Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, AOMA is required to have you respond affirmatively to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no.

(Pursuant to the requirements of section 183.10(a)(11) of this title and section 205.302 V.A.C.$ article 4495b, governing the practice of acupuncture)

I (patient's name) ______________________________________
am notifying the AOMA Graduate School of Integrative Medicine of the following:

___ Yes ___ No I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

___ Yes ___ No I have received a referral from my chiropractor within the last 30 days for acupuncture. The date of the referral is ______, and the most recent date of 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 whether to follow this advice.

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

___ Chronic Pain
___ Smoking addiction
___ Weight loss
___ Alcoholism
___ Substance abuse

Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

______________________________  __________________________
Patient Signature Required                Date

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

______________________________  __________________________
Patient Signature Required                Date

______________________________  __________________________
Acupuncturist’s Signature                Date

The AOMA Graduate School of Integrative Medicine is not responsible for untrue statements made by patients.
HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the AOMA Graduate School of Integrative Medicine (AOMA) “Notice of Privacy Practices”. I understand that I have the right to review AOMA’s “Notice of Privacy Practices” prior to signing this document.

I understand that AOMA staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

I also understand that my clinical information may be used for educational and/or research purposes by AOMA or individuals authorized by AOMA. All information that can identify me personally will be removed.

By signing this form, I am giving AOMA authorization to contact me and am giving my informed consent to utilize my information for research and educational purposes. I acknowledge that all information discussed during the assessment and treatment at AOMA Clinics will be held confidential except in the instance where my safety or the safety of others may be at risk.

________________________________________________
Patient Name (print)  ______________________________
Date

________________________________________________
Patient Signature  ______________________________
AOMA Privacy Rep/Date

Authorization for Release of Health Information (Optional)

I, __________________________________________, hereby authorize the AOMA Graduate School of Integrative Medicine the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

________________________________________________
________________________________________________
________________________________________________
________________________________________________

________________________________________________
Patient’s Signature  ______________________________
Date
INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the student interns and/or the licensed acupuncturists on staff at the AOMA Graduate School of Integrative Medicine (AOMA) who now or in the future treat me while employed by, working or associated with or substituting for AOMA, including those working at this clinic or any other associated clinics: acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with my student interns, professional practitioners, and/or with other clinic personnel the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from those locations; nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I understand that acupuncture and Oriental medicine treatments may not have the desired therapeutic affect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is reasonable cause to believe that treatment is not appropriate for a patient who is under the influence of illegal drugs, alcohol, or appears to be overly medicated, then a treatment may not be performed at that time. The patient will be informed that they may not be treated at that time and will be requested to reschedule their appointment.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures and conditions of treatment. 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 at the AOMA clinic.

______________________________  ______________________________
Patient’s name (please print)  Patient’s signature

______________________________  ______________________________
Print Name of Patient’s Representative (if applicable)  Relationship or Authority of Patient’s Rep.

______________________________  ______________________________
Signature of Patient’s Representative (if applicable)  Date Signed
**Patient Intake Form**

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

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<th>Mr.</th>
<th>Mrs.</th>
<th>Ms./Miss</th>
<th>Dr.</th>
<th>He/His</th>
<th>She/Her</th>
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<th>Today’s date</th>
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<td>If yes, name of insurance company</td>
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<td>Does your insurance cover acupuncture?</td>
<td>Yes</td>
<td>No</td>
<td>Who is your employer?</td>
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**Main problem(s):**

___________________________________________________________________________________________

What diagnosis, if any, have you received for this problem? _________________________________________________________________________

When did this problem begin? __________ What are the causes of this problem? _________________________________________________________________________

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _________________________________________________________________________

What kind of treatment have you tried? _________________________________________________________________________

What makes this problem worse? _________________________________________________________________________

What makes this problem better? _________________________________________________________________________

Is there anybody in your family with the same/similar problems? _________________________________________________________________________

Remarks and additional information: _________________________________________________________________________

**Medical History** (Please include the month/year when the event occurred or when the diagnosis was established)

**Surgeries:** _________________________________________________________________________ **Hospitalization:** _________________________________________________________________________

**Significant trauma:** (auto accidents, sports injuries, etc) _________________________________________________________________________

**Allergies:** (drugs, chemicals, foods, environmental): _________________________________________________________________________
Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):


Occupation: __________________________ Do you usually work indoors outdoors?

Occupational stress (chemical, physical, psychological, etc):


Personal

Height___________ Weight now___________ Weight one year ago___________

Weight maximum ________ @Year


Habits

Do you smoke?  Yes  No  What? ___________ How many per day? _______ Since when? _______

Please describe any use of drugs for non-medical purposes:


Do you exercise regularly?  Yes  No  Please describe your exercise program:

How many hours do you sleep in general? _______  What time do you usually go to bed? _______

Diet

How much coffee do you drink? _______ cups/day  Colas _______ number/day  Tea _______ cups/day

What kind of alcoholic beverages do you usually drink, if any? _______  Average number of drinks/week? _______

How much water do you drink per day? _______

Are you a vegetarian?  Yes  No  Yes, but not so strict  Do you eat a lot of spicy food?  Yes  No

Remarks and additional information (e.g. diet) _____________________________________________________________

Indicate pain level and/or painful or distressed areas:


Wong-Baker FACES® Pain Rating Scale

0  2  4  6  8  10

No Hurt  Hurts Little Bit  Hurts Little More  Hurts Even More  Hurts Whole Lot  Hurts Worst
<table>
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<th>Self</th>
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<th>Self</th>
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<td>Cancer (what type)</td>
<td>Breathing problems</td>
<td>Tuberculosis</td>
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<td>Diabetes</td>
<td>Heart disease</td>
<td>High cholesterol</td>
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<td>Hepatitis</td>
<td>Digestive disorders</td>
<td>High blood pressure</td>
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<td>Thyroid disease</td>
<td>Venereal disease</td>
<td>Emotional disorders</td>
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<td>Seizures</td>
<td>Alcoholism</td>
<td>Anemia</td>
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<td>Arthritis</td>
<td>Depression or anxiety</td>
<td>Other</td>
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Please check if you have or have had (in the last three months) any of the following diseases or conditions.

