

Patient Information Confidential

- FULL LEGAL NAME as appeared on your driver license, state-issued ID, or passport.
(No 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 _____

APRIL BUI HOLISTIC ACUPUNCTURE

9039 Katy Freeway . Suite 504 . Houston, Texas 77024

713-922-3474 . abha.inquiry@gmail.com . www.abui-acupunctureclinic.com

PATIENT'S NAME: (Last)

(First)

(Middle)

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

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> COVID-19, date _____ | <input type="checkbox"/> Seizures | <input type="checkbox"/> IBS | <input type="checkbox"/> Sleep disorders |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> COPD | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Bell's palsy |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Allergies | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sinus disorders | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Renal failure <input type="checkbox"/> left <input type="checkbox"/> right |
| <input type="checkbox"/> Hyperglycemia | <input type="checkbox"/> Cold/Flu | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis-rheum | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Arthritis-osteo | <input type="checkbox"/> Migraines | <input type="checkbox"/> Herpes: <input type="checkbox"/> genital <input type="checkbox"/> oral |
| <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Gout | <input type="checkbox"/> Liver fatty | <input type="checkbox"/> STD, type: _____ |
| <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Hernia hiatal | <input type="checkbox"/> Liver enlarged | <input type="checkbox"/> HIV+: cd4 _____ viral _____ |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Hernia inguinal | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> AIDS: cd4 _____ viral _____ |

Tumor, where: _____ benign malignant, provide details in Cancer Section

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Thrombo-phlebitis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Acne | <input type="checkbox"/> Anal sores, eruptions |
| <input type="checkbox"/> Hair loss excessive | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Hives/Rashes | <input type="checkbox"/> Rectal prolapse |
| <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Eczema | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Excessive heat | <input type="checkbox"/> Edema | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Parasites/worms _____ |
| <input type="checkbox"/> Indigestion/bloating | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Diarrhea chronic | <input type="checkbox"/> Heart palpitations |
| <input type="checkbox"/> Acid reflux/heartburn | <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Constipation | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Difficult breathing <input type="checkbox"/> wheezing |
| <input type="checkbox"/> Nausea/vomit | <input type="checkbox"/> Foul breath | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Chronic cough <input type="checkbox"/> dry <input type="checkbox"/> phlegm |
| <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Cloudy urine | <input type="checkbox"/> Pressure, stuffiness in ears |
| <input type="checkbox"/> Night urination excessive | <input type="checkbox"/> Copious urine | <input type="checkbox"/> Bladder prolapse | <input type="checkbox"/> Teeth/gum problems, chronic |
| <input type="checkbox"/> Hesitant urination | <input type="checkbox"/> Scanty urine | <input type="checkbox"/> Stones kidney | <input type="checkbox"/> Vision, very poor |
| <input type="checkbox"/> Strong odor in urine | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Stones bladder | <input type="checkbox"/> Hearing, very poor |
| <input type="checkbox"/> Burning urination | <input type="checkbox"/> Dark urine | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Deafness <input type="checkbox"/> full <input type="checkbox"/> partial _____ |

NEURO/MUSCULAR/SKELETAL:

- | | | |
|--|---|---|
| <input type="checkbox"/> Carpel tunnel | <input type="checkbox"/> Bones broken/fractured | <input type="checkbox"/> Sciatica <input type="checkbox"/> left leg <input type="checkbox"/> right leg <input type="checkbox"/> front <input type="checkbox"/> back <input type="checkbox"/> side |
| <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Neuropathy <input type="checkbox"/> hands/fingers <input type="checkbox"/> feet/toes |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Restricted joints | <input type="checkbox"/> Paralysis, where: _____ |

