Manning Wellness Clinic

2702 McKinney Ave. Suite 202
Dallas, TX 75204
PH (214) 720-2225 Fax (214) 720-2288
www.manningwellness.com

Name _____ **Marital Status: S M D W**

Date of Birth _____**Age** _____ **Social Security#** _____-_____-_____ **M / F**

Address _____ **APT #**_____

City _____ **State** _____ **Zip** _____

Email Address: _____

Home#: (_____**)** _____ **Cell#: (**_____**)**_____ **Work#: (**_____**)** _____

Occupation_____ **Job Description:** _____

Spouse Name: _____ **Spouse Occupation:**_____

Emergency Contact: (Name) _____ **Relationship** _____ **Phone**_____

Have you ever received Acupuncture? Y/N When, Where? _____

How did you find out about our Clinic? _____

Current Health History

Chief complaint _____**Date it began**_____

Pains are: ❑**Sharp** ❑**Dull** ❑**Constant** ❑**Intermittent**

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of day? _____

Is this condition interfering with Work? _____**Sleep?** _____**Daily routine?** _____ **Other?**_____

Is this condition getting progressively worse? **YES / NO**

Other Doctors seen for this condition? _____

Any medications or surgeries for this condition? _____

Any home remedies? _____

Are you experiencing other symptoms?

- ❑ Headaches
- ❑ Neck Pain
- ❑ Sleeping Problems
- ❑ Back Pain
- ❑ Nervousness
- ❑ Tension
- ❑ Irritability
- ❑ Chest Pains
- ❑ Dizziness
- ❑ Neck stiffness
- ❑ Pins & Needles in Legs
- ❑ Pins & Needles in Arms
- ❑ Numbness in Fingers
- ❑ Numbness in Toes
- ❑ Shortness of Breath
- ❑ Fatigue
- ❑ Depression
- ❑ Fever
- ❑ Loss of Memory
- ❑ Ringing in Ears
- ❑ Fainting
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Diarrhea
- ❑ Cold Feet
- ❑ Cold Hands
- ❑ Stomach Upset
- ❑ Constipation
- ❑ Buzzing in Ears
- ❑ Loss of Balance

Other concerns: _____

Notes: _____

Health Information Practices

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. This may be via mail, telephone or email.

May we leave a message either on voicemail or with the person answering the call?

Print Name of patient _____

Signature of patient or guardian _____ **Date** _____

ACUPUNCTURE INFORMED CONSENT

I, _____, the patient, acknowledge that Chinese medicine is not western

(PRINT PATIENT NAME)

medicine, and as such, this care does not replace medical care. I am stating that I have a medical doctor to treat my medical conditions. The acupuncturist is not treating my medical conditions.

After 60 days or 20 treatments, whichever comes first, if 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 or not to follow this advice.

I hereby request and consent to acupuncture and other procedures associated with TCM performed by Laura Yoo, L.Ac. I understand that methods of treatment may include but are not limited to: acupuncture, electrical stimulation, cupping, gua sha, herbal medicine, nutritional counseling, and heat therapy.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needle sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include miscarriage, organ puncture, and infection.

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

I will immediately notify the practitioner of any unanticipated or unpleasant effects associated with treatment. I have discussed the nature and purpose of my treatment with Laura Yoo, L.Ac.

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.

Print Name of patient _____

Signature of patient or guardian _____ **Date** _____