10330 Lake Road, Building D
Houston, Texas 77070

Welcome to Cypress Area Acupuncture. Please provide the following information, so that we may do our best to provide the most effective treatment for you. Cypress Area Acupuncture considers this information physician-patient communication and withholds it in confidence. If you have any questions, please ask for assistance.

Date: ___________ Gender: __________________ Date of Birth: ________________

Full Name: ____

Home Address: ____

City: __________________State: ____________________Zip Code: _____________

Phone (Home/Cell): ______________________ Work Phone: _____________________

Email: ____

Marital Status: Single Married Separated Divorced Widowed

Occupation: _______________________ Employer: ____________________________

Emergency Contact:

Name: _________________________________ Phone #: _________________________

Relationship: ______________________________

Primary Physician's Name: ____

How did you hear about us?: ____

Have you ever had acupuncture before?: _____________________________________

FAMILY History

Please list the health of your family members as Excellent, Good, Fair, or Poor. Indicate if they have any of the following: allergies or asthma, anemia, arthritis, bleeding tendencies, cancer or tumor, colitis, depression, diabetes, drug or alcohol abuse, epilepsy, glaucoma, heart disease, high-blood pressure, immunologic disease, kidney or bladder trouble, liver disease, mental illness, migraines, obesity, osteoporosis, stomach issues, stroke, TB, other. If deceased, please list the cause and at what age they passed.

Father: ______________________________

Mother: ______________________________

Brothers/Sisters (please indicate sex): ______________________________

____

____

Children (please indicate sex): ______________________________

____

____

Grandparents: ______________________________

____

Other Relatives: ______________________________

____

Health Habits (Check Yes or No and circle day or week)

Tobacco smoking	☐ Yes	☐ No	_____ packs per day / week	Type of tobacco _____			
Coffee	☐ Yes	☐ No	_____ cups per day / week	☐ Reg	☐ Decaf		
Tea	☐ Yes	☐ No	_____ cups per day / week	☐ Reg	☐ Herbal		
Alcohol	☐ Yes	☐ No	_____ drinks per day / week	☐ Wine	☐ Beer	☐ Liquor	
Soft drinks	☐ Yes	☐ No	_____ drinks per day / week	☐ Regular	☐ Diet		
Artificial Sweeteners	☐ Yes	☐ No	_____ packs per day / week				

Glasses water/fluid per day _________ plain water _________ juice _________ other

What exercises/activities do you do and how often? ______________________________

How many hours of sleep do you get per night? _________ Is it restful? _________

Do you have an adequate energy level? ______________________________

Mark the stress level in your life (0 is the least, 10 is the most): 1 2 3 4 5 6 7 8 9 10

How much does stress affect you (0 is the least, 10 is the most)? 1 2 3 4 5 6 7 8 9 10

What is your job satisfaction (0 is the least, 10 is the most)? 1 2 3 4 5 6 7 8 9 10

What are the major stresses in your life presently? ______________________________

How many hours per week do you work? _______ How many hours per week do you have for free time? _______

Favorite pastime/recreational activity:

Tests and Immunizations (Mark an X next to those you have had.

Year		Year		Year	
_______	☐ Chest X-ray	_______	☐ Other X-rays	_______	☐ Tetanus "shot"
_______	☐ Kidney X-ray	_______	☐ TB test	_______	☐ Flu injection
_______	☐ G.I. series	_______	☐ Electrocardiogram	_______	☐ Pneumovax injection
_______	☐ Colon X-ray	_______	☐ MRI or CAT-SCAN	_______	☐ Ubella injection
_______	☐ Back X-ray	_______	☐ Treadmill or Stress-EKG	_______	☐ Other injection

Health Maintenance:

_______	☐ Last check-up	_______	☐ Rectal exam	_______	☐ Mammogram
_______	☐ Cholesterol test	_______	☐ Stool blood test	_______	☐ Pap smear
_______	☐ Blood tests	_______	☐ Sigmoidoscopy	_______	☐ Bone density test

PATIENT History

Name: ______________________________ Date:

Age: _____ Birthdate: ____________ Sex: ____ Marital Status: ___________ Height: _______ Weight: _______

Occupation: ______________________________ Years: ____________

Spouse's Name/Occupation: ______________________________ Years: ____________

Who referred you to this office? ____________________

Main Reason for This Visit: ______________________________

Known Diagnoses or Health Problems: | Personal Health Goals:

Previous/Present Doctor: ____________________ ____________________

Other practitioners involved in your care (Please list, including specialty):

Past Medical History (Please list or describe):

	Year/Date		*Year/Date*
Operations or surgery:		Head Injury:	
		Hospitalizations:	
Accidents:		Serious Illnesses:	
Broken Bones:		Blood Transfusions:	
		Pacemaker:	

Medications, Allergies, and Sensitivities

Please list any medications or drugs, and any foods or other substances to which you are allergic:

Are you or have you been exposed to any of the following?

