APRIL BUI HOLISTIC ACUPUNCTURE | APRIL BUI, LAC | TEXAS LICENSE NO. AC01093
9039 Katy Freeway . Suite 504 . Houston, Texas 77024
713-922-3474 . acu.inquiry@gmail.com . www.abui-acupunctureclinic.com

Patient Information Confidential

- FULL LEGAL NAME as appeared on your driver license, state-issued ID, or passport.
  Not accepted – aliases, diminutives, nicknames, spiritual names, baptismal names, etc.

  Last: _____ First: _____ Middle: _____

- Date of Birth _____

- Gender ☐Male ☐Female

- Phone mobile _____

  Alternate phone _____

- Email _____

- Address _____

  City_____ State_____ Zip_____

- Emergency contact's name _____

  Phone _____ Relationship _____

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PATIENT'S NAME: (Last) (First) (Middle)

MEDICATIONS & SUPPLEMENTS

Please list all medications and supplements which you are currently taking, whether or not your medications and supplements directly relate to the condition(s) which you're seeking treatment with us. **It is your responsibility to fully disclose all your medications and supplements so that we can properly evaluate, diagnose, and administer your treatment as well as to avoid potential herb-drug adverse interactions.**

Medications, prescribed or over-the-counter:	Purpose:	How long:

Supplements include vitamins, minerals, herbs, prescribed or over-the-counter:

- Surgeries in the past three years: Date

  _____
  _____

- Are you wearing a pacemaker? ☐No ☐Yes Other devices or implants :

  _____

- Are you allergic to any type of oil or fragrance? Other known allergies:

  _____ _____

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(✓) All that applies currently or within the past year:

__Heart disease	__Seizures	__IBS	__Sleep disorders
__Stroke	__COPD	__Crohn's disease	__Bell's palsy
__High blood pressure	__Allergies	__Diverticulitis	__Anemia
__Low blood pressure	__Sinus disorders	__Ulcer	__Hemophilia
__High cholesterol	__Bronchitis	__Gastritis	__Renal failure ☐left ☐right
__Hyperglycemia	__Cold/Flu	__Cataracts	__Urinary tract infection
__Hypoglycemia	__Asthma	__Glaucoma	__Shingles
__Diabetes	__Arthritis-rheum	__Headaches	__Hepatitis ☐A ☐B ☐C ☐D ☐E
__Chronic fatigue	__Arthritis-osteo	__Migraines	__Herpes: ☐genital ☐oral
__Hypothyroid	__Gout	__Liver fatty	__STD, type:_____
__Hyperthyroid	__Hernia hiatal	__Liver enlarged	__HIV+: cd4_____ viral_____
__Fibromyalgia	__Hernia inguinal	__Multiple sclerosis	__AIDS: cd4_____ viral_____

__Tumor, where:_____ ☐benign ☐malignant, provide details in Cancer Section

__Thrombo-phlebitis	__Dizziness	__Acne	__Anal sores, eruptions
__Hair loss excessive	__Vertigo	__Hives/Rashes	__Rectal prolapse
__Excessive sweating	__Varicose veins	__Eczema	__Gallstones
__Excessive heat	__Edema	__Psoriasis	__Parasites/worms_____
__Indigestion/bloating	__Poor appetite	__Diarrhea chronic	__Heart palpitations
__Acid reflux/heartburn	__Excessive hunger	__Constipation	__Chest pain
__Abdominal pain	__Excessive thirst	__Blood in stool	__Difficult breathing ☐wheezing
__Nausea/vomit	__Foul breath	__Hemorrhoids	__Chronic cough ☐dry ☐phlegm

__Urinary incontinence	__Painful urination	__Cloudy urine	__Pressure, stuffiness in ears
__Night urination excessive	__Copious urine	__Bladder prolapse	__Teeth/gum problems, chronic
__Hesitant urination	__Scanty urine	__Stones kidney	__Vision, very poor
__Strong odor in urine	__Blood in urine	__Stones bladder	__Hearing, very poor
__Burning urination	__Dark urine	__Ringing in ears	__Deafness ☐full ☐partial_____

NEURO/MUSCULAR/SKELETAL:

__Carpel tunnel	__Bones broken/fractured	__Sciatica ☐left leg ☐right leg ☐front ☐back ☐side
__Tendonitis	__Muscle weakness	__Neuropathy ☐hands/fingers ☐feet/toes
__Bursitis	__Restricted joints	__Paralysis, where:_____

Disc degeneration, location _____ Spinal stenosis, location _____

Disc herniated, location _____ Pinched nerve, location _____

Other condition(s) not listed above: _____

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PATIENT'S NAME: (Last) (First) (Middle)

PAIN QUESTIONAIRE - Please circle the major areas of pain on pictures below.

