

Dear New Patient,

I am happy to welcome you as a new patient to my clinic. It was built on a deep love for this medicine and it has been my dream to do this work since I was 15 years old. As an acupuncturist and herbalist I offer an integrated approach to healthcare. I give acupuncture and herbs as appropriate to your condition. Sometimes you may need one or the other, sometimes you may need both. I always include nutrition suggestions for all conditions as well as lifestyle ideas that may quicken your healing.

I prefer that all of my patients take certain supplements and greens for their overall health. I take these things myself as well as give them to my own family. It is because of this, I know them to be effective, not only to speed up the recovery of your condition, but so that you can experience vibrant health.

I carry only the highest quality pharmaceutical grade herbs and supplements on the market. They are all natural and contain no fillers. They are screened for pesticides, heavy metals, and other hazardous substances. The companies that I use as vendors all have excellent reputations in the alternative medicine community. The needles that I use are no thicker than a human hair. They come in sterile packages and discarded after use.

Enclosed are the intake forms for you to fill out and bring to your 1st appointment. The initial consultation typically lasts about 1 1/2 hours. I recommend eating a nutritious meal within 1 1/2 hours of the appointment due to the strong effect that acupuncture has on the body. I also request that you wear comfortable loose fitting clothes so that I will be able to access the points I need and so you will be able to rest comfortably during the treatment!

Thank you for choosing me as your acupuncturist. I look forward to treating you.

Debbie Vaughn, L.Ac

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Traditional Chinese Medicine Health Profile

Welcome new patient! All of the information you provide is confidential. Please fill this form out as completely as you can. Some questions may seem unrelated to your condition but they will be helpful in determining your diagnosis and treatment plan.

Name: _____ Date: ____/____/____

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____

Email Address: _____

Emergency contact and Phone # _____

Age: ____ Date of Birth: ____/____/____ Occupation: _____

Male ____ Female ____ Height: ____/____ Weight: _____ lbs.

Marital Status: _____ Number of Children: _____

How did you hear about the clinic? _____

Have you been evaluated by a Medical Doctor for this condition?

List the medications/supplements you are currently taking:

Medicine/Supplement	Dose	Reason	How long?	Prescribed by	Date of last check-up

What health concerns would you like to treat with Chinese Medicine? Please rank the severity of your symptoms on a scale of 1-10, with 10 being the most severe.

Symptom	1-10
1. _____	____
2. _____	____
3. _____	____
4. _____	____
5. _____	____

How do these symptoms affect your daily life?

Lab Results: (Include copies)

Do you have allergies, food sensitivities or strong cravings for certain foods?

Have you had any accidents, surgeries or hospitalizations? (Include dates).

How was your health as a child? _____

How do you feel about these areas of you life?

	Great	Good	Ok	Poor	Bad	Comments
Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Mark the symptoms that you have experienced in the last 6 months:

Qi Xu

- Fatigue
- Easily catch colds
- Shortness of breath
- Feel worse after exercise
- Prolonged recovery from illnesses
- Pale complexion
- Perspire easily
- Hemorrhoids
- Varicose veins

Xue Xu

- Dizziness
- Pale Complexion
- Insomnia
- Blurred Vision
- See floating spots
- Light headed
- Muscle cramps
- Dry skin, nails, hair
- Dry or hard stool

Gan Mai

- Short temper
- Dry eyes
- Frustration
- Alternating constipation/diarrhea
- Frequent sighing
- Bitter/metallic taste in the mouth

Xin Mai

- Anxiety/nervousness
- Palpitations
- Laugh and cry easily
- Easily overheat/perspire
- Insomnia
- Vivid dreams/nightmares

- | | |
|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Wake up un-refreshed |
| <input type="checkbox"/> High pitched ringing in the ears | <input type="checkbox"/> Sores of mouth and tongue |
| <input type="checkbox"/> Brittle nails and hair | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Headaches at the top of the head | <input type="checkbox"/> Mental confusion |
| <input type="checkbox"/> Numbness/tingling sensations | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Easily startled/timid |
| <input type="checkbox"/> Sexually transmitted disease, which? _____ | |

Pi Mai

- Bruise easily
- Loose stools/diarrhea
- Gas and bloating
- Hard to regulate weight
- Constant worrying
- Lack of muscle tone/strength
- Fatigue after eating
- Poor appetite
- Irritable Bowel Syndrome
- Eat irregularly or too quickly
- Water retention

Shen Mai

- Low sexual appetite
- Tend to overwork
- Infertility
- Sore low back
- Sore knees
- Low pitched ringing in ears
- Wake up to urinate at night
- Incontinence
- Bone/teeth problems
- Last in birth order
- Decline in vision/hearing

Fei Mai

- Sinus problems
- Asthma
- Chronic cough
- Constant phlegm in chest, throat
- Low resistance to colds or flu
- Skin problems

Shi

- Feel achy/heavy
- Mental Fogginess
- Edema/swelling
- Nausea
- Urinary difficulty
- Urinary tract infections

Yin xu

- Hot flashes
- Night sweats
- Heat in hands, feet and chest
- Crave cold foods/drinks

Yang xu

- Feel cold, chilly
- Cold feet
- Diarrhea- undigested food
- Crave warm foods/drinks

Family Medical History: List any significant illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders

Mother: _____

Father: _____

Siblings: _____

Grandparents: _____

Lifestyle

- How often do you exercise? What kind? _____

- What time do you typically wake up and go to sleep? _____

- What do you usually eat for:

- * Breakfast: _____

- * Lunch: _____

- * Snack: _____

- * Dinner: _____

- What do you do to deal with stress? Do you have enough time for these things?

- Indicate the use and frequency of the following:

	Yes	No	How much?		Yes	No	How Much?
Coffee				Water			
Tobacco				Soda			
Alcohol				Recreational Drugs			

Women

Age of 1st period: ___ Regular periods? ___ # days of menstrual flow: _____

days between periods: _____ Average # pads: 1st day ___ 2nd day _____

Do you have clots? _____ Size: _____ Severe cramps? _____

Do you take birth control pills? _____ Do you bleed between periods? _____

Pregnant? _____ # of Pregnancies: _____ # of Children: _____

Endometriosis: _____ Fibroids: _____ Ovarian cysts?: _____

Do you have any of these PMS symptoms?

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Water retention | <input type="checkbox"/> Headaches | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Migraines | <input type="checkbox"/> Depression |

Other: _____

Age of menopause (if applicable): _____

Men

Prostate problems Delayed stream Dribbling urination

Impotence Premature ejaculation Rectal dysfunction

Coldness or numbness in genitals Testicular pain

Other: _____

Informed Consent for Acupuncture Treatment

I consent to the performance of acupuncture and other oriental medicine procedures on me (or on the patient named below for whom I am legally responsible).

I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that lasts a few days.

There have been very rare instances reported of fainting, usually due to a patient being treated on an empty stomach. There have been extremely rare instances of spontaneous miscarriage and pneumothorax.

The herbs and nutritional supplements are considered safe in the practice of Chinese Medicine. Some herbs are inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions, I will call right away.

I understand that my medical records will be kept confidential and will not be released to a third party without my written consent.

I understand that payment is due at the time of service and that if I wish to file with my insurance, I must still pay Debbie Vaughn, L.Ac. in full. A receipt with procedure and ICD-9 codes will be provided at my request. I understand that 24 hour notice is required for cancellations and that otherwise I will be charged the full price of the visit.

I am notifying the Acupuncturist, Debbie Vaughn, L.Ac. of the following:

Yes No I have been evaluated by a physician or dentist 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. _____ (initials)

Yes No I have received a referral from my chiropractor within the last 30 days for acupuncture.

After being referred by a chiropractor, after 30 days or 20 treatments, whichever comes first, if no substantial improvement occurs, I understand that the Acupuncturist is required to refer me to a physician. It is my responsibility and **choice** whether to follow this advice.

Patient's Name (print) _____

Signature _____

Date _____

Name of patient's representative (if applicable) _____

Representative's signature _____

Fee Schedule

New Patient Visit	\$90 (Includes consultation and treatment)
Follow-up Treatments	\$70
Consultation	\$70 per hour
Package Discount	\$300 for 5 treatments (15% off)

Many insurance companies provide benefits for acupuncture. I will gladly provide you with a receipt that displays the appropriate billing codes. You can then submit the receipt to your insurance company for reimbursement.

Payment Policy

Payment is required in full at the time of service in the form of cash and checks.

Cancellation Agreement

I look forward to treating you. The time you schedule is reserved just for you. There is a \$25 fee for missed appointments or cancellations without **24 hour** notice.

Referral Policy

I reserve the right to refuse treatment at any time if I feel that the treatment is inappropriate to either myself or the patient. If such a case occurs, I will refer you to the most appropriate place to continue seeking healthcare.

I have read, understand and agree to the above conditions.

Signature

Date