Notification Form Regarding
Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care." As a result, Devon Gray, L.Ac. is required to have you respond affirmatively to the following statements before you may be treated. Please be advised that she will not be permitted to treat you with acupuncture if your response to all of these statements is no.

(Pursuant to the requirements of section 183.10(a)(11) of this title and section 205.302 V.A.C>S article 4495b, governing the practice of acupuncture)

I, (patient's name) _____, am notifying Devon Gray, L.Ac. of the following:

❑Yes
❑No

I have been evaluated by a physician, dentist, or nurse practitioner 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.

OR

❑Yes
❑No

I have received a referral from my chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of treatment prior to acupuncture treatment is _____. 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.

OR

❑Yes
❑No

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

❑Chronic Pain
❑Alcoholism
❑Smoking Addiction
❑Substance Abuse
❑Weight Loss

Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

_____ _____

Patient Signature (required) Date

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

_____ _____

Patient Signature (required) Date

_____ _____

Acupuncturist's Signature Date

TAO BLOSSOM, PLLC and Devon Gray, L.Ac. are not responsible for untrue statements made by patients.

HIPAA Acknowledgment and Appointment Reminders Form

I acknowledge that I have been provided access to TAO BLOSSOM's "Notice of Privacy Practices." I understand that I have the right to review TAO BLOSSOM's "Notice of Privacy Practices" prior to signing this document.

I understand that TAO BLOSSOM, PLLC and associates may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

I also understand that my clinical information may be used for educational and/or research purposes by TAO BLOSSOM or individuals authorized by TAO BLOSSOM. All information that can identify me personally will be removed.

By signing this form, I am giving TAO BLOSSOM, PLLC authorization to contact me and am giving my informed consent to utilize my information for research and educational purposes. I acknowledge that all information discussed during the assessment and treatment at TAO BLOSSOM will be held confidential except in the instance where my safety or the safety of others may be at risk.

_____ _____

Patient Name (please print) Patient Signature (required)

_____

Date

_____ _____

Acupuncture Practice Privacy Rep Signature Date

Authorization for Release of Health Information (Optional)

TAO BLOSSOM

I, (patient's name) _____, hereby authorize Devon Gray, L.Ac. the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____

_____

_____

_____ _____

Patient Signature (required) Date

Informed Consent to Oriental Medicine Health Care

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturist, Devon Gray, L.Ac. who now or in the future treats me with acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with my licensed acupuncturist the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from those locations; nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I

wish to rely on the practitioner to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.
I understand that acupuncture and Oriental medicine treatments may not have the desired therapeutic affect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is reasonable cause to believe that treatment is not appropriate for a patient who is under the influence of illegal drugs, alcohol, or appears to be overly medicated, then a treatment may not be performed at that time. The patient will be informed that they may not be treated at that time and will be requested to reschedule their appointment.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures and conditions of treatment. 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 Name (please print)	Patient Signature (required)
	_____
	Date
_____	_____
Patient's Representative - if applicable	Signature of Patient's Representative
_____	_____
Relationship or Authority of Patient's Rep.	Date

Medicines

What medicines / drugs / vitamins / herbs are you currently taking or have you taken within the last two months?

NAME	DOSAGE	FREQUENCY	START / END DATE
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-

Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Today's Date	Last Name	First Name M.I.
Date of Birth	Phone Number	Email Address

Street Address _____ City, State & Zip Code _____

Family Physician _____ Chiropractor _____

Emergency Contact _____ Emergency Contact Phone Number _____

Insurance

Will you need a super bill to submit to your insurance company? ❑ Yes ❑ No

(Please note that all treatments must be paid at time of service. Request for reimbursement is between you and your insurance carrier. Tao Blossom makes no claim nor guarantee of financial reimbursement.)

How did you hear about us?

❑Website
❑Search Engine _____
❑Word of Mouth / Friends / Relatives
❑Business Directory _____
❑Location / Signage
❑Other _____

Contact Preferences

May we contact you by email? ❑ Yes ❑ No
May we contact you by phone? ❑ Yes ❑ No

May we leave a voice message? ❑ Yes ❑ No

Chief Complaint(s): _____

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____

What are the causes of this problem? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?

