



## Acupuncture & Nutrition Clinic

Karen Siegel Propis MPH, MS, R.D., L.D., LAc

9660 Hillcroft, Suite 202, Houston, Texas 77096

Welcome to our office!

Our entire team would like to thank you for selecting us to care for your acupuncture and/or nutritional needs.

We strive to provide each person with the highest quality care in a gentle, efficient, and pleasant manner. It is our goal to help you enjoy the benefits of good health for the rest of your life.

To make the first appointment as comfortable as possible for you, we ask that you fill out the enclosed patient information sheets at your convenience. Please fill them out prior to your appointment and bring them with you to your first visit.

If you have any questions, please do not hesitate to call. We are looking forward to meeting you on your initial visit. The date and time of your appointment is filled in for you on the enclosed questionnaire.

Thank you and we look forward to seeing you soon.

Sincerely,

A handwritten signature in black ink that reads "Karen Siegel". The signature is written in a cursive, flowing style.

Karen Siegel, MPH, MS, RD, LD, LAc



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www.acupunctureandnutritionclinic.com

## PATIENT INFORMATION

First Name:		Middle Initial:	Last Name:	
Home Address:			City:	State:
			Zip:	
Home Phone:	Business Phone:	Mobile Phone:	Email Address:	

**CONFIRMATIONS:** We will contact you one business day prior to your scheduled appointment with a reminder. Please check your preferred method of contact (choose one):  
 Home Phone     Business Phone     Mobile Phone     Email

Birth Date (mm/dd/yyyy):	Current Age:	Height:	Weight:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		I Number of Children:	Ages of Children:	
Occupation:				
Employer's Name and Address:				
Personal Physician's Name (and address if available):				Month/year of last doctor visit:

Emergency Contact Name:	Phone number:	Relationship to you:

Have you ever tried Chinese Medicine before?  Acupuncture <input type="checkbox"/> yes <input type="checkbox"/> no  Chinese Herbs <input type="checkbox"/> yes <input type="checkbox"/> no	Who can we thank for referring you? <input type="checkbox"/> A friend <input type="checkbox"/> A physician <input type="checkbox"/> Another healthcare practitioner <input type="checkbox"/> Other  Name: _____  If Other, please specify <input type="checkbox"/> Radio <input type="checkbox"/> Internet search (which search engine? _____)  <input type="checkbox"/> Print ad
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I understand that I should be evaluated by a physician for the condition I am requesting for treatment or consultation. Treatment and diagnosis at The Acupuncture and Nutrition Clinic is done using the system of Traditional Chinese Medicine and its treatment methods Acupuncture, Chinese Herbs, and Food Therapy. **It does not constitute a western diagnosis.** I understand Traditional Chinese Medicine diagnosis and other complementary therapies should not be relied upon as my sole treatment for my condition. I understand if no substantial improvement is made for the condition being treated, I am to seek advice from a western medical doctor. Further, if I am concurrently undergoing western medical treatment for any condition, it is my responsibility to advise my physician of my Traditional Chinese treatment and any herbal supplements I am taking.

I understand that only single-use, pre-sterilized, disposable needles are used at this clinic. Minor bruising may occasionally appear after treatment.

Signed \_\_\_\_\_

Date: \_\_\_\_\_



# Acupuncture & Nutrition Clinic

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Last name

First name

Middle Initial

Please check any of the following symptoms that you currently have or have had recently:

**Habits:**

- Cigarettes  Soft Drinks
- Salt  Coffee  Alcohol
- Recreational Drugs
- Black Tea  Sugar  Stress
- Artificial Sweeteners
- Marijuana  Occupational Hazards
- Other: \_\_\_\_\_

**Exercise:**

- Never  Little  Moderate
  - Heavy
- Type of Exercise: \_\_\_\_\_

How often: \_\_\_\_\_

**Emotional:**

I would generally describe myself as (check all that apply):

- Happy  Easy going  Restless
- Irritable  Indecisive  Angry
- Cry easily  In a hurry
- Depressed  Stressed out
- Difficulty expressing emotion
- Short attention span
- Other: \_\_\_\_\_

**Diet (Typical Foods):**

- Beef  Eggs  Cheese
- Grains  Tofu  Pork
- Bread  Margarine  Yogurt
- Poultry  Fish  Milk
- Ice Cream  Sweets
- Health Foods  Butter
- Vegetables  Salads
- Spicy Foods  Fried Foods
- Other: \_\_\_\_\_

**Appetite/eating habits:**

- Up and down  Poor  Good
  - Hungry a lot  Loss of taste
- Do you eat three meals per day?
- Yes  No
- Do you eat at regular hours?
- Yes  No
- Cravings: \_\_\_\_\_

**Weight:**

- Normal  Underweight
  - Overweight
  - Recent gain  Recent loss
- If recent gain or loss, how much?

