TIGER LILY
WELLNESS & ACUPUNCTURE
2111 Dickson Dr. Suite 26 Austin, TX. 78704
512 899 8996

Please help us provide you with the best possible treatment plan by completing this form.
If you have any questions, please ask. Thank you!
All your information is absolutely confidential

Name_____ **Date:** _____

Home Address: _____

City/ State/ Zip: _____

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

Email: _____

Occupation: _____**Employer:**_____

Sex: F M Height: _____ **Weight:** _____ **Birthday:** ____/_____/_____ **Age:** _____
Lbs. M D Y

Person Responsible for Your Account: _____ -If other than patient

Marital Status: S M P D W Number of Children: _____

Activities you enjoy:_____

How did you find out about our office? _____

Supplements (vitamins, herbs, minerals, etc.): _____

Have you received Acupuncture before? Yes No

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Normal	
1.	❑	❑	❑	❑	_____
2	❑	❑	❑	❑	_____
3.	❑	❑	❑	❑	_____
4.	❑	❑	❑	❑	_____

How do these conditions impair your daily activities?
_____
_____
_____

Other physicians/therapist seen for this condition: _____

Treatments/Medications: _____

Results: _____

PATIENT_____ DATE_____

INSTRUCTIONS: **Please only number the boxes which apply to you**.
(1) for MILD symptoms (occurs once or twice a month)
(2) for MODERATE symptoms (occurs once a week)
(3) for SEVERE symptoms (you are aware of it almost constantly)

IF IT DOES NOT APPLY TO YOU LEAVE IT BLANK

GROUP ONE

1 ☐ Acid foods upset
2 ☐ Get chilled, often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meal
6 ☐ Keyed up – fail to calm
7 ☐ Cuts heal slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous stomach
15 ☐ Appetite reduced
16 ☐ Cold sweats often
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach frequent

GROUP TWO

21 ☐ Joint stiffness after arising
22 ☐ Muscle-leg-toe cramps at night
23 ☐ "Butterfly" stomach, cramps
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seems hungry; feels "lightheaded" often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" infrequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

GROUP THREE

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals delayed
49 ☐ Heart palpitates if meals missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours sleep – hard to get back to sleep
53 ☐ Crave candy or coffee in afternoons
54 ☐ Moods of depression – "blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks

GROUP FOUR

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hunger"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Opens windows in closed room
61 ☐ Susceptible to colds and fevers
62 ☐ Afternoon "yawner"
63 ☐ Get "drowsy" often
64 ☐ Swollen ankles worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion.
68 ☐ Bruise easily, "black and blue" spots
69 ☐ Tendency to anemia
70 ☐ "Nose bleeds" frequent
71 ☐ Noises in head, or "ringing in ears"
72 ☐ Tension under the breast-bone, or feeling of tightness"" worse on exert

73 ☐ Dizziness
74 ☐ Dry Skin
75 ☐ Burning feet
76 ☐ Blurred vision
77 ☐ Itching skin and feet
78 ☐ Excessive falling hair
79 ☐ Frequent skin rashes
80 ☐ Bitter, metallic taste in mouth in mornings
81 ☐ Bowel movements painful or difficult
82 ☐ Worrier, feels insecure

GROUP FIVE

83 ☐ Feeling queasy; headache over eyes
84 ☐ Greasy foods upset
85 ☐ Stools light-colored
86 ☐ Skin peels on foot soles
87 ☐ Pain between shoulder blades
88 ☐ Use laxatives
89 ☐ Stools alternate from soft to watery
90 ☐ History of gallbladder attacks or gallstones

91 ☐ Sneezing attacks
92 ☐ Dreaming, nightmare type bad dreams
93 ☐ Bad breath (halitosis)
94 ☐ Milk products cause distress
95 ☐ Sensitive to hot weather
96 ☐ Burning or itching anus
97 ☐ Crave sweets

98 ☐ Loss of taste for meat
99 ☐ Lower bowel gas several hours after eating
100 ☐ Burning stomach sensations, eating relieves

GROUP SIX

101 ☐ Coated tongue
102 ☐ Pass large amounts of foul-smelling gas

103 ☐ Indigestion ½ - 1 hour after eating; may be up to 3 – 4 hrs.
104 ☐ Mucous colitis or "irritable bowel"
105 ☐ Gas shortly after eating
106 ☐ Stomach "bloating" after eating

GROUP SEVEN

(A)

107 ☐ Insomnia
108 ☐ Nervousness
109 ☐ Can't gain weight
110 ☐ Intolerance to heat
111 ☐ Highly emotional
112 ☐ Flush easily
113 ☐ Night sweats
114 ☐ Thin, moist skin
115 ☐ Inward trembling
116 ☐ Heart palpitates
117 ☐ Increased appetite without weight gain
118 ☐ Pulse fast at rest
119 ☐ Eyelids and face twitch
120 ☐ Irritable and restless
121 ☐ Can't work under pressure

(B)