Disc degeneration, location _____ Spinal stenosis, location _____

Disc herniated, location _____ Pinched nerve, location _____

Other condition(s) not listed above: _____

APRIL BUI HOLISTIC ACUPUNCTURE

9039 Katy Freeway . Suite 504 . Houston, Texas 77024

713-922-3474 . abha.inquiry@gmail.com . www.abui-acupunctureclinic.com

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

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

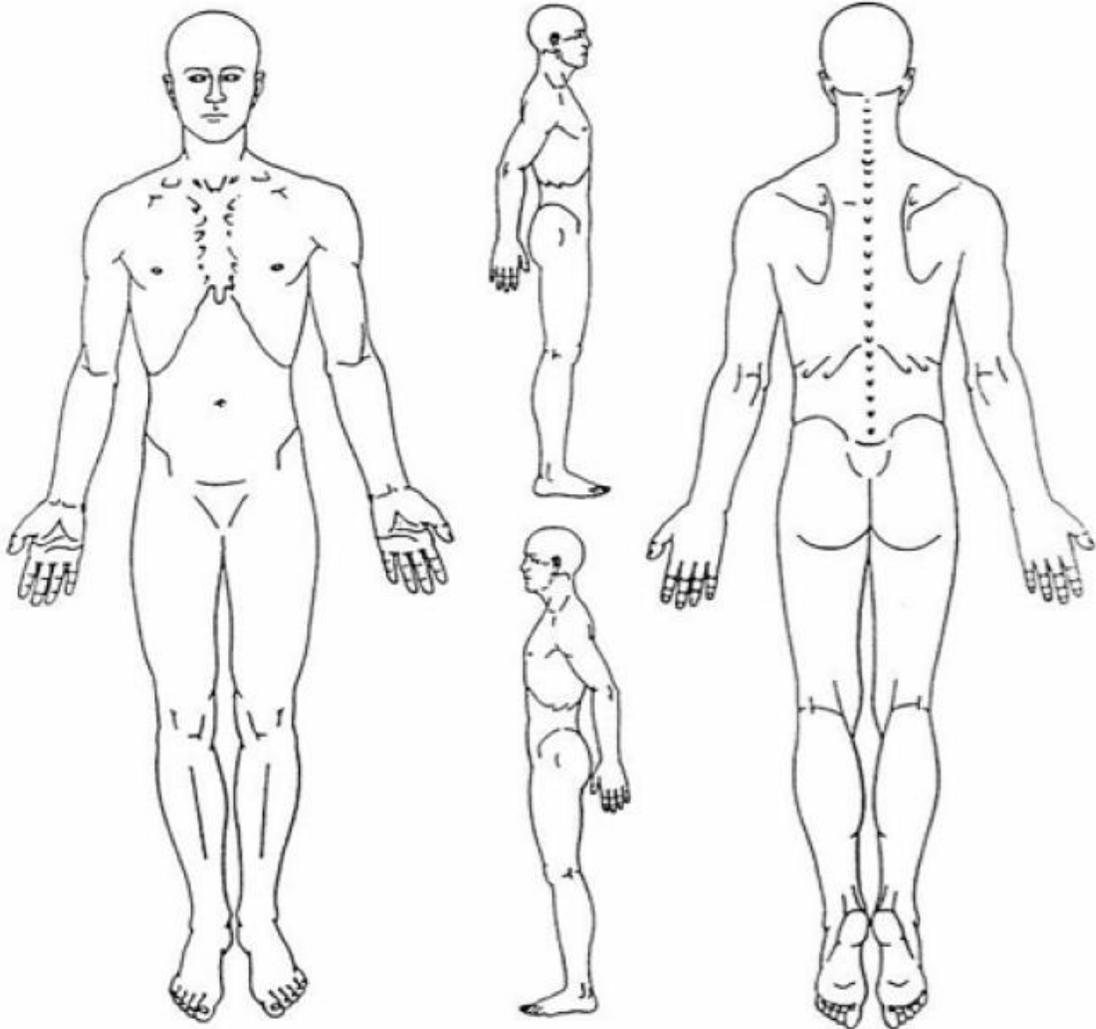
- How long have you had the pain: _____ days _____ weeks _____ months _____ years
- Frequency of pain: All day Morning mostly Evening mostly Comes and goes
- Pain increases: with movement when stationary AM PM other _____
- Pain decreases: with movement when stationary AM PM other _____