Chemicals____ radiation____ paints____ fumes____ dust____ solvents____ unpurified water_____

Travel to 3rd world country____ wilderness areas____ other______________________

Number of courses of antibiotics: Less than 5____ 5-10____ More than 10____

Courses of steroids (how many): ______________________________

List all medications you are taking (including over the counter meds and birth control pills – past or current):

Name:	Dose:	Frequency:

List any vitamin, herb, or supplements you are taking:

Name:	Dose:	Frequency:

SYMPTOMS – sheet A

Have you ever had any of the following? Please indicate "C" for current and "P" for past:

GENERAL

___Fever, chills, sweats
___ Night sweats
___ Fatigue
___ Nervousness/anxiety
___ Irritability
___ Depression
___ Generally feel "run down"
___ Sexual abuse (optional)
___ Emotional abuse (optional)
___ Loss of weight

SKIN

___ Non-healing sore
___ Hives, rash
___ Eczema, psoriasis
___ Frequent infection or boils
___ Abnormal pigmentations, moles
___ Warts
___ Herpes:
  ___ lips
  ___ genital
  ___ zoster (shingles)
___ Skin cancer or melanoma
___ Brittle or weak nails
___ Infected nails

ENDOCRINE

___ Diabetes
___ Thyroid disease
___ Heat or cold intolerance
___ Dry skin
___ Change in hair growth or texture
___ Excessive thirst or urination
___ Sexual problems
___ Hormone therapy
___ Low or high sex drive
___ Radiation to neck or face area
___ Low blood sugar

HEAD-EYES-EARS-NOSE-THROAT

___ Headache
___ sinus (allergy)
___ tension
___ migraine
___ Head feels "heavy"
___ Loss of memory
___ Light-headedness or "spaciness"
___ Light bothers eyes
___ Eye disease or injury
___ Blurry vision
___ Double vision
___ Loss of vision
___ Glaucoma, cataracts
___ Loss of balance
___ Dizziness or vertigo
___ Loss of hearing
___ Ear disease
___ Impaired hearing
___ Ringing/buzzing in ears
___ Ear pain
___ Discharge from ear
___ Runny nose or nasal discharge
___ Nosebleeds
___ Chronic sinus trouble
___ Snoring
___ Sore throats
___ Hoarseness
___ Tooth & gum problems
___ Loss of taste
___ Sores in mouth
___ Sore tongue

RESPIRATORY

___ Frequent "colds"
___ Difficulty breathing
___ Chronic or frequent cough
___ Asthma or wheezing
___ Emphysema
___ Spitting up blood
___ Pleurisy (pain with breathing)
___ Pneumonia
___ Coughing up sputum

CARDIOVASCULAR

___ High blood pressure
___ Palpitation, irregular heart beat
___ Rheumatic fever
___ Chest pain or angina
___ Shortness of breath with walking
___ Shortness of breath lying down
___ Difficulty walking two blocks
___ Heart trouble
___ Heart attack
___ Heart murmur
___ Awakening in night smothering
___ Swelling of hands, feet or ankles
___ Need more than 1 pillow to sleep
___ Calf pain walking relieved by rest
___ Varicose veins

HEMATOLOGIC

___ Excessive bleeding/bruising
___ Anemia
___ Phlebitis/blood clots in veins
___ Are you slow to heal after cuts or bruising?
___ Difficulty w/bleeding excessively after tooth extraction or surgery
___ Mononucleosis

GASTROINTESTINAL

___ Painful bowel movement
___ Vomiting blood or food
___ Heartburn/indigestion
___ Food sticks in throat
___ Difficulty swallowing
___ Diarrhea or loose stools
___ Ulcer (stomach or duodenal)
___ Gallbladder disease or stones
___ Liver trouble/hepatitis
___ Bloody or black stools
___ Constipation
___ "Nervous" stomach
___ Nausea and/or vomiting
___ Bloating in stomach after eating
___ Bloating or gas in lower abdomen
___ Thin or ribbon like stools
___ Hard/difficult bowel movements