Since what date? month / year

**Energy:**

- Up and down  Low  Excessive
- Low after eating
- Tired in the afternoon  Normal
- Other: \_\_\_\_\_

**Body temperature:**

- Warm natured  Flushed face
- Feel warm late afternoon and night
- Sweat Easily  Night Sweats
- Chill easily / feel cold / aversion to cold
- Feel hot / aversion to heat
- Warm Palms / Soles
- Cold hands and feet
- Other: \_\_\_\_\_

**Digestion:**

- Indigestion  Bloating  Heartburn
- Nausea  Vomiting  Full feeling
- Belch or burp  Gas
- Abdominal pain or cramps
- Difficulty digesting fatty or oily foods
- Bitter taste in mouth  Gallstones
- Other: \_\_\_\_\_

**Bowels:**

- Frequency of Bowel movement:  
 \_\_\_\_\_ per  day  week
- Loose stool  Diarrhea
  - Hemorrhoids  Constipation
  - Colon problems  Pain or cramps
  - Use laxatives
  - Other: \_\_\_\_\_

**Urination:**

- Frequency of urination:  
 \_\_\_\_\_ times per day
- Color:
- clear  light yellow  yellow
  - bright yellow  dark
- Symptoms:
- Burning  Bladder infections
  - Urgency  Nighttime
  - Incontinence
  - Kidney stones or infections

**Thirst:**

- Less than normal
  - Excessive  Normal
  - Thirsty but do not drink
- # of drinks (glasses) per day \_\_\_\_\_
- I prefer my drinks:
- cold  warm/hot  room temperature

**Cardiovascular**

- Diagnosed heart problems
- Palpitations  Bleed easily  Low blood pressure
- High blood pressure
- High cholesterol  Murmur
- Varicose veins  Ankle swelling
- Chest pain  Bruise easily
- Hand swelling  Irregular heart beat
- Other: \_\_\_\_\_

**Sleep:**

- Falling asleep:
- Easy  Avg  Difficult
- Staying asleep:
- Easy  Avg  Difficult
- Waking up:
- Easy  Avg  Difficult
- Sleep quality (check all that apply):
- Restless
  - Lots of dreams
  - Easily awakened
  - Nightmares
  - Difficulty falling back to sleep

Bedtime \_\_\_\_\_

Wake time \_\_\_\_\_

# of times you wake up in middle of the night: \_\_\_\_\_

**Headaches / dizziness:**

- Headaches  Migraines
- Vertigo  Dizziness
- Motion sickness
- Poor balance
- Faint easily
- Poor memory
- Other: \_\_\_\_\_

**Skin:**

- Dry  Hives  Itching
- Oily  Acne  Rashes
- Bruise easily  Eczema
- Cuts heal slowly
- Other: \_\_\_\_\_

**Hair:**

- Dry  Oily  Dandruff
- Falling out  Early grey
- Normal
- Other: \_\_\_\_\_

**Nails:**

- Soft  Spots  Ridges/ lines
- Grow slowly  Grow fast
- Purple  Pale
- Break easily
- Other: \_\_\_\_\_

**Ears:**

- Poor hearing
- Ringing (high pitch)
- Ringing (low pitch)
- Discharges  Ear aches
- Other: \_\_\_\_\_

**Eyes:**

- Wear glasses or contacts
- Eyelids swollen
- Dry  Itch  Twitch
- Poor night vision
- Light-sensitive
- Color blindness
- Tear easily  Normal
- Other: \_\_\_\_\_

**Nose:**

- Stuffy nose  Hayfever
- Sneeze a lot  Bleeding
- Loss of smell
- Sinusitis  Rhinitis
- Normal
- Other: \_\_\_\_\_

**Mouth and throat:**

- Dry  Gum problems
- Frequent colds  TMJ
- Feel lump in throat
- Thyroid problems
- Grind teeth  Normal
- Other: \_\_\_\_\_

**Respiratory:**

- Shortness of breath
- Difficulty inhaling
- Sigh a lot  Dry cough
- Cough w/phlegm
- Asthma  Bronchitis
- Emphysema  Wheezing
- Cough with blood
- Tightness in chest
- Other: \_\_\_\_\_

**Pain:**

- Neck  Back  Shoulder
- Sciatica  Hands  Wrists
- Cramps  Hips  Knees
- Cold or Damp weather
- Foot/ankle  Spine
- Arthritis  Flank area
- Other: \_\_\_\_\_

Please list the primary concerns you would like to address:

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Patient Name: \_\_\_\_\_

**Last Physical**

Date: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Results:  
\_\_\_\_\_  
\_\_\_\_\_

**Medication (within last 2 months, prescriptions, vitamins, over-the-counter)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History (include dates)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cancer _____    | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Rheumatic Fever _____  |
| <input type="checkbox"/> Diabetes _____  | <input type="checkbox"/> Heart Disease _____       | <input type="checkbox"/> Alcoholism _____       |
| <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Stroke _____              | <input type="checkbox"/> Seizures _____         |
| <input type="checkbox"/> Asthma _____    | <input type="checkbox"/> HIV _____                 | <input type="checkbox"/> Thyroid Disease _____  |
| <input type="checkbox"/> Other _____     | <input type="checkbox"/> Pacemaker _____           | <input type="checkbox"/> Venereal Disease _____ |
|  |  | <input type="checkbox"/> Substance abuse _____  |

Surgeries (type and date): \_\_\_\_\_

Significant trauma (auto accidents, falls, etc): \_\_\_\_\_

Significant dental work (type and date): \_\_\_\_\_

Birth history (prolonged labor, forceps delivery, caesarian, other): \_\_\_\_\_

Currently pregnant or suspect you may be pregnant? \_\_\_\_\_

Allergies (drugs, chemicals, food, airborne): \_\_\_\_\_

**Family Medical History**

- |  |   |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arteriosclerosis |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Cancer: _____    |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Allergies: _____ |

## Lifestyle

Occupational Stress (chemical, physical, psychological, etc)

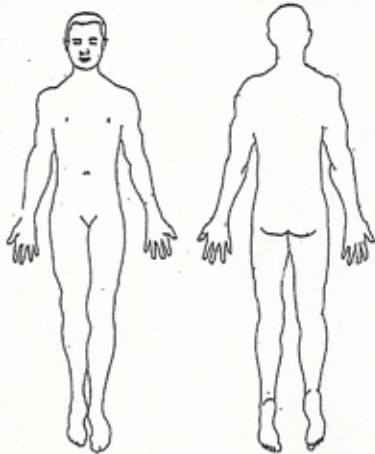
Do you exercise regularly? Please describe.

How many meals a day? \_\_\_\_\_

How many snacks? \_\_\_\_\_

## Pain

Indicate Painful or Distressed Areas (Mark "x")



What are your treatment goals?

- Temporary relief of symptoms/pain
- Eliminate root cause of problem (if possible)
- Maintenance care (periodic balancing/tune up)

Please rate your pain on a scale of **1 to 10** (1 is the least amount of pain and 10 is the worst imaginable).

How severe is your pain right now? \_\_\_\_\_

What is the worst pain level in the past week? \_\_\_\_\_

Please give us any other relevant information you think might be useful for your condition.

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# Form to be Completed by Patient, Notifying the Acupuncturist of Whether He/She Has Been Evaluated by a Physician, and Other Information.

Pursuant to the requirements of 22 T.A.C. § 183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ. Code Ann., §20S,351, governing the practice of acupuncture.)

I (patient's name) \_\_\_\_\_ am notifying the acupuncturist (practitioner's name): Karen Siegel, LAc. of the following:

## Recent visit to Physician?

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.

- Yes  
 No

(initials) \_\_\_\_\_

(date) \_\_\_\_\_

## Recent visit to Chiropractor?

I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after two 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

(initials) \_\_\_\_\_

(date) \_\_\_\_\_

## Optional Form to be Complete by Patient, Attesting that the Acupuncturist Has Referred Him/Her

(Pursuant to the requirement of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ. Code Ann. §205.351 governing the practice of acupuncture.)

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

Patient's signature \_\_\_\_\_ (date) \_\_\_\_\_

Acupuncturist's signature \_\_\_\_\_ (date) \_\_\_\_\_

# [PATIENT'S COPY]

## Acupuncture and Nutrition Clinic

### NOTICE OF PRIVACY POLICIES

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

#### INTRODUCTION

At the Acupuncture and Nutrition Clinic we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 1, 2003, and applies to all protected health information as defined by federal regulations.

#### Understanding Your Health Record/Information

Each time you visit the Acupuncture and Nutrition Clinic, a record of your visit is made. Typically, this record contains your name, contact information, symptoms, examination, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

#### Your Health Information Rights

Although your health record is the physical property of the Acupuncture and Nutrition Clinic, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been

taken.

#### Our Responsibilities

The Acupuncture and Nutrition Clinic is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization

If have questions and would like additional information, you may contact the Acupuncture and Nutrition Clinic office at 713-721-7755. If you believe your privacy rights have been violated, you can file a complaint with this clinic, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either this Clinic or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights U.S. Department of Health and Human Services  
200 Independence Avenue, S.W. Room 509F, HHH Building  
Washington, D.C. 20201



# Acupuncture & Nutrition Clinic

Karen Siegel Propis MPH, MS, R.D., L.D., LAc

9660 Hillcroft, Suite 202, Houston, Texas 77096

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\*You may refuse to sign this document\*

I, *(please print)* \_\_\_\_\_, have a received a copy of this office's Notice of Privacy Practices

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

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## **A Message to My Patients About Arbitration**

Attached is an Arbitration Agreement which my insurance requires me to obtain in order to treat you. I respectfully urge you to sign. We will thereby agree that any disputes arising out of the services you receive from this office will be resolved through binding arbitration rather than in a court of law.

Binding arbitration has benefits for both doctors and patients. Jurists such as former United States Supreme Court Chief Justice Warren Burger and California Supreme Court Chief Justice Malcolm Lucas, favor arbitration as an alternative method of dispute resolution. The California Supreme Court has noted that arbitration is speedier and less costly than are jury trials for resolving disputes between doctors and patients. Both parties are spared some of the rigors of trial, and the publicity which may accompany judicial proceedings. In addition, because virtually no appeals of an arbitrated award are allowed, the prevailing party can expect either prompt payment or prompt dismissal of the case without facing the lengthy appeals process.

Please sign the agreement when you arrive at our clinic after first reading it carefully and asking any questions you may have.