**General**
- Poor appetite
- Sweat easily
- Bleed or bruise easily
- Desire hot food
- Night sweats
- Fatigue
- Localized weakness
- Desire cold food
- Strong thirst (cold or hot drinks)
- Sudden energy drop (What time of day) __________
- Favorite time of year __________
- Worst time of year __________

**Skin & hair**
- Rashes
- Ulcerations
- Hives
- Night sweats
- Sweating easily
- Itching
- Relaxation
- Other?

**Musculoskeletal**
- Joint disorders
- Muscle weakness
- Pain/soreness in the muscles
- Swelling of hands/feet
- Back pain
- Sinus problems
- Chest pain
- Gravelly
- Neck pain
- Shoulder pain
- Numbness
- Tingling
- Paralysis
- Neck tightening
- Spinal curvature
- Knee pain
- Other
- Tingling
- Paralysis
- Neck tightening
- Spinal curvature
- Knee pain
- Other
- Tingling
- Paralysis
- Neck tightening
- Spinal curvature
- Knee pain
- Other

**Head, eyes, ears, nose, and throat**
- Dizziness
- Concussions
- Migraines
- Glasses/contacts
- Eye strain
- Eye pain
- Color blindness
- Night blindness
- Poor vision
- Cataracts
- Blurry vision
- Earaches
- Ringing in ears
- Poor hearing
- Spots in front of eyes
- Sinus problems
- Nose bleeding
- Sore throat
- Grinding teeth
- Teeth problems
- Facial pain
- Sinus problems
- Nose bleeding
- Sore throat
- Grinding teeth
- Teeth problems
- Facial pain
- Jaw clicks
- Sores on lips/tongue
- Difficulty swallowing
- Other
- Jaw clicks
- Sores on lips/tongue
- Difficulty swallowing
- Other

**Cardiovascular**
- High blood pressure
- Low blood pressure
- Chest pain
- Palpitation
- Fainting
- Phlebitis
- Irregular heartbeat
- Rapid heartbeat
- Varicose veins
- Other
- Respiratory
- Cough
- Coughing blood
- Wheezing
- Difficulty breathing
- Bronchitis
- Pneumonia
- Chest pain
- Production of phlegm – What color? ______

**Gastrointestinal**
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Gas
- Belching
- Black stools
- Blood in stools
- Indigestion
- Bad breath
- Rectal pain
- Hemorrhoids
- Abdominal pain/cramps
- Gallbladder problems
- Parasites
- Chronic laxative use
- Bowel movements: Frequency ________ Color ________ Odor ________ Texture/ Form __________________
<table>
<thead>
<tr>
<th>Neuro-psychological</th>
<th>Loss of balance</th>
<th>Lack of coordination</th>
<th>Concussion</th>
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<tbody>
<tr>
<td>Depression</td>
<td>Anxiety</td>
<td>Stress</td>
<td>Bad temper</td>
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<tr>
<td>Genito-urinary</td>
<td>Painful urination</td>
<td>Frequent urination</td>
<td>Blood in urine</td>
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<td>Kidney stones</td>
<td>Unable to hold urine</td>
<td>Dribbling</td>
<td>Pause of flow</td>
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<td>Genital pain</td>
<td>Genital itching</td>
<td>Genital rashes</td>
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<td>Bi-polar</td>
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**Reproductive**

Sex assigned at birth: Male  Female  Gender reassignment operation(s) ________________________________

Frequent vaginal infections  Pelvic infection  Endometriosis  Vaginal/genital discharge

Fibroids  Ovarian cysts  Irregular periods  Clots  Pain/cramps prior/during periods

Breast tenderness  Breast Lumps  Fertility Problems  Hot flashes  Moodiness related to periods

_____ Number of pregnancies  _____ Number of births  _____ Miscarriages  _____ Abortions

_____ Premature births  _____ C-sections  _____ Difficult deliveries

Date of last menstrual period _____________  Are you currently, or could you possibly be, pregnant?  Yes  No

Age of first menstrual period ________  Duration of periods ______ days  Duration of cycle ______ days

Do you practice birth control?  Yes  No  If yes, what type and for how long? ________________________________

If you’re taking oral contraceptives, what are you taking and for how long? ________________________________

<table>
<thead>
<tr>
<th>Prostate problems</th>
<th>Discharge</th>
<th>Erectile dysfunction</th>
<th>Ejaculation problems</th>
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</thead>
<tbody>
<tr>
<td>Frequent seminal emission</td>
<td>Fertility problems</td>
<td>Painful/swollen testicles</td>
<td>Other</td>
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</table>

I have completed this form correctly to the best of my knowledge.

**Signature:**

Adult Patient  Parent or Guardian  Spouse

**Are there any other health issues you want to discuss with us?**

Signature  Date