GENITOURINARY

___ Frequent urination
___ Involuntary loss of urine
___ Burning or painful urination
___ Blood in urine
___ Straining to urinate
___ Hernia
___ Sexually transmitted disease
___ Kidney stones
___ Kidney infections

FEMALE

___ Last menstrual period_____date
___ Currently pregnant
___ Age periods started
___ Duration of flow ____ days
___ Days in cycle _______ days
___ Pelvic pain or infection
___ Excess discharge
___ Excess discharge
___ PMS
___ Menstrual cramping
___ Irregular cycle
___ Number of pregnancies
___ Number of children
___ Number of ectopic pregnancies
___ Number of miscarriages
___ Number of abortions
___ DES exposure
___ Uterine fibroids
___ Hysterectomy
___ Date of menopause ______
___ Hot flashes
___ Menopausal bleeding
___ Breast pain
___ Breast lumps
___ Nipple discharge or bleeding
___ Abnormal PAP smear

MALE

___ Testicular pain/swelling
___ Urinary frequency or burning
___ Difficulty in starting stream of urine
___ Discharge from penis
___ Frequent night urination
___ Prostate pain/swelling
___ Undescended testicle
___ Impotence

LOCOMOTOR-MUSCULOSKELETAL

___ Joint swelling
___ Arthritis or joint pain
___ Weakness of muscles or joints
___ Back pain (see next page)
___ Difficulty walking
___ Leg cramps
___ Leg ulcers

MENTAL EMOTIONAL/NEUROLOGIC

___ Fainting spells
___ Epilepsy/Seizures
___ Stroke or mini-stroke
___ Paralysis
___ Weakness of an arm or leg
___ Insomnia or trouble sleeping

Tendency towards:

___ Sadness/grief/depression
___ Anger/irritability
___ Anxiety/fear
___ Mental overactivity

SYMPTOMS – sheet B

NECK
___ Pain
Neck pain with movement:
___ forward
___ backward
___ turning to the left
___ turning to the right
___ bending to the left
___ bending to the right
___ Pinched nerve in neck
___ Neck feels out of place
___ Muscle spasms in neck
___ Grinding sounds in neck
___ Popping sounds in neck
___ Arthritis in neck
___ Swollen glands

SHOULDERS
___ Pain in shoulder joint (R / L)
___ Pain across shoulders
___ Bursitis (R / L)
___ Arthritis (R / L)
___ Can't raise arm:
___ above shoulder level
___ over head
___ Can't put arm behind back (as if putting on a bra)
___ Tension in shoulders
___ Pinched nerve in shoulder (R / L)
___ Muscle spasms in shoulders

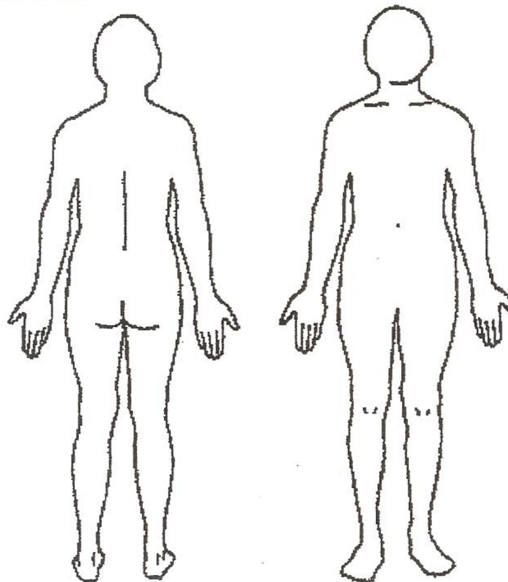
ARMS AND HANDS
___ Pain in upper arm (R / L)
___ Pain in elbow (R / L)
___ Movement aggravates pain
___ Pain in forearm (R / L)
___ Pain in hands (R / L)

___ Pain in fingers (R / L)
___ Feeling of pins & needles in arms (R / L)
___ Feeling of pins & needles in fingers (R / L)
___ Numbness in arms (R / L)
___ Numbness in fingers (R / L)
___ Fingers go to sleep (R / L)
___ Hands cold (R / L)
___ Swollen joints in fingers (R / L)
___ Arthritis in fingers (R / L)
___ Loss of grip strength (R / L)

MID-BACK & CHEST
___ Mid-back pain
___ Pain between shoulder blades
___ Sharp stabbing pain
___ Dull ache
___ Pain from front to back
___ Muscle spasms in mid back
___ Pain in kidney area
___ Chest pain
___ Shortness of breath
___ Pain around ribs

LOW BACK
___ Low back pain
___ Upper lumbar
___ Lower lumbar
___ Sacroiliac pain
Low back pain is worse when:
___ working
___ lifting
___ stooping
___ standing
___ sitting
___ bending
___ coughing
___ lying down (sleeping)
___ walking
___ other
Pain relieved with:
___ ice
___ heat
___ movement
___ physical therapy
___ topical analgesics
___ medications
___ other
___ Slipped disk
___ Low back feels out of place
___ Muscle Spasms

Please indicate where you have pain by shading the areas in the outlines below.



