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: _____

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: _____

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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**

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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 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

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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
C***ash, MasterCard, Visa, American Express & Discover.***

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**

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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, 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**_____