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



APRIL BUI HOLISTIC ACUPUNCTURE

9039 Katy Freeway . Suite 504 . Houston, Texas 77024

713-922-3474 . abha.inquiry@gmail.com . www.abui-acupunctureclinic.com

PATIENT'S NAME: (Last)

(First)

(Middle)

MEN:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Prostate enlarged | <input type="checkbox"/> Penile discharge | <input type="checkbox"/> Libido decreased | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Libido excessive | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Urinary difficulty | <input type="checkbox"/> Painful ejaculation | <input type="checkbox"/> Low testosterone | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Testicular pain | <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Poor cognition |
| <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Infertile | <input type="checkbox"/> Mood imbalance | <input type="checkbox"/> Vasectomy |

Other conditions: _____

PSA/most recent test date: _____, normal elevated _____

WOMEN:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Painful period | <input type="checkbox"/> PMS, severe | <input type="checkbox"/> Breastfeeding |
| <input type="checkbox"/> Mastitis | <input type="checkbox"/> Heavy period | <input type="checkbox"/> Vaginal infections recurring | <input type="checkbox"/> Infertile |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Scanty period | <input type="checkbox"/> Excessive vaginal discharge | <input type="checkbox"/> Miscarriage, habitual |
| <input type="checkbox"/> PID | <input type="checkbox"/> Irregular period | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Pregnancy disorders |
| <input type="checkbox"/> Cysts | <input type="checkbox"/> Prolonged period | <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Postpartum disorders |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Absent period | <input type="checkbox"/> Prolapsed uterus | <input type="checkbox"/> Hysterectomy |

- | | | | | |
|--|-------------------------------------|--|---|-------------------------------------|
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Irritability | <input type="checkbox"/> Dizziness | Other conditions:

_____ |
| <input type="checkbox"/> Night sweat | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Memory poor | |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Energy low | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Cognition poor | |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Libido low | <input type="checkbox"/> Depression | <input type="checkbox"/> Sleep poor | |

PAP/most recent test date: _____ normal abnormal, describe _____

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

- | | |
|--|---|
| Cycle: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Very short | Pain: <input type="checkbox"/> Abdomen <input type="checkbox"/> Back <input type="checkbox"/> Breasts <input type="checkbox"/> Head <input type="checkbox"/> Legs |
| Volume: <input type="checkbox"/> Normal <input type="checkbox"/> Heavy-very heavy <input type="checkbox"/> Light | <input type="checkbox"/> Mild <input type="checkbox"/> Medium <input type="checkbox"/> Strong |
| Clots: <input type="checkbox"/> Few <input type="checkbox"/> Lots <input type="checkbox"/> Large <input type="checkbox"/> Small | <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After |
| Color: <input type="checkbox"/> Pale <input type="checkbox"/> Red <input type="checkbox"/> Dark red <input type="checkbox"/> Black | Water retention: <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Strong odor: <input type="checkbox"/> No <input type="checkbox"/> Yes | Mood: <input type="checkbox"/> Irritable, angry <input type="checkbox"/> Depressed <input type="checkbox"/> 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

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 Warm – Hot, ___ AM ___ PM
 Where: _____ Where: _____

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 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.

Clinic Policies & Release of Liability

- Appointment cancellation or rescheduling – please notify us 24 hours in advance.
- **Late Cancellation & No Show Charge** (exceptions apply to emergencies or hazardous weather)
 - 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 will be charged a no-show fee.
 - **Late cancellation & no show fee = 75% of the price of each scheduled service. Fee must be paid before rescheduling any future appointment.**
- 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. April Bui Holistic Acupuncture - 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.
- Any herbal medicine prescribed to the patient by April Bui Holistic Acupuncture is strictly for the patient's use only and is not to be shared with or used by anyone else. April Bui Holistic Acupuncture is not responsible for the 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 April Bui Holistic Acupuncture may incur at any time due to or on behalf of the patient. Payment for services rendered is not refundable regardless of any reason.
- April Bui Holistic Acupuncture 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 Holistic Acupuncture including all of its staff members from any liability for claims of injury, loss, or damages resulting from my voluntary use of the services and facility at April Bui Holistic Acupuncture 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