HIPS, LEGS, AND FEET
___ Pain in buttocks (R / L)
___ Pain in hip joint (R / L)
___ Pain down leg (R / L)
___ Pain down both legs
___ Knee pain (R / L)
___ Leg cramps (R / L)
___ Cramps in feet (R / L)
___ Pins & needles in legs (R / L)
___ Numbness of leg (R / L)
___ Numbness of feet (R / L)
___ Numbness of toes (R / L)
___ Feet feel cold (R/L)
___ Swollen ankles (R / L)
___ Swollen feet (R / L)

THERAPEUTIC TECHNIQUES
___ Acupuncture
___ Herbal Medicine
___ Homeopathy/Bach Flower
___ Hellerwork
___ Rolfing/Structural intergration
___ Massage
___ Chiropractic
___ Psychotherapy (Optional)
___ Visualization/Guided Imagery
___ Biofeedback
___ Feldenkrais
___ Polarity
___ Reiki
___ Tragerwork
___ Craniosacral Therapy
___ Physical Therapy
___ Therapeutic Exercise
___ Movement Therapy
___ Nutrition
___ Other ____________________

HIPPA Notice
Privacy Disclosure and Policies

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

Safeguards in place 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) are kept on permanent file.

Public Interaction:
Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction. It is our preference to discuss your health in the clinic setting only in order to protect your privacy and ensure important information is kept in your chart.

Consultations:
We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or via email are confidential, and names are not used unless consent is provided from you in writing. In administering your health care, we may gather and maintain information that may include these examples of non-public personal information:

- 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 party administrators.

Records Release:
Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply:
Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of a individual; the provision of healthcare to an individual; or in the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have JoNell Norcini, Licensed Acupuncturist maintain my records confidentially in accordance with the law. I agree to inform JoNell Norcini, L.Ac. if I need any special arrangements pertaining to this issue.

Signature ______________________________ **Date** __________

Printed Name ______________________________

Cypress Area Acupuncture
10330 Lake Road, Building D
Houston, TX 77070

Consent to Treatment Page 1 of 2

I, ___________________________________, come to Cypress Area Acupuncture seeking TCM (Traditional Chinese Medicine) treatment for my condition. I hereby authorize Licensed Acupuncturist, JoNell Norcini, to perform appropriate therapy as my condition indicates or requires. I understand that, as in any medical therapy, there is no guarantee to the results from acupuncture, herbal therapy, and related treatments.

(Initial) ___________ Acupuncture:

- I understand that acupuncture is performed by the insertion of sterile, single-use needles through the skin to treat bodily dysfunction or disease, to modify or prevent pain perception, and to normalize the body's physiological functions.
- Nothing is applied to the needles prior to insertion.
- Acupuncture is a safe and risk-free treatment in competent hands; however, some side effects may occur. Common side effects include local, minor bruising and/or bleeding at site of acupuncture. Dizziness, fainting, or discomfort may also occur; however, such effects can be substantially minimalized by eating a healthy protein snack within 1 to 2 hours prior to each treatment.
- I understand that one-time use, pre-sterilized disposable needles are the only needles used at Cypress Area Acupuncture.

(Initial) _____________ I understand that I am free to stop acupuncture or other treatment modalities at any time.

(Initial) __________ **Pregnancy**: I will notify JoNell Norcini, L.Ac. should I become pregnant, or if I am in the process of trying to become pregnant, so as to avoid any points and/or herbal therapies that are contraindicated in pregnancy. Otherwise, Chinese Medicine can be beneficial for fertility, prenatal and postpartum care.

(Initial) __________ **Herbal Therapy**:

- I understand that herbal therapy may be recommended to treat dysfunction, to modify or prevent pain perception, and to normalize the body's physiological function.
- I understand that I am not required to take herbal therapy, but must follow the directions for administration and dosage if I decide to take the herbs prescribed. (JoNell Norcini will discuss with you the potential side