122 ☐ Increase in weight
123 ☐ Decrease in appetite
124 ☐ Fatigue easily
125 ☐ Ringing in ears
126 ☐ Sleepy during day
127 ☐ Sensitive to cold
128 ☐ Dry or scaly skin
129 ☐ Constipation
130 ☐ Mental sluggishness
131 ☐ Hair coarse, falls out
132 ☐ Headaches upon arising wear off during day
133 ☐ Slow pulse, below 65
134 ☐ Frequency of urination
135 ☐ Impaired hearing
136 ☐ Reduced initiative

(C)

137 ☐ Failing memory
138 ☐ Low blood pressure
139 ☐ Increased sex drive
140 ☐ Headaches, "splitting or rending" type
141 ☐ Decreased sugar tolerance

(D)

142 ☐ Abnormal thirst
143 ☐ Bloating of abdomen
144 ☐ Weight gain around hips or waist
145 ☐ Sex drive reduced or lacking
146 ☐ Tendency to ulcers, colitis
147 ☐ Increased sugar tolerance
148 ☐ Women: menstrual disorders
149 ☐ Young girls: lack of menstrual function

(E)

150 ☐ Dizziness
151 ☐ Headaches
152 ☐ Hot flashes
153 ☐ Increased blood pressure
154 ☐ Hair growth on face or body (female)
155 ☐ Sugar in urine (not diabetes)
156 ☐ Masculine tendencies (female)

(F)

157 ☐ Weakness, dizziness
158 ☐ Chronic fatigue
159 ☐ Low blood pressure
160 ☐ Nails weak, ridged
161 ☐ Tendency to hives
162 ☐ Arthritic tendencies
163 ☐ Perspiration increase
164 ☐ Bowel disorders
165 ☐ Poor circulation
166 ☐ Swollen ankles
167 ☐ Crave salt
168 ☐ Brown spots or bronzing of skin
169 ☐ Allergies – tendency to asthma
170 ☐ Weakness after colds, influenza
171 ☐ Exhaustion – muscular and nervous
172 ☐ Respiratory disorders

GROUP 8

173 ☐ Apprehension
174 ☐ Irritability
175 ☐ Morbid fears
176 ☐ Never seems to get well
177 ☐ Forgetfulness
178 ☐ Indigestion
179 ☐ Poor appetite
180 ☐ Craving for sweets
181 ☐ Muscular soreness
182 ☐ Depression/Feeling something dreadful
183 ☐ Noise sensitivity
184 ☐ Acoustic hallucinations
185 ☐ Tendency to cry without reason

186 ☐ Hair is Coarse and/or thinning
187 ☐ Weakness
188 ☐ Fatigue
189 ☐ Skin sensitive to touch
190 ☐ Tendency towards hives
191 ☐ Nervousness
192 ☐ Headache
193 ☐ Insomnia
194 ☐ Anxiety
195 ☐ Anorexia
196 ☐ Inability to concentrate or Confusion
197 ☐ Frequent stuffy nose / sinus infection
198 ☐ Allergy to some foods
199 ☐ Loose Joints

FEMALE ONLY

200 ☐ Very easily fatigued
201 ☐ Premenstrual tension
202 ☐ Painful menses
203 ☐ Depressed feelings before menstruation
204 ☐ Menstruation excessive
205 ☐ Painful breasts
206 ☐ Menstruate too frequently
207 ☐ Vaginal discharge

208 ☐ Hysterectomy/ ovaries removed
209 ☐ Menopausal hot flashes
210 ☐ Menses scanty or missed
211 ☐ Acne, worse at menses
212 ☐ Depression of long standing

Women Only:

Regular menstrual cycle? ❑Y ❑ N Pregnant? ❑ Y ❑ N
Number of Children:_____ Number of pregnancies:_____
Age of first menstruation:_____ Age of menopause(if applicable)_____
Average number of days of flow:_____ Average number of days of entire cycle: ____

	Severe	Moderate	Slight	Normal
Vaginal Discharge	❑	❑	❑	❑
Bleeding Between periods	❑	❑	❑	❑

Do you experience any of the following?
❑ Nausea ❑ Food Craving ❑ Depression ❑ Vomiting ❑ Headaches ❑ Irritability

❑ Water retention ❑ Migraines ❑ Anxiety ❑ Breast tenderness

❑ Other emotions: _____ ❑ Dull Pain, Where?_____

❑ Sharp Pain, Where? _____

❑ Other: _____

Please fill in the following menstrual chart: If you do not have a cycle please write N/A on the chart below.