_____

What kind of treatment(s) have you tried? _____

What makes this problem worse? _____

What makes this problem better? _____

Is there anybody in your family with the same/similar problems? _____

Remarks and additional information: _____

_____

_____

Medical History

Height: _____ Weight now: _____

Weight one year ago: _____ Weight maximum: _____

Do you use tobacco products? ❑ Yes ❑ No How much per day? _____

Please describe any use of drugs for non-medical purposes: _____

How often do you exercise? _____ Types: _____

How many hours do you sleep/night? _____ Typical bedtime: _____

How many cups of coffee/caffeinated tea do you drink daily? _____

What kind of alcoholic beverages do you usually drink, if any? _____

Are you a vegetarian? ❑ Yes ❑ No

Any other dietary restrictions? _____

Remarks and additional information: _____
Surgeries and/or hospitalizations: _____

_____

Significant trauma (auto accidents, sports injuries, etc): _____

_____

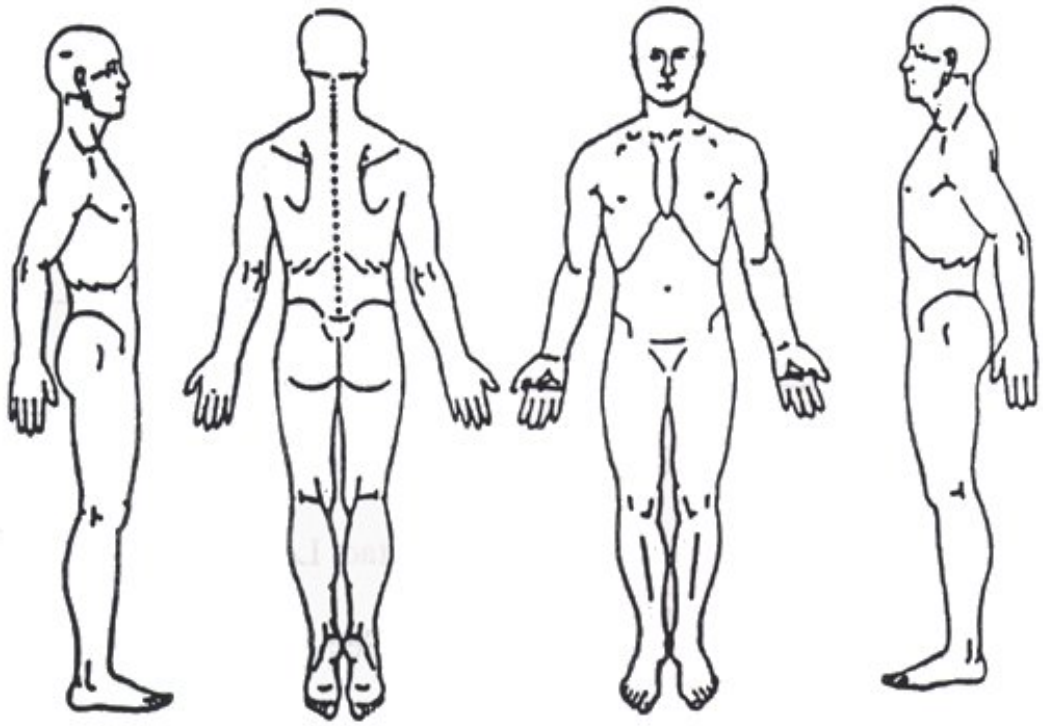
Allergies (drugs, chemicals, foods, environmental): _____

_____

Occupation: _____
Occupational stress (chemical, physical, psychological, etc.): _____
_____

Please indicate painful or distressed areas: _____

_____



Patient Intake Form, continued

Diagnosis	Self	Family (who?)
Diabetes		
Venereal Disease		
Hepatitis		
Alcoholism		
Thyroid Disease		
Depression / anxiety		
Seizures		
Tuberculosis		
Arthritis		
High Cholesterol		
Breathing problems		
High blood pressure		
Heart Disease		
Emotional disorders		
Digestive disorders		
Anemia		
Cancer (type: _____)		
Other: _____		

Please check if you have or have had any of the following diseases or condition in the last three months:

General:

- ❑ Poor Sleep
- ❑ Night Sweats
- ❑ Poor Appetite
- ❑ Fevers
- ❑ Weight Gain
- ❑ Weight Loss
- ❑ Ulcerations
- ❑ Sweat Easily
- ❑ Tremors
- ❑ Sudden energy drop (time of day? _____)
- ❑ Chills
- ❑ Change in Appetite
- ❑ Bleed or Bruise easily
- ❑ Strong thirst (circle one: crave **cold** or **hot** drinks?)
- ❑ Other: _____

Favorite time of year? _____
Least liked time of year? _____

Skin & Hair:

- ❑ Eczema
- ❑ Recent Moles
- ❑ Acne
- ❑ Change in hair or skin texture
- ❑ Itching
- ❑ Hives
- ❑ Dandruff
- ❑ Rashes
- ❑ Loss of Hair
- ❑ Dry Skin
- ❑ Other: _____

Musculoskeletal:

- ❑ Difficulty Walking
- ❑ Numbness
- ❑ Shoulder Pain
- ❑ Muscle Weakness
- ❑ Spinal Curvature
- ❑ Paralysis
- ❑ Hip Pain
- ❑ Back Pain
- ❑ Knee Pain
- ❑ Neck Pain
- ❑ Swelling of Hands/Feet
- ❑ Muscle Pain/Soreness
- ❑ Joint Sprain
- ❑ Joint Disorders
- ❑ Hernia
- ❑ Tingling Hand/Wrist Pain
- ❑ Other: _____