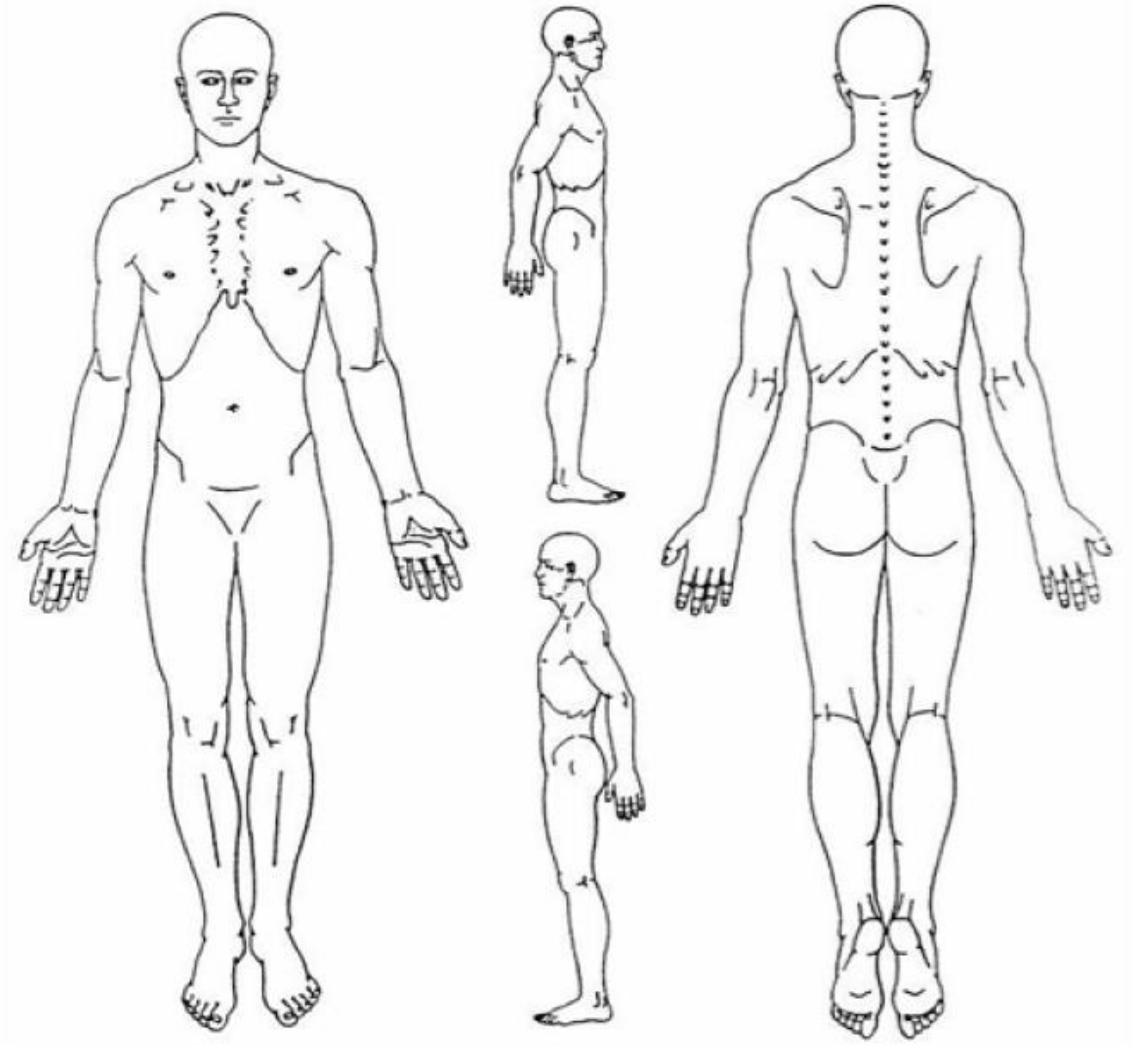
- How long have you had the pain: _____days _____weeks _____months _____years
- Frequency of pain: ☐All day ☐Morning mostly ☐Evening mostly ☐Comes and goes
- Pain increases: ☐with movement ☐when stationary ☐AM ☐PM other_____
- Pain decreases: ☐with movement ☐when stationary ☐AM ☐PM other_____

