APRIL BUI HOLISTIC ACUPUNCTURE
9039 Katy Freeway . Suite 504 . Houston, Texas 77024
713-922-3474 . abha.inquiry@gmail.com . www.abui-acupunctureclinic.com

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 _____

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

MEDICATIONS & SUPPLEMENTS

Please list all medications and supplements that 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 10 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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PATIENT'S NAME: (Last) (First) (Middle)

(✓) All that applies:

__COVID-19, date_____	__Seizures	__IBS	__Sleep disorders
__Heart disease	__COPD	__Crohn's disease	__Bell's palsy
__High blood pressure	__Allergies	__Diverticulitis	__Anemia
__Stroke	__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_____

Do you have diminished or total loss of feeling and sensitivity to temperature heat & cold or to the touch in any areas of the body? ☐No ☐Yes, location(s)_____

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 _____

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

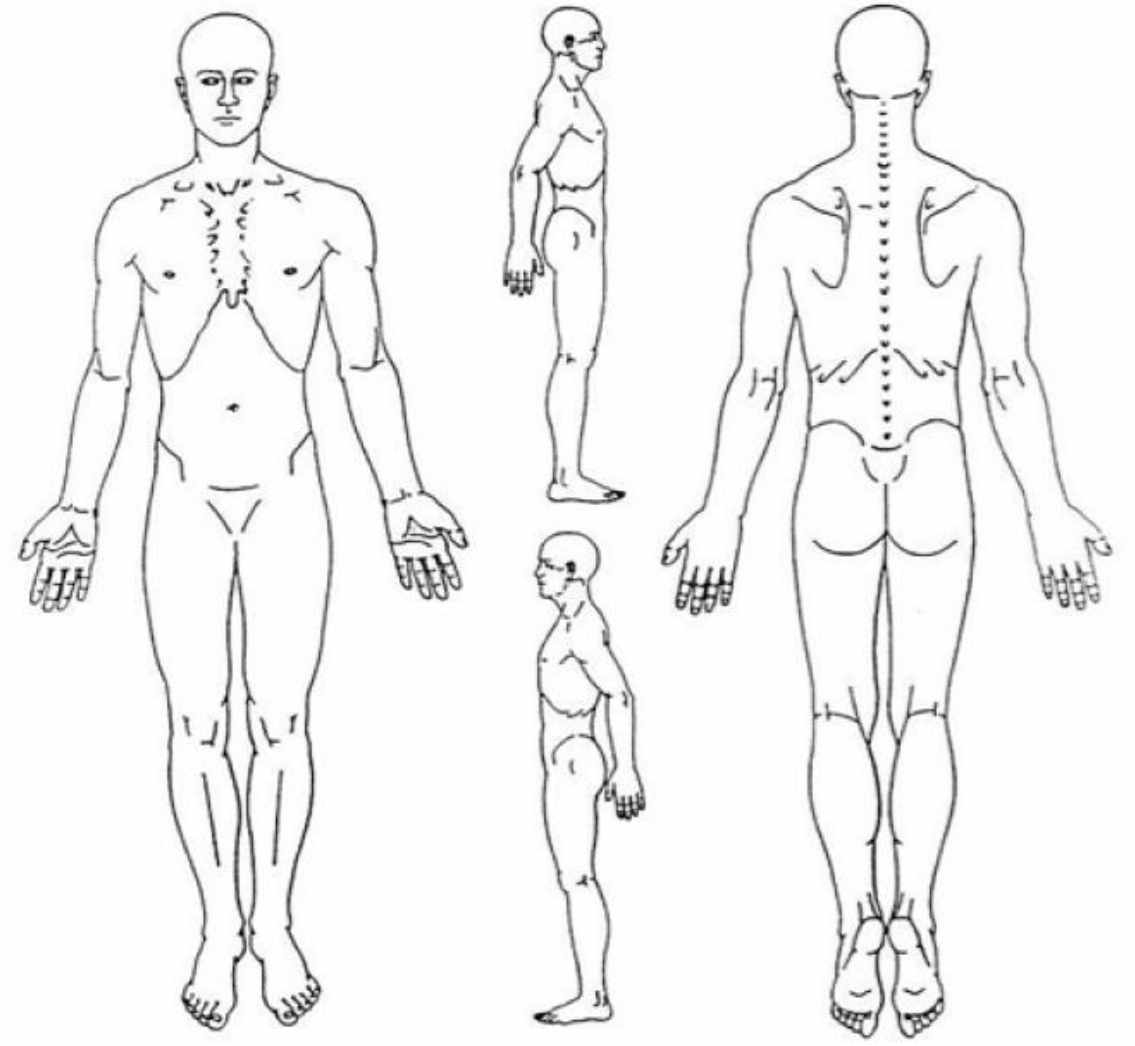
- How long have you had the pain: _____days _____weeks _____months _____years
- Frequency of pain: ☐All day ☐Morning mostly ☐Evening mostly ☐Comes and goes
- Pain increases: ☐with movement ☐when stationary ☐AM ☐PM other_____
- Pain decreases: ☐with movement ☐when stationary ☐AM ☐PM other_____

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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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_____

Consumption of:

☐Alcohol ___yrs ☐Cigarette___yrs ☐Recreational drugs (type)_____, ___yrs

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

Any other condition(s) you have that we should know about? Please explain:

_____

_____

How long have you had the above condition(s):_____

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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 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 fee**
    - Patient may cancel up to two hours before an appointment without being charged – cancellation any time after will incur a late cancellation fee.
    - Patient who abandons an appointment by not showing up and not giving us a timely advance notice 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 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 rendered services is not refundable.
- 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 treatment protocol, violation of clinic policies or any other causes which deemed as inappropriate and unacceptable conduct.
- **Release of Liability:**

  Patient, guardian or representative of the patient, and any person(s) accompanying the patient on clinic premises shall release April Bui Holistic Acupuncture including all of its associates and staff members from any liability for claims of injury, loss, or damages resulting from their voluntary use of the services and facility at April Bui Holistic Acupuncture on this date and at any time in the future.

By signing and is made effective as of the date below, patient or patient's guardian/representative has read and agreed to comply with clinic policies and release of liability statement outlined above herein.

Patient or Guardian/Representative: _____/_____/_____
Signature PRINT NAME Date

Guardian/Representative on behalf of: _____/_____
Patient's name Relationship to patient