

**Hawken Acupuncture 10405 E. Northwest Hwy, Suite 322, Dallas, Texas 75238**  
**972.804.9113**

**Personal Information**

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

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

State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_ Ok to leave message on phones? Yes No

Occupation \_\_\_\_\_ Person responsible for account \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

How you heard of us \_\_\_\_\_ Previous Acupuncture? Yes No When? \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_ Number of children \_\_\_\_\_

Sex Assigned at Birth \_\_\_\_\_ Gender \_\_\_\_\_ Sexual Orientation \_\_\_\_\_

Living Arrangement: Alone Spouse/Partner(s) Child(ren) Sibling(s) Parent(s)/ Guardian(s) Group setting

Personal care attendant Other \_\_\_\_\_

***Please indicate any significant illnesses you or a blood relative (grandparent, parent, or sibling) have had:***

Illness	You	Relative	When?	Illness	You	Relative	When?
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Seizures	<input type="checkbox"/>	<input type="checkbox"/>	

Other diseases (you):  Gonorrhea  Syphilis  HIV  HPV  Chlamydia  Herpes Date of Diagnoses \_\_\_\_\_

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

	Yes	No	Amount		Yes	No	Amount
Coffee/black tea				Alcohol			
Recreational Drugs				Tobacco			
Water				Soda Pop			

***Please check  the box if any of the following statements are true:***

I have known allergies  Yes  No I am taking Coumadin/Warfarin/Plavix or other blood thinners  Yes  No

I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)  Yes  No

I have a pacemaker  Yes  No I have other electrical implants  Yes  No If yes, please describe:

\_\_\_\_\_

\_\_\_\_\_



# General Health

**What sort of diet do you have? (check one)**  Standard American  Fast Food  Balanced Food Groups  
 Muscle Building  Vegetarian  Vegan  Low Fat  Low Carb  Other: \_\_\_\_\_

**Activity Level (check one):**  Sedentary Job WITHOUT exercise  Sedentary Job with SOME exercise  
 Sedentary Job with MUCH exercise  Active Job WITHOUT exercise  
 Active Job with SOME exercise  Active Job with MUCH exercise

What type of exercise do you do? \_\_\_\_\_

How frequently? \_\_\_\_\_

How long (time or mileage)? \_\_\_\_\_

**How would you describe your stress level?**  Low  Medium  High  Very High

**Please write your answers or circle Y/N as appropriate:**

How would you describe your energy level on a 1-10 scale, with 0 being asleep and 10 a good consistent energy (not manic and hyper)? \_\_\_\_\_

Is there a time of day when your energy is highest? What time? \_\_\_\_\_

Is there a time of day when your energy is lowest? What time? \_\_\_\_\_

Do you fall asleep quickly after going to bed? Y/N

Do you wake to urinate? Y/N If Yes, how many times during the night? \_\_\_\_\_

If no, do you sleep through the night? Y/N

If no, how long does it take you to fall back to sleep (give range of time) \_\_\_\_\_

Are you rested when you wake? Y/N

Regarding your body temperature (NOT measured with a thermometer, but how you FEEL), do you run:

Hot  Cold  Even temperature

Do you have any unexpected sweating (not under exertion)? Y/N

How hungry are you? (meaning an actual feeling of hunger in the stomach, NOT a desire to eat for other reasons)

Low  Average  High

How thirsty are you?  Not thirsty  Average  Excessively thirsty

Do you experience bloating after eating? Y/N

How often, in a day, do you have a bowel movement (number) \_\_\_\_\_ (give range, if number varies - for example, 1-4. If you have one, and then soon have another, this still counts as 2)

What is the typical consistency of the stool? (Check all that apply)  watery diarrhea  loose, no form

soft, broken tubes  one single, easy to pass tube  knobby  hard  small pellets

Do you have urgency with bowel movements? Y/N

Do you have to strain to pass stool? Y/N

Does it seem like you are urinating the same amount (volume) that you are drinking? Y/N

Do you have frequent urination? Y/N

If you could name one emotion that you feel is dominant for you – one that you feel more than any other, what would that be? \_\_\_\_\_

If applicable: what was the first day of your last menstrual period? \_\_\_\_\_

**Please fill out the section (A. or B.) that applies to you, and the Symptom Survey below**

**A.**

Are you pregnant?  Yes  No  
Date of last Pap smear \_\_\_\_\_ Date of last Mammogram \_\_\_\_\_ Date of last Bone Density Scan \_\_\_\_\_  
Results: Pap \_\_\_\_\_ Mammogram \_\_\_\_\_ Bone Density \_\_\_\_\_  
Are you using contraception?  Yes  No If Yes, what type? \_\_\_\_\_  
Age of 1st period (menarche) \_\_\_\_\_ Age of last period (menopause) \_\_\_\_\_ Number of days between periods \_\_\_\_\_  
Number of days of bleeding \_\_\_\_\_ How heavy is the bleeding?  light  average  heavy  
Color of blood:  light red  red  dark red  purple  brown  black Is there clotting?  Yes  No  
Average number pads/tampons used: 1st day \_\_\_\_\_ 2nd day \_\_\_\_\_ 3rd day \_\_\_\_\_ 4th day \_\_\_\_\_ +days \_\_\_\_\_  
Have you been diagnosed with:  Fibroids  Fibrocystic Breasts  Endometriosis  Ovarian Cysts  PID  Other  
Do you have chronic vaginal discharge?  Yes  No Are your periods painful?  Yes  No  
Location of menstrual pain:  Lower abdomen  Lower back  Thighs  Other \_\_\_\_\_  
Nature of menstrual pain (please indicate before (B), during (D), or after (A) menses)  
Cramping \_\_\_\_\_ Stabbing \_\_\_\_\_ Burning \_\_\_\_\_ Aching \_\_\_\_\_ Dull \_\_\_\_\_ Bloating \_\_\_\_\_  
Consistent \_\_\_\_\_ Intermittent \_\_\_\_\_ Bearing down sensation \_\_\_\_\_  
Other symptoms related to menses:  Discharge  Vaginal dryness  Headache  Nausea  Constipation  
 Swollen breasts  Diarrhea  Mood swings  Ravenous appetite  Poor appetite  Hot flashes  
 Night sweats  Insomnia  Decreased libido  Increased libido

**B.**

Date of last prostate check up \_\_\_\_\_ PSA results \_\_\_\_\_ Manual prostate exam results \_\_\_\_\_  
Frequency of urination: Daytime \_\_\_\_\_ Nighttime \_\_\_\_\_ Color of urine:  Clear  Murky  
Symptoms related to prostate:  Rectal dysfunction  Increased libido  Decreased libido  
 Premature ejaculation  Impotence  Prostate problems  Delayed stream  Dribbling  Incontinence  
 Retention of urine  Back pain  Groin pain  Testicular pain Other \_\_\_\_\_

**Symptom Survey (for everyone)**

**Please check  if you experience or have experienced**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> lack of appetite  | <input type="checkbox"/> colitis                              | <input type="checkbox"/> gall stones                                | <input type="checkbox"/> hair loss                       |
| <input type="checkbox"/> excessive appetite  | <input type="checkbox"/> diverticulitis                       | <input type="checkbox"/> light colored stool                        | <input type="checkbox"/> urinary problems                |
| <input type="checkbox"/> loose stool or diarrhea   | <input type="checkbox"/> cough                                | <input type="checkbox"/> soft or brittle nails                      | <input type="checkbox"/> fatigue                         |
| <input type="checkbox"/> digestive problems/<br>indigestion                              | <input type="checkbox"/> shortness of breath                  | <input type="checkbox"/> easily angered or agitated                 | <input type="checkbox"/> edema                           |
| <input type="checkbox"/> vomiting  | <input type="checkbox"/> decreased sense of<br>smell          | <input type="checkbox"/> difficulty in making<br>plans or decisions | <input type="checkbox"/> blood in stool                  |
| <input type="checkbox"/> belching/burping  | <input type="checkbox"/> nasal problems                       | <input type="checkbox"/> spasms or twitching of<br>muscles          | <input type="checkbox"/> black tarry stool               |
| <input type="checkbox"/> heartburn/reflux  | <input type="checkbox"/> skin problems                        | <input type="checkbox"/> pain or coldness in<br>the genital area    | <input type="checkbox"/> difficulty stopping<br>bleeding |
| <input type="checkbox"/> feeling the retention of<br>food in the stomach                 | <input type="checkbox"/> claustrophobia                       | <input type="checkbox"/> cold hands and feet                        | <input type="checkbox"/> recent use of<br>antibiotics    |
| <input type="checkbox"/> tendency to become<br>obsessive in work,<br>relationships, etc. | <input type="checkbox"/> bronchitis                           | <input type="checkbox"/> intolerance to weather<br>changes          | <input type="checkbox"/> abdominal pain                  |
| <input type="checkbox"/> insomnia, difficulty<br>sleeping                                | <input type="checkbox"/> asthma                               | <input type="checkbox"/> low back pain                              | <input type="checkbox"/> chest pain                      |
| <input type="checkbox"/> heart palpitations  | <input type="checkbox"/> hay fever                            | <input type="checkbox"/> knee problems                              | <input type="checkbox"/> sciatic pain                    |
| <input type="checkbox"/> nightmares  | <input type="checkbox"/> jaundice (yellowish<br>eyes or skin) | <input type="checkbox"/> hearing impairment                         | <input type="checkbox"/> headaches                       |
| <input type="checkbox"/> mentally restless   | <input type="checkbox"/> eye problems                         | <input type="checkbox"/> ear ringing                                | <input type="checkbox"/> dizziness                       |
| <input type="checkbox"/> laughing for no<br>apparent reason                              | <input type="checkbox"/> difficulty digesting oily<br>food    | <input type="checkbox"/> kidney stones                              | <input type="checkbox"/> fainting easily                 |
|  |   | <input type="checkbox"/> decreased sex drive                        | <input type="checkbox"/> high cholesterol                |
|  |   |   | <input type="checkbox"/> sudden weight loss              |