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color: (normal, pale, bright red, rust, dark, other)							
Amount of flow: (normal, heavy, light)							
Pain/Cramps: (location, dull, sharp, other)							
Clots: (large, small, black, purple, red, other)							
Nausea							
Vomiting							
Other							

MALE ONLY:

186 ☐ Prostate trouble
187 ☐ Urination difficulty or dribbling
188 ☐ Night urination frequent
189 ☐ Depression
190 ☐ Pain on inside of legs or heels
191 ☐ Feeling of incomplete bowel evacuation
192 ☐ Lack of energy
193 ☐ Migrating aches and pains
194 ☐ Tire too easily
195 ☐ Avoids activity
196 ☐ Leg nervousness at night
197 ☐ Diminished sex drive

	Severe	Moderate	Slight	Normal
❑ Swollen Testes	❑	❑	❑	❑
❑ Testicular Pain	❑	❑	❑	❑
❑ Impotence	❑	❑	❑	❑
❑ Premature ejaculation	❑	❑	❑	❑
❑ Feeling of coldness or numbness in external genitalia	❑	❑	❑	❑
❑ Other: _____	❑	❑	❑	❑

Other comments: _____

Patient signature: _____

Acupuncturist Signature: _____

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Acknowledgement Form

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that TigerLily Acupuncture and Chinese Herbal Clinic's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review TigerLily Acupuncture and Chinese Herbal Clinic's "Notice of Privacy Practices" prior to signing this document. TigerLily Acupuncture and Chinese Herbal Clinic's "Notice of Privacy Practices" has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information that will occur in my treatment, payment of my bills or in the performance of health care operations of TigerLily Acupuncture and Chinese Herbal Clinic. The Notice of Privacy Practices for TigerLily Acupuncture and Chinese Herbal Clinic is also provided on request at the front desk of this practice and on TigerLily Acupuncture and Chinese Herbal Clinic's website at www.tigerlilyacupuncture.com. This Notice of Privacy Practices also describes my rights and TigerLily Acupuncture's duties with respect to my Protected Health Information.

TigerLily Acupuncture and Chinese Herbal Clinic reserve the right to change the privacy practices that are described in the "Notice of Privacy Practices". I may obtain a revised notice of privacy practices by calling TigerLily Acupuncture and Chinese Herbal Clinic's office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

_____

Name of Patient or Personal Representative (Print)

_____

Signature of Patient of Personal Representative **Date**

_____

Description of Personal Representative's Authority

Douglas Rutkowski, LAc. April 14, 2005

Name of Privacy Officer

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Notification Form Regarding Evaluation of Patient by Physician

(Pursuant to the requirement of section 183.6(e) of the title and section 6.11, Subsection (d) V. A. C. article 44956b, governing the practice of acupuncture)

I (patient's name),_____am notifying TigerLily Acupuncture and Chinese Herbal Clinic of the following:

Yes__ No__ I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that a physician should evaluate me for the condition being treated by the acupuncturist.

AND

Yes__ No__ I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of chiropractic treatment prior to acupuncture treatment is _____. After bring referred by a chiropractor, if after 120 days or 30 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 to follow his advice.

_____

Patients Signature (required) Date

If the Acupuncturist refers me to a physician, it is my responsibility and choice to follow her/his advice.

_____

Patients Signature (required) Date

_____

Acupuncturist's Signature Date

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PATIENT INFORMATION

Appointments:
Treatments are by appointment only. If you find that you need to cancel an appointment, it is important that we receive forty-eight (48) hour notice. This enables us to fill the time slot. We reserve the right to charge a $85.00 fee for appointments canceled with less than twenty-four hour notice or for "no show" appointments.

Scheduling
In order to be considered an established patient in our clinic, a scheduled future appointment is required. At the conclusion of every appointment, you will be rescheduled for your next appointment based on the doctor's discretion and your availability.

Payment for Services Rendered
Payment is due at time of service and may be paid in ***cash, check, MasterCard or Visa.***

Herbal Refills
If you require a refill on an herbal formula prescribed during a previous treatment, we encourage you to make a follow-up appointment to determine if the formula is still appropriate for your current needs.

Insurance
We would be happy to file your claims for you. Please indicate if you have insurance before your appointment begins so that we can copy your insurance card and check your benefits. If you have benefits for acupuncture, we will give you a clear explanation of your benefits, including number of visits/year, co-pay & deductible. If your insurance company fails to issue a payment for a treatment, you will be responsible for the prompt pay cash discount price for the visit of $85 or $125.

Acupuncture and NRT Care Plans
Most patients purchase Care Plans for Acupuncture and Nutritional Response Testing (NRT) sessions because discounts are applied to the session cost. If you should ever need to seek a refund for a Care Plan, your treatments will be re-priced at the regular session price ($85 for acupuncture and $60 for NRT) and your refund will be the balance remaining.

Please sign and date on the line provided below. Thank you for allowing us to provide you with a quality, low-cost alternative to traditional health care.

_____

Patient's Signature **Date**

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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 the acupuncture on me (or on the patient named below, for whom I am legally responsible) by Douglas Rutkowski and/or Vanessa Rutkowski, 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 limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (chinese massage), Chinese herbal medicine, nutritional counseling. 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 be 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 have been informed that acupuncture is 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 of fainting. 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. Burns, and/or scarring are potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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 some herbs may be inappropriate during pregnancy. Some possible side effect of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told abut the risks ad benefits of acupuncture and other procedures, and I 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 SIGNATURE_____DATE_____