PAIN SCALE - indicate level of pain next to affected area(s)

Lowest 1 2 3 4 5 6 7 8 9 10 Highest

Pain sensation for affected area(s):

A: Achy M: Moving
B: Burning P: Pressure
D: Dull S: Stabbing
F: Fixed T: Throbbing



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PATIENT'S NAME: (Last) (First) (Middle)

MEN:

__Prostate enlarged __Penile discharge __Libido decreased __Fatigue
__Prostatitis __Premature ejaculation __Libido excessive __Dizziness
__Urinary difficulty __Painful ejaculation __Low testosterone __Weight gain
__Testicular pain __Nocturnal emission __Muscle weakness __Poor cognition
__Erectile dysfunction __Infertile __Mood imbalance __Vasectomy

Other conditions:_____

PSA/most recent test date:_____, ☐normal ☐elevated_____

WOMEN:

__Breast lumps __Painful period __PMS, severe __Breastfeeding
__Mastitis __Heavy period __Vaginal infections recurring __Infertile
__Fibroids __Scanty period __Excessive vaginal discharge __Miscarriage, habitual
__PID __Irregular period __Vaginal dryness __Pregnancy disorders
__Cysts __Prolonged period __Painful intercourse __Postpartum disorders
__Endometriosis __Absent period __Prolapsed uterus __Hysterectomy

__Hot flashes __Hair loss __Irritability __Dizziness Other conditions:
__Night sweat __Dry skin __Anxiety __Memory poor _____
__Weight gain __Energy low __Panic attacks __Cognition poor _____
__Muscle weakness __Libido low __Depression __Sleep poor

PAP/most recent test date:_____ ☐normal ☐abnormal, describe_____

Menstruation, date of last period:_____ Total days:_____

Cycle: ☐Regular ☐Irregular ☐Very short
Volume: ☐Normal ☐Heavy–very heavy ☐Light
Clots: ☐Few ☐Lots ☐Large ☐Small
Color: ☐Pale ☐Red ☐Dark red ☐Black
Strong odor: ☐No ☐Yes

Pain: ☐Abdomen ☐Back ☐Breasts ☐Head ☐Legs
☐Mild ☐Medium ☐Strong
☐Before ☐During ☐After
Water retention: ☐No ☐Yes
Mood: ☐Irritable, angry ☐Depressed ☐Cry easily

*** Are You Currently Pregnant?** ☐No ☐Yes, ____months____weeks____days Due date:_____

Special care or restrictions: _____

Birth control: ☐Pill ☐IUD ☐Condom ☐Tubal ligation or sterilization ☐Other_____

Birth history, number of: ___Vaginal births ___C-sections ___Miscarriages ___Abortions ___Stillborn

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PATIENT'S NAME: (Last) (First) (Middle)

CANCER HISTORY:

- Type of cancer: _____ Location:_____ Diagnosed on date:_____
- Is cancer hormone-sensitive? ☐No ☐Yes, ___Estrogen sensitive ___Testosterone sensitive
- Current status: ☐Remission since date_____ ☐Active, stage 1 2 3 4
- Metastasized locations:_____
- Treatment(s): Chemo from_____ to_____ Surgery, date_____
  Radiation from_____ to_____ Other_____

Special care or restrictions:_____

EMOTIONAL, MENTAL:

__Anxiety	__Stress acute	__ADD, ADHD	__Bulimia
__Panic attacks	__Stress post-traumatic	__Autism	__Anorexia
__Depression	__Anger, irritability	__Schizophrenia	__Socially withdrawn
__Suicidal	__Bipolar	__Paranoia	__History of abuse

__Phobias, describe_____

__OCD, describe_____ Other_____

SUBSTANCE USE:

☐Alcohol, _____years ☐Cigarettes, _____years ☐Other_____

Drugs (other than prescribed):

_____, how long_____ _____, how long_____

_____, how long_____ _____, how long_____

- Stress level: ☐Low ☐Moderate ☐High ☐Very high
- Exercise: ____Days per week ____None
- Sleep: ☐Rested upon waking ☐Tired upon waking ☐Wake often during night ☐Disturbing dreams
- Body temperature: ☐Normal ☐Mostly cold, ___AM ___PM Where:_____ ☐Warm – Hot, ___AM ___PM Where:_____

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Notification of Prior Evaluation by a Physician

(Pursuant to the requirement of "183.6(e) of this title (relating to Denial of License; Discipline of License) and Tex. Occ Code Ann., "205.351, governing the practice of acupuncture.)

I (Patient's name in PRINT) _____ am notifying April Bui Holistic Acupuncture – April Bui, LAC of the following:

- I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I understand that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

  ☐ **Yes** ☐ **No Patient's Initial**_____ **Date**_____

- I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after 2 months or 20 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.

  ☐ **Yes** ☐ **No Patient's Initial**_____ **Date**_____

NOTE: Exemptions according to Rule 183.6(e) Scope of Practice 3)… an acupuncturist holding a current and valid license may without an evaluation or a referral from a physician, dentist, or chiropractor perform acupuncture on a person for smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse.

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Clinic Policies & Release of Liability

- Appointment cancellation or rescheduling – please notify us 24 hours in advance.
- **Late cancellation & no show fees:**
    - Patient may cancel up to two hours before an appointment without being charged – cancellation any time after will incur a late cancellation fee.
    - No show and no prior notice will be charged a no-show fee.
    - **Late cancellation & no show fees equal 70% of the price of each scheduled service. Fees must be paid before rescheduling any future appointments.**
- Patient understands that all of patient's records and lab reports is kept confidential and will not be released without the patient's written consent, with the exception of the following entities who may have access to any of the patient's records or lab reports without the patient's written consent:
    1. The acupuncture clinic of April Bui LAC, including all clinical and administrative staff members.
    2. Government authorities, law enforcement or medical authorities in an emergency, in response to court order or when required by federal, state, or local law.
- If patient becomes pregnant or believes that she might be pregnant while undergoing treatment at the clinic of April Bui LAC, patient must immediately discontinue all herbal medicine dispensed by our acupuncturist and patient must immediately notify our acupuncturist.
- Any herbal medicine which we prescribe to the patient is strictly for the patient's use only and is not to be shared with or used by anyone else. The clinic of April Bui LAC is not responsible for any unauthorized use of the patient's herbal medicine by any person other than the patient.
- Patient agrees to pay in full for all services rendered, product purchases, appointment related surcharges, and any charges, fees, or expenses which our clinic may incur at any time due to or on behalf of the patient. Payment for services rendered is not refundable regardless of any reason.
- The clinic of April Bui LAC reserves the right to refuse all services to anyone if and when deemed necessary on any reasonable grounds including but not limited to falsification of any information in these forms, refusal to sign all forms, refusal to comply with our clinic policies or treatment protocol, or any other reasons which deemed as inappropriate and unacceptable conduct.

By signing below, I (patient's name in PRINT) _____ have read and agreed to the clinic policies outlined above and I agree to release April Bui LAC, including all staff members of her establishment, from any liability for claims of injury, loss, or damages resulting from my voluntary use of her establishment's services and facility on this date and at any time in the future.

Patient's Signature: _____, Date_____

Representative of patient (if applicable):

_____/_____/_____/_____

Signature | PRINT NAME | Relationship to patient | Date

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 acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, 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 not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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. I understand that while this document describes the major risks of treatment, other side effects 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 the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have 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 understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify the clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. **I understand that results are not guaranteed.**

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 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's Name (PRINT): _____

Last First Middle

PATIENT SIGNATURE (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

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