# Please complete this section if you are seeking treatment for pain

Describe location of pain: \_\_\_\_\_

Describe the onset of the pain: \_\_\_\_\_

Circle the words that best describe your pain:

dull sharp stabbing achy sore sudden cramping throbbing burning constant  
comes & goes radiating electric fixed moves about severe moderate chronic other: \_\_\_\_\_

Circle if any help your pain:

ice heat rest movement other: \_\_\_\_\_

*Weather:* hot cold dry humid windy rainy stormy

Circle if any make your pain worse:

ice heat rest movement other: \_\_\_\_\_

*Weather:* hot cold dry humid windy rainy stormy

Are there movements that aggravate the pain? \_\_\_\_\_

How does exercise affect your pain? \_\_\_\_\_

Do any medications help your pain? If yes, list them: \_\_\_\_\_

List other treatments you've had for the pain: \_\_\_\_\_

# Evaluation Request Form

*Please circle the appropriate answers, initial, sign, and date*

I have been evaluated by a physician (MD/DO) or dentist for the condition being treated within 12 months before receiving acupuncture treatment.

Yes No

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

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I recognize that I should be evaluated by a physician (MD/DO) or dentist for the condition being treated by the acupuncturist. This serves as a referral by the acupuncturist for me to see a physician. It is my responsibility and choice whether or not to follow this advice.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

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I have received a referral from my chiropractor within the last 30 days for acupuncture.

Yes No

After being referred by a chiropractor, if after 60 days 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, and consider this written notice a referral in advance. It is my responsibility and choice whether or not to follow this advice. This does not apply to the following conditions: chronic pain, alcoholism and substance abuse, smoking cessation, or weight loss.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

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## **Our Office Policy**

We do not bill insurance directly. Patients are expected to take care of their fees as services are rendered. You may request a detailed receipt to submit to your insurance company.

Our policy is to charge the full appointment fee for a missed appointment. If you need to cancel your appointment, please inform us at least 24 hours prior to your appointment to avoid being charged.

*I have read and agree to the terms above.*

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Payment and Appointment Cancellation Policies

Payment is expected at the time of service.

At Hawken Acupuncture, PLLC, we require a 24-hour notice for cancellation of an appointment, emergencies excepted. It is the policy of our clinic to hold a credit card number on file in order to reserve all of your appointments.

Please note that the held credit card will not be charged unless you miss an appointment or do not give our office 24-hours notice that you need to change your scheduled appointment. \_\_\_\_\_ (initial)

If you do not show for your appointment, or cancel your appointment giving us less than 24-hours notice, you will be charged the usual fee for your missed appointment. \_\_\_\_\_ (initial)

We appreciate your understanding and consideration.

Patient Credit Card Information:

Name on Card: \_\_\_\_\_

MC/Visa/Discover # \_\_\_\_\_ Exp \_\_\_\_\_

I, (print name) \_\_\_\_\_ understand and agree to the payment and cancellation policies for Hawken Acupuncture, PLLC as part of my healthcare treatment.

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

Today's Date: \_\_\_\_\_

# Notice of Privacy Practices Patient Acknowledgement

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I have received and understood this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosure of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This includes, but is not limited to:

- \* A statement that this practice is required by law to maintain the privacy of protected health information.
- \* A statement that this practice is required to abide by the terms of the notice currently in effect.
- \* Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- \* A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- \* A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- \* My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - \* The right to complain to this practice, and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - \* The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - \* The right to receive confidential communications of protected health information.
  - \* The right to inspect and copy protected health information.
  - \* The right to amend protected health information.
  - \* The right to request an accounting of disclosures of protected health information.
  - \* The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, the practice will provide me a revised Notice of Privacy Practices upon request.

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

Relationship to patient (if signed by a personal representative of patient): \_\_\_\_\_