

# lazuli oriental medicine clinic

email : [info@lazuliom.com](mailto:info@lazuliom.com) • ph: 713-965-6796 • fax: 866-633-8749

Name \_\_\_\_\_ Date \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status:  Single  Married  Living with Partner  Separated  Divorced  Widowed

Spouse or Partner's name: \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other \_\_\_\_\_

E-mail \_\_\_\_\_

May we leave confidential messages on your voicemail ? Home:  Yes  No Cell:  Yes  No

If a friend, relative or co-worker (please specify) answers the phone, may we leave a message with them?

\_\_\_\_\_

Occupation \_\_\_\_\_ Employed by \_\_\_\_\_

Employers Address & Phone \_\_\_\_\_

**Emergency Contact:** Name \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Whom should we thank for referring you to our office? \_\_\_\_\_

Have you had acupuncture therapy before?  Yes  No With Whom? \_\_\_\_\_

**Date of last physical examination** \_\_\_\_\_

**Name & address of physician** \_\_\_\_\_

\_\_\_\_\_

**Phone number of physician:** \_\_\_\_\_

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## NOTES ABOUT TEXAS ACUPUNCTURE REGULATIONS:

**You may receive acupuncture without a referral or prior testing for smoking addiction, weight loss, alcoholism, chronic pain, substance abuse.**

**For any other condition, you MUST indicate that you** have been evaluated by a physician or dentist, as appropriate, for the condition being treated **within 12 months before acupuncture begins** OR have been referred by a licensed chiropractor (DC) 30 days before acupuncture begins

**(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., §205.351, governing the practice of acupuncture.)**

I \_\_\_\_\_ am notifying Marie Eclache, L.Ac. and Wesley

Hamner, L.Ac., of the following:

Yes  No 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.

\_\_\_\_ (initials of patient)      Date: \_\_\_\_\_

Yes  No 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.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

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

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

**Please indicate if any of the following pertain to you: (marking “yes” does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):**

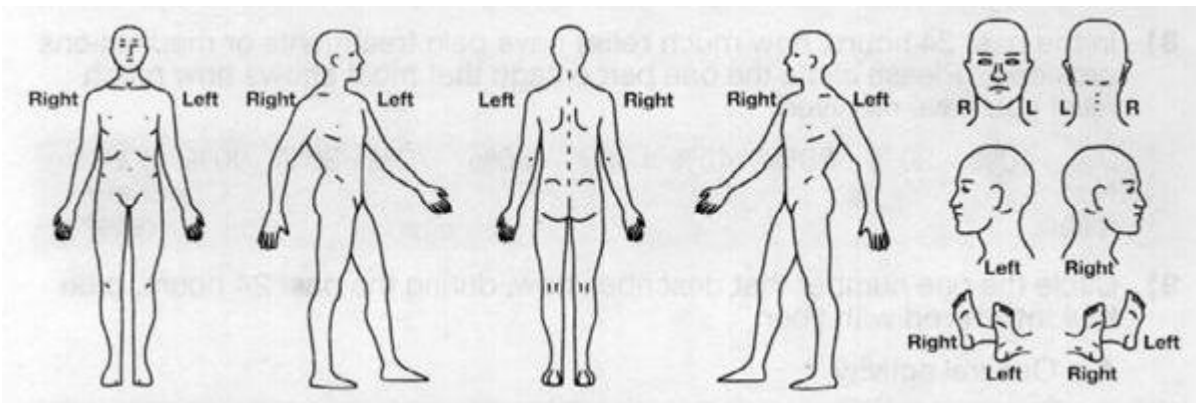
- Hepatitis     HIV     High Blood Pressure     Seizures     Pacemaker     Blood-Thinning Meds     Pregnancy  
 Tuberculosis (TB)     Other viral / bacterial infections (explain) \_\_\_\_\_

**Please list any prescription or over-the-counter medications, vitamins, supplements, and herbs you are presently taking:  
 (please attach separate form if there is not sufficient space below)**

Medication name	Dosage	When did you start taking & why?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to anything? \_\_\_\_\_

If you have any pain, please indicate on the figures below the areas of the body where you experience it, and intensity from 0 – 10 (0 is no pain, 10 is worst pain ever experienced)



How would you characterize your pain:

- dull/achy     sharp/stabbing     burning     tingling     numbness     electrical

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How long have you had this condition and how did it start?

