotoxin Illness Total .....

GREEN	YELLOW	RED
0-9	10-20	21-33

Instructions
Rate each of the following symptoms to the best of your ability based on the **last 6 months**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

Lyme Disease Risks

	Never	Occasionally	Often	Regularly
Ever diagnosed with Lyme Disease?	N	Y	(10)	
Dry Sockets or infected tooth extractions	0	1	2	3
Ever bitten by a tick?	N	Y	(6)	
Ever had a bullseye rash on any part of your body?	N	Y	(8)	
Mother ever diagnosed with Lyme disease?	N	Y	(6)	
Spouse/partner/significant other diagnosed with Lyme disease?	0	2	4	6
Ever diagnosed with chronic fatigue syndrome, fibromyalgia, lupus, rheumatoid arthritis (RA), multiple sclerosis (MS), or an Autoimmune condition?	N	Y	(6)	
Ever diagnosed with Parkinson's disease, Alzheimer's disease, or Tourette's Syndrome?	N	Y	(6)	
Frequently go camping, hunting, or engage in outdoor activities?	N	Y	(4)	
History of a heart murmur or valve prolapse	N	Y	(4)	

Lyme Disease Risks Total .....

GREEN	YELLOW	RED
0-9	10-18	19-59

NAME ..... DATE .....

Lyme Disease Current Symptoms

	Never	Occasionally	Often	Regularly
Arthritis-like joint pain or swelling	0	2	4	6
Pain migrates or moves around to different areas?	0	2	4	6
Forgetfulness or poor short-term memory	0	2	4	6
Confusion, difficulty thinking	0	1	2	3
Disorientation (getting lost; going to wrong places)	0	1	2	3
Difficulty with speech or writing	0	4	6	8
Tingling, numbness, burning, or stabbing sensations	0	4	6	8
Disturbed sleep: too much, too little, early awakening	0	2	4	6
Unexplained fevers, sweats, chills, or flushing	0	1	2	3
Unexplained weight change (loss or gain)	0	1	2	3
Difficulty swallowing	0	1	2	3
Fatigue, lack of energy	0	1	2	3
Sore throat or swollen glands	0	1	2	3
Pelvic or testicular pain	0	4	6	8
Crepitus (joint cracking)	0	4	6	8
Stiff neck	0	2	4	6
Twitching of facial or other muscles	0	1	2	3
Muscle pain or cramps	0	1	2	3
Costochondritis (sternum/breastbone and rib junction pain)	0	4	6	8
Right shoulder pain (AC joint)	0	1	2	3
Facial paralysis (Bell's palsy)	0	4	6	8
Unexplained menstrual irregularity	0	4	6	8
Unexplained breast milk production	0	4	6	8
Irritable bladder or bladder dysfunction	0	4	6	8
Sexual dysfunction or low libido	0	4	6	8
Blurry or double vision	0	1	2	3
Ear buzzing, ringing, or pain	0	1	2	3
Vertigo or increased motion sickness	0	4	6	8
Light-headedness, poor balance, difficulty walking	0	4	6	8

Instructions
Rate each of the following symptoms to the best of your ability based on the **last 6 months**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

	Never	Occasionally	Often	Regularly
Woozy (mentally unclear or hazy)	0	2	4	6
Tremors	0	2	4	6
Headaches	0	1	2	3
Impulsivity, aggression, or bipolar	0	1	2	3
Depression	0	1	2	3
Hallucinations, paranoia, or schizophrenia	0	2	4	6
Panic attacks	0	1	2	3
Eating disorder	0	4	6	8
Pulse skips	0	4	6	8
Skin hypersensitivity	0	2	4	6
Gastrointestinal problems	0	4	6	8
Change in bowel function	0	4	6	8
Exaggerated symptoms or worse hangover from alcohol	0	4	6	8

Lyme Disease Current Symptoms Total .....

GREEN	YELLOW	RED
0-31	32-95	96-238

NAME ..... DATE .....