Genito-Urinary:

- ❑ Kidney Stones
- ❑ Genital Pain
- ❑ Painful Urination
- ❑ Dribbling
- ❑ Genital Itching
- ❑ Urgency to Urinate
- ❑ Frequent Urinary Tract Infections
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Pause of Flow
- ❑ Genital Rashes
- ❑ Unable to Hold Urine
- ❑ STD
- ❑ Other: _____

Head, Eyes, Ears, Nose and Throat:

- ❑ Dizziness
- ❑ Eye Pain
- ❑ Earaches
- ❑ Grinding Teeth
- ❑ Concussions
- ❑ Cataracts
- ❑ Problems with Teeth
- ❑ Sores on Lips/Tongue
- ❑ Sinus problems
- ❑ Poor Hearing
- ❑ Facial Pain
- ❑ Migraines
- ❑ Night Blindness
- ❑ Spots in Front of Eyes
- ❑ Difficulty Swallowing
- ❑ Fainting
- ❑ Poor Vision
- ❑ Ringing in Ears
- ❑ Jaw Clicks
- ❑ Nose Bleeding
- ❑ Other: _____

Cardiovascular:

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Irregular Heartbeat
- ❑ Palpitation
- ❑ Rapid Heartbeat
- ❑ Chest Pain
- ❑ Vein Inflammation
- ❑ Varicose Veins
- ❑ Cold Hands/Feet
- ❑ Other: _____

Respiratory:

- ❑ Bronchitis
- ❑ Asthma
- ❑ Coughing Blood
- ❑ Chest Pain
- ❑ Wheezing
- ❑ Difficulty Breathing
- ❑ Cough
- ❑ Pneumonia
- ❑ Sleep Apnea
- ❑ Production of Phlegm (what color? _____)
- ❑ Other: _____

Gastrointestinal:

Bowel movements

Texture/Form: _____

Frequency: _____

Color: _____

Odor: _____

- ❑ Gas
- ❑ Indigestion
- ❑ Parasites
- ❑ Nausea
- ❑ Black Stools
- ❑ Hemorrhoids
- ❑ Vomiting
- ❑ Blood in Stools
- ❑ Belching
- ❑ Diarrhea
- ❑ Excessive Bad Breath
- ❑ Rectal Pain
- ❑ Constipation
- ❑ Gallbladder Problems
- ❑ Abdominal Pain/Cramps
- ❑ Chronic Laxative Use
- ❑ Other: _____

Neuro-Psychological:

- ❑ Stress
- ❑ Depression
- ❑ Bi-polar
- ❑ Anxiety
- ❑ Bad Temper
- ❑ Loss of Balance
- ❑ Lack of Coordination
- ❑ Other: _____

Reproductive:

Male

- ❑ Pelvic Infection
- ❑ Frequent Seminal Emission
- ❑ Prostate Problems
- ❑ Ejaculation Problems
- ❑ Erectile Dysfunction
- ❑ Painful/Swollen Testicles
- ❑ Other: _____

Female

- ❑ Pelvic Infection
- ❑ Ovarian Cysts
- ❑ Breast Lumps
- ❑ Hot Flashes
- ❑ Endometriosis
- ❑ Vaginal/Genital Discharge
- ❑ Frequent Vaginal Infections
- ❑ Fibroids
- ❑ Fertility Problems
- ❑ Other: _____

Menstrual Cycle:

- ❑ Irregular Periods
- ❑ Breast Tenderness
- ❑ Moodiness or Sensitivity
- ❑ Cramps Prior/During Periods
- ❑ Clots or Sharp Pain
- ❑ Other: _____

First Day of Last Menstrual Period: _____
Age of First Menstrual Period: _____

Duration of Periods: _____ days
Duration of Cycle: _____ days

Pregnancies:

Are you, or could you possibly be, pregnant?
❑ Yes ❑ No

Number of Pregnancies: _____
Number of Births: _____
Number of Premature Births: _____
Number of C-Sections: _____
Number of Difficult Deliveries: _____
Number of Abortions: _____
Number of Miscarriages: _____

Do you practice birth control?
❑ Yes ❑ No

If yes, what type and for how long?

_____
_____

Gender reassignment operation(s):

_____
_____
_____
_____

Sex assigned at birth: ❑ Male ❑ Female

If you feel there are any personally relevant health issues not covered in these forms please inform your practitioner.

I have completed this form correctly to the best of my knowledge.

_____	_____
Patient Name (please print)	Patient Signature (required)
	_____
	Date
_____	_____
Patient's Representative - if applicable	Signature of Patient's Representative
_____	_____
Relationship or Authority of Patient's Rep.	Date