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What other forms of treatment have you sought, and what were the results?

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What helps your condition? \_\_\_\_\_

What aggravates your condition? \_\_\_\_\_

## MAJOR HOSPITALIZATIONS / OPERATIONS / MAJOR ACCIDENTS & TRAUMAS:

**YEAR**

**Nature of operation / illness**

_____	_____
_____	_____
_____	_____
_____	_____

## Please indicate the use and frequency of the following:

Coffee \_\_\_\_\_ Soda \_\_\_\_\_ Water \_\_\_\_\_

Alcohol \_\_\_\_\_ Recreational drugs \_\_\_\_\_ Tobacco \_\_\_\_\_

FAMILY HISTORY: Please list any chronic disease, cancer, cardiovascular, mental disorders or other within your family :

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**This is a sample of the original consent form you will be asked to sign so that we may provide your treatment. It is provided here so you have some time to look it over before your appointment.**

## 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 named 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 of 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 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 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 I 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 effects 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 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.

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 written 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 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.

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## ♀ For Women Only

Age at first period \_\_\_\_\_ When was your last period ? \_\_\_\_\_

Are you or do you think you could be pregnant ?  No  Yes

Are you on birth control ?  No  Yes

Have you ever been on birth control ?  No  Yes What kind of birth control, and how long were you on it?

\_\_\_\_\_

Menopause ?  No  Yes When? / /

Hysterectomy / Ovariectomy ?  No  Yes When? / /

Reason: \_\_\_\_\_

Number of Pregnancies: \_\_\_\_\_ Number of children (live births) \_\_\_\_\_

Number of days between periods (your cycle) \_\_\_\_\_

Number of days of flow \_\_\_\_\_

### Color of flow:

- pale/light red
- red
- bright red
- dark red
- dark red/brown

### Amount of flow:

- spotting
- light
- even throughout
- heavy
- clots

### Clots?

- Yes  No
- color? \_\_\_\_\_
- size? \_\_\_\_\_

### Pain and cramping:

- Yes  No
- before flow
- during flow
- after flow

Discharge (color: \_\_\_\_\_)  PMS

Swollen Breasts

Mood Swings

Dizziness

Increased Appetite

Decreased Appetite

Acne / breakouts

Headaches (before / during / after period)

Nausea (before / during / after period)

Constipation (before / during / after period)

Loose stools (before / during / after period)

Insomnia (before / during / after period)

Spotting (before / during / after period)

Frequent yeast infections

## **NOTICE CONCERNING COMPLAINTS**

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

**Texas Medical Board  
Attention: Investigations  
333 Guadalupe, Tower 3, Suite 610  
P.O. Box 2018, MC-263  
Austin, Texas 78768-2018**

Assistance in filing a complaint is available by calling the following telephone number:

**1-800-201-9353**

For more information please visit our website at

**[www.tmb.state.tx.us](http://www.tmb.state.tx.us)**

## **AVISO SOBRE LAS QUEJAS**

Las quejas sobre médicos, así como sobre otros profesionales acreditados e inscritos en la Junta de Examinadores Médicos del Estado de Texas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugía, se pueden presentar en la siguiente dirección para ser investigadas:

**Texas Medical Board  
Attention: Investigations  
333 Guadalupe, Tower 3, Suite 610  
P.O. Box 2018, MC-263  
Austin, Texas 78768-2018**

Si necesita ayuda para presentar una queja,  
llame al:

**1-800-201-9353**

Para obtener más información, visite nuestro sitio  
web en

**[www.tmb.state.tx.us](http://www.tmb.state.tx.us)**

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### **PROTECTION OF HEALTH INFORMATION AND PRIVACY**

This notice describes our office's policy for how your privacy is being protected, how medical information about you may be used and disclosed, and how you can get access to this information.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - e.g. your name, address, Social Security number, etc.).

If you would like to access this information, please contact us in writing with your request at the address below:

Marie Eclache, L.Ac. and Wes Hamner, L.Ac.  
Lazuli Oriental Medicine  
7941 Katy Fwy, PMB 158  
Houston, TX 77024

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## CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

SOCIAL SECURITY # 000-00-\_\_\_\_

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

X \_\_\_\_\_  
PATIENT SIGNATURE OR GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE