

**Georgetown Acupuncture and Herbs**  
**Office of Kenichi Nishiya, L.Ac**  
**1915 S. Austin Avenue, Suite 102, Georgetown, Texas**  
**(512) 868-2757**

This is a confidential questionnaire to help us determine the best course of treatment for you. If you have any questions, please do not hesitate to ask for assistance.

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

Home Telephone: \_\_\_\_\_ Work / Cell Phone: \_\_\_\_\_

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

City / State / Zip Code: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Person responsible for your account: \_\_\_\_\_

Sex: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Have you ever received acupuncture before? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

*(Pursuant to the requirement of Section 6.11, Subsections (b) through (d), V.A.C.S., article 4495b, governing the practice of acupuncture.)*

\_\_\_\_\_ Yes \_\_\_\_\_ No

I have been evaluated by a physician or dentist for the condition being treated within six months, before the acupuncture was performed.

\_\_\_\_\_ Yes \_\_\_\_\_ No

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

*I recognize that I should be evaluated by a physician for the condition being treated by the acupuncturist. After being referred by a chiropractor, if after 30 days or 20 treatments, whichever comes first, and 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 this advice.*

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

**To be completed by Patient, if the Acupuncturist has referred him/her to a physician.**

*(Pursuant to the requirement of Section 6.11, Subsections (b) through (d), V.A.C.S., article 4495b, governing the practice of acupuncture.)*

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

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

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

**HEALTH HISTORY FORM**

What are the main problems for which you are seeking treatment?

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**History of present illness**

Where does it hurt? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

What does it feel like when it hurts? \_\_\_\_\_

Does the pain/problem occur at a specific time? \_\_\_\_\_

What other associated problems have you been having? \_\_\_\_\_

What makes the pain/problem worse or better? \_\_\_\_\_

Previous Hospitalizations/Surgeries/Serious Illnesses

When?

_____	_____
_____	_____
_____	_____
_____	_____

Medications (include non-prescription, vitamins, supplements, etc.)

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Do you have HIV/AIDS, Hepatitis or any blood borne disease? \_\_\_\_\_

**Family Medical History**

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

Please mark an "x" next to any conditions you have had and a 'check' after conditions you currently have.

MENTAL/EMOTIONAL

- Mood swings/depression
- Eating disorder
- History of counseling
- Tension
- Anxiety or nervousness
- Considered/attempted suicide

ENDOCRINE

- Thyroid problems
- Heat or cold intolerance
- Fatigue
- Hypoglycemia
- Excess thirst or hunger
- Diabetes
- Seasonal depression

IMMUNE

- Chronic fatigue syndrome
- Chronically swollen glands
- Chronic infections
- Frequent colds
- Autoimmune disease
- Allergies or hay fever

NEUROLOGIC

- Seizures
- Vertigo or dizziness
- Paralysis
- Muscle weakness
- Numbness or tingling
- Loss of balance
- Loss of memory

SKIN

- Fungus
- Rashes
- Color change
- Eczema
- Acne or boils
- Itching

HEAD

- Jaw/TMJ problems
- Headaches
- Migraines
- Head Injury

RESPIRATORY

- Cough
- Pain on breathing
- Wheezing or asthma
- Shortness of breath
- Bronchitis
- Spitting up blood

NOSE AND SINUSES

- Stuffiness
- Nose Bleeds
- Hay fever
- Sinus problems
- Loss of smell
- Sinus headache

EARS

- Impaired hearing
- Earaches
- Ringing

MOUTH AND THROAT

- Teeth grinding
- Hoarseness
- Copious saliva
- Dry mouth
- Gum problems
- Sore tongue or lips
- Frequent sore throat
- Mouth sores

EYES

- Floaters or 'spots'
- Cataracts
- Blurriness
- Double Vision
- Glaucoma
- Near/Far sightedness
- Tearing or dryness
- Eye pain/strain
- Impaired vision

MUSCULOSKELETAL

- Joint pain
- Joint stiffness
- Arthritis
- Weakness
- Sciatica
- Broken bones
- Muscle pain
- Muscle spasm
- Osteoporosis

URINARY/KIDNEY

- Pain on urination
- Increased frequency
- Frequency at night
- Kidney stones
- Infections
- Urine leakage

CARDIOVASCULAR

- Heart disease
- Murmurs
- Chest pain
- Poor circulation
- Blood clots
- Deep leg pain
- Heart Valve problems

- Palpitations
- Easy bruising
- Anemia
- Varicose veins
- Fainting
- Swelling in ankles

REPRODUCTIVE

- Pain with intercourse
- Chlamydia
- Herpes
- Genital warts
- Discharge or sores
- Sexual difficulties
- Trouble conceiving
- Low sex drive

GASTROINTESTINAL

- Nausea
- Trouble swallowing
- Passing gas
- Vomiting
- Diarrhea
- Constipation
- Change in appetite
- Acid Reflux

- Ulcer
- Belching
- Black stool
- Change in thirst
- Hemorrhoids
- Pain or cramps
- Blood in toilet
- Ulcer

**HABITS**

Do you exercise?        Y        N        How often / What do you do? \_\_\_\_\_  
Do you sleep well?       Y        N        How many hours do you sleep? \_\_\_\_\_  
Drink coffee?            Y        N        How much? \_\_\_\_\_  
Drink soft drinks?       Y        N        How much? \_\_\_\_\_  
Use tobacco?            Y        N        Type / Frequency? \_\_\_\_\_  
Drink alcohol?           Y        N        Type / Frequency? \_\_\_\_\_  
Use recreational drugs? Y        N        Type / Frequency? \_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_  
How often do you eat fast food? \_\_\_\_\_

Food intolerances (if known)  
\_\_\_\_\_  
\_\_\_\_\_

Typical Breakfast: \_\_\_\_\_  
Typical Lunch: \_\_\_\_\_  
Typical Dinner: \_\_\_\_\_

**FEMALE ONLY (Circle if it applies to you)**

PMS	Irregular Cycles	Bleeding between cycles	Painful Menses
Heavy cycle	Clotting	Discharge	Breast lumps or pain
Endometriosis	Ovarian Cysts	Abnormal Paps	Menopausal symptoms

Are your menstrual cycles regular? \_\_\_\_\_  
Are you on birth control pills or other forms of contraception? \_\_\_\_\_  
How many days of bleeding per cycle? \_\_\_\_\_  
What is the length of your menstrual cycle (days)? \_\_\_\_\_  
Last gynecological exam date: \_\_\_\_\_  
What was the result of the exam? \_\_\_\_\_

# of pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_ # of miscarriages \_\_\_\_\_ # of abortions \_\_\_\_\_

**MALE ONLY (Circle if it applies to you)**

Hernias	Testicular Masses	Prostate disease	Impotence
Testicular Pain	Premature Ejaculation	Low sex drive	High Sex drive

# Georgetown Acupuncture and Herbs Informed Consent to Oriental 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 Georgetown Acupuncture and Herbs for today and in the future: acupuncture and other oriental health 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 massage, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation, cupping, mild bleeding therapy; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations, exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with an acupuncturist the nature and purpose of acupuncture and the other Oriental Medicine procedures. Although I am aware that acupuncture and the other procedures have helped many 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 allopathic medicine, in the practice of Oriental Medicine there are some risks. 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, pneumothorax (punctured lung), puncture of other organs, pain or other strong sensation at the location where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms, general aches, sprains, strains, dislocation, fractures, disc injuries, and strokes. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish the acupuncturist to exercise such judgment, during the course of my treatment, based on the facts known, to be in my interest. I authorize the acupuncturist to perform any necessary services needed during the diagnosis and treatment.

I have read, or have had read to me, this informed consent form. I have had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment from Georgetown Acupuncture and Herbs.

\_\_\_\_\_  
Patient's name (please print)

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

\_\_\_\_\_  
Date signed

If patient is a minor or has a legal guardian, a parent or guardian needs to sign below:

\_\_\_\_\_  
Print name of patient's representative

\_\_\_\_\_  
Relationship or authority

\_\_\_\_\_  
Signature of patient's representative

\_\_\_\_\_  
Date Signed