Babesia

	Never	Occasionally	Often	Regularly
Abdominal pain	0	2	4	6
Air hunger (episodes of breathlessness)	0	4	8	10
Anemia (low iron/hemoglobin on blood test)	0	1	2	3
Back stiffness	0	1	2	3
Chills	0	1	2	3
Cough	0	1	2	3
Depression	0	1	2	3
Diarrhea	0	2	4	6
Disturbed sleep: frequent waking	0	4	6	8
Excessive sleepiness	0	1	2	3
Exaggerated changes in mood	0	1	2	3
Encephalophathy (*brain malfunction, brain issues*)	0	1	2	3
Fatigue, tiredness, poor stamina	0	1	2	3
Fevers	0	1	2	3
Headaches	0	1	2	3
Hemolysis (*destruction of red blood cells*)	0	2	4	6
Enlarged liver	0	2	4	6
Imbalance	0	2	4	6
Joint stiffness	0	1	2	3
Joint pain or swelling	0	1	2	3
Generalized ill feeling	0	1	2	3
Muscle pains or cramps	0	1	2	3
Nausea, vimiting	0	2	4	6
Neck stiffness, pain	0	1	2	3
Night sweats	0	1	2	3
Poor appetite	0	2	4	6
Shaking chills	0	4	6	8
Shortness of breath	0	1	2	3

Instructions
Rate each of the following symptoms to the best of your ability based on the **last 6 months**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

	Never	Occasionally	Often	Regularly
Enlarged spleen	0	1	2	3
Tachycardia	0	1	2	3
Heart palpitations, pulse skips	0	4	6	8
Unexpected fevers, sweats, chills, or flushing	0	2	4	6
Dark urine with or without blood	0	4	6	8
Weakness	0	1	2	3
Weight loss	0	1	2	3
Lymph gland swelling	0	1	2	3
Anxiety or panic attacks	0	1	2	3
Depression	0	1	2	3
Low white blood cell count on labs	0	1	2	3
Low platelet count on lab test	0	1	2	3
Elevated sedimentation (sed) rate on labs	0	1	2	3
Dizziness	0	1	2	3
Feeling spacey	0	1	2	3

Babesia Total .....

GREEN	YELLOW	RED
0-29	30-70	71-180

NAME ..... DATE .....

Bartonella

	Never	Occasionally	Often	Regularly
Abdominal pain	0	2	4	6
Anemia (low iron/Hemoglobin on blood test)	0	1	2	3
Anxiety	0	2	4	6
Back stiffness	0	1	2	3
Chills	0	1	2	3
Disturbed sleep: too much, too little, fractured, early awakening	0	1	2	3
Ear buzzing, ringing, pain, sound sensitivity	0	2	4	6
Brain dysfunction	0	1	2	3
Hemolysis (destruction of red blood cells)	0	2	4	6
Endocarditis	0	2	4	6
Myocarditis	0	2	4	6
Fatigue, tiredness, poor stamina	0	1	2	3
Low-grade fever	0	2	4	6
Headaches	0	1	2	3
Enlarged liver	0	2	4	6
Immune deficiency	0	2	4	6
Feeling of coming down with the flu	0	2	4	6
Insomnia	0	1	2	3
Jaundice (yellowing of skin)	0	4	6	8
Joint pain or swelling	0	1	2	3
Lymph nodes swollen	0	4	6	8
Generalized ill feeling	0	1	2	3
Muscle pains or cramps, especially in calves	0	4	6	8
Foot pain or plantar fasciti-typs pain (heels or soles of the feet)	0	4	6	8
Stretch mark-like rash (not from overweight)	0	6	8	12
Maculopapular rash (small red bumps)	0	4	6	8
Spider veins	0	2	4	6
Seizures	0	4	6	8
Sleepiness or drowsiness	0	2	4	6

Instructions
Rate each of the following symptoms to the best of your ability based on the **last 6 months**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

	Never	Occasionally	Often	Regularly
Sore throat	0	2	4	6
Enlarged spleen	0	2	4	6
Shinbone pain	0	4	6	8
Tremors	0	2	4	6
Twitching of facial muscles	0	2	4	6
Upset stomach or abdominal pain	0	2	4	6
Weight loss	0	1	2	3
Eyes: blurred vision, red eyes, dry eyes, depth perception issue, light sensitivity	0	2	4	6
Anxiety, panic attacks, or excessive worry	0	2	4	6
Obsessive-compulsive disorder (OCD)	0	4	6	8

Bartonella Total .....

GREEN	YELLOW	RED
0-29	30-79	80-223

Causes Mold

NAME ..... DATE .....

Mold

Never Occasionally Often Regularly

See mold growing at home, work, or school?	N Y:10
Ever experience water damage at home, work, or school?	N Y 4
Home, workplace or school has a damp or mildewy odor	0 1 2 3
Spending time in basement causes or worsens symptoms	0 1 2 3
Basement ever wet?	N Y 4
Symptoms decrease when spend time in a different location for at least a few days	N Y 4
Plumbing in your kitchen or bathroom leaks or has leaked in the past	N Y 4
Wet spots anywhere near your home (whether currently or past)	N Y 4
Often see condensation (fog) on the inside of windows and/or cold inside surfaces in your home	N Y 4
Car has a mildewy smell	N Y 4
Brain fog	0 1 2 3
Reactions to supplements opposite of expected	0 1 2 3
Nosebleeds	0 1 2 3
Body rashes	0 1 2 3
Any skin conditions	N Y 4
Does anyone in your home have asthma-like symptoms?	N Y 4
Sinus infections	0 1 2 3
One or more family members have chronic sinus infections or irritations	0 1 2 3
Runny, blocked, or stuffy nose	0 1 2 3
Experience static shocks	0 1 2 3
Wheezing or whistling in your chest	0 1 2 3
Wake up in the morning with a feeling of tightness in your chest	0 1 2 3
Wake up during the night with shortness of breath	0 1 2 3
Shortness of breath when you're not doing anything strenuous	0 1 2 3

Instructions

Rate each of the following symptoms to the best of your ability based on the **last 6 months**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

Never Occasionally Often Regularly

Wake up during the night with an attack of coughing	0 1 2 3
Chest tightness when around animals or a dusty part of the house	0 1 2 3
Achy all over	0 1 2 3
Headaches	0 1 2 3
Extreme or unusual fatigue	0 1 2 3
Hoarse voice	0 1 2 3
Memory loss	0 1 2 3
Difficulty recalling names of people you know	0 1 2 3
Nausea	0 1 2 3
Vomiting	0 1 2 3

Mold Total .....

GREEN	YELLOW	RED
0-19	20-60	61-118

Causes General Toxicity

NAME ..... DATE .....

General Toxicity

Never Occasionally Often Regularly

Live on or near a gulf course?	N Y (4)
Live near a freeway or high-tension wires?	N Y (4)
Wear conventional sunscreen?	N Y (4)
Wear perfume or cologne?	N Y (4)
Use air fresheners in your house, car, or workplace?	N Y (4)
Were you the first-born child?	N Y (4)
Receive static shocks (doorknob, car, light switch, other people, etc.)	0 1 2 3
Headaches or migraines	0 1 2 3
Word reversal or trouble finding words	0 1 2 3
Sensitivity to skin or touch	0 1 2 3
Poor short-term memory	0 1 2 3
Chronic sinus issues or congestion	0 1 2 3
Difficulty losing weight regardless of diet or exercise	0 1 2 3
Excessive perspiring during day or night	0 1 2 3
Cold extremities (hands and feet)	0 1 2 3
Issues processing new information	0 1 2 3
Chronic fungal viral infection, including *Candida*, foot fungus, warts, or jock itch	0 1 2 3
Get sick often	0 1 2 3
Weakness or numbness in extremities	0 1 2 3
Joint pain	0 1 2 3
Muscle cramps, aches, sharp pains	0 1 2 3
Muscle twitching	0 1 2 3
Stomach pain	0 1 2 3
Appetite swings	0 1 2 3
Rashes or rosacea	0 1 2 3

General Toxicity Total .....

GREEN	YELLOW	RED
0-19	20-50	51-81

Are any of the following current or past occupations or hobbies?

- ☐ Agricultural product handler
- ☐ Asbestos abatement technician
- ☐ Auto mechanic
- ☐ Battery manufacturer
- ☐ Battery recycler
- ☐ Canning paint worker
- ☐ Carpenter
- ☐ Ceramic manufacturer
- ☐ Construction laborer or worker
- ☐ Cosmetic manufacturer
- ☐ Cosmetologist
- ☐ Dental assistant
- ☐ Dental lab worker
- ☐ Dentist
- ☐ Diesel equipment mechanic
- ☐ Dynamite manufacturer or Dynamiter
- ☐ Electronic assembly worker
- ☐ Electronic component manufacturer
- ☐ Electroplater
- ☐ Engraver
- ☐ Explosive expert
- ☐ Fertilizer manufacturer
- ☐ Fiberglass installer
- ☐ Fiberglass manufacturing worker
- ☐ Firefighter
- ☐ Firing range operator
- ☐ Fisherman
- ☐ Fluorescent tube manufacturer
- ☐ Foundry worker
- ☐ Glass manufacturing worker
- ☐ Glassblower
- ☐ Grinding Operator
- ☐ Hairdresser
- ☐ Hazardous material worker
- ☐ Ink manufacturer
- ☐ Jeweler
- ☐ Laboratory worker
- ☐ Landfill worker
- ☐ Landscaper
- ☐ Lumber processor
- ☐ Lumber yard worker
- ☐ Metal recycler
- ☐ Metal sculptor
- ☐ Miner
- ☐ Nail technician
- ☐ Paint manufacturer
- ☐ Painter - Residential / commercial
- ☐ Painter - Fine Arts
- ☐ Pharmaceutical worker
- ☐ Plastic product manufacturer
- ☐ Plumber
- ☐ Plumbing supply manufacturer
- ☐ Policeman
- ☐ Potter
- ☐ Preservative manufacturer
- ☐ Printer
- ☐ Search and rescue worker
- ☐ Ship repairer
- ☐ Shooting instructor
- ☐ Smelting paint worker
- ☐ Solderer
- ☐ Tanner
- ☐ Tattoo artist
- ☐ Truck mechanic
- ☐ Waste handler
- ☐ Welder
- ☐ Well digger

If you checked any of the above, you are at an increased risk of heavy metal toxicity.

FEMALE ONLY

- ☐ Very easily fatigued
- ☐ Premenstrual tension
- ☐ Painful menses
- ☐ Depressed feelings before menstruation
- ☐ Menstruation excessive
- ☐ Painful breasts
- ☐ Menstruate too frequently
- ☐ Vaginal discharge
- ☐ Hysterectomy/ ovaries removed
- ☐ Menopausal hot flashes
- ☐ Menses scanty or missed
- ☐ Acne, worse at menses
- ☐ 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	❑	❑	❑	❑
Bleeding Between periods	❑	❑	❑	❑

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
❑ Swollen Testes	❑	❑	❑	❑
❑ Testicular Pain	❑	❑	❑	❑
❑ Impotence	❑	❑	❑	❑
❑ Premature ejaculation	❑	❑	❑	❑
❑ Feeling of coldness or numbness in external genitalia	❑	❑	❑	❑
❑ Other: _____	❑	❑	❑	❑

Other comments: _____

Patient signature: _____

Acupuncturist Signature: _____

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

Acknowledgement Form

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that TigerLily Wellness & Acupuncture's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review TigerLily Wellness & Acupuncture's "Notice of Privacy Practices" prior to signing this document. TigerLily Wellness & Acupuncture'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 Wellness & Acupuncture. The Notice of Privacy Practices for TigerLily Wellness & Acupuncture is also provided on request at the front desk of this practice and on TigerLily Wellness & Acupuncture's website at www.tigerlilyacupuncture.com. This Notice of Privacy Practices also describes my rights and TigerLily Wellness & Acupuncture's duties with respect to my Protected Health Information.

TigerLily Wellness & Acupuncture 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 Wellness & Acupuncture'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 of Personal Representative **Date**

_____

Description of Personal Representative's Authority

Douglas Rutkowski, LAc. April 14, 2005

Name of Privacy Officer **Date**

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

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 Wellness & Acupuncture 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.

_____

Patient's Signature (required) Date

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

_____

Patient's Signature (required) Date

_____

Acupuncturist's Signature Date

TIGER LILY
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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 forty-eight (48) hour notice. This enables us to fill the time slot. We reserve the right to charge a $100 fee for acupuncture and $75 fee for Autonomic Response Testing (ART) for appointments canceled with less than twenty-four hour notice or for "no show" appointments.

Scheduling
In order to be considered an established patient in our clinic, a scheduled future appointment is required. At the conclusion of every appointment, you will be rescheduled for your next appointment based on the doctor's discretion and your availability.

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 send you receipts for you to file with your insurance. Please let us know when you check out or before you leave the clinic.

Acupuncture and ART Care Plans
Most patients purchase Care Plans for Acupuncture and Autonomic Response Testing (ART) sessions because discounts are applied to the session cost. If you should ever need to seek a refund for a Care Plan, your treatments will be re-priced at the regular session price ($100 for acupuncture and $75 for ART) and your refund will be the balance remaining.

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**

TIGER LILY

WELLNESS & ACUPUNCTURE

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

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, Tiu-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 of 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 abut the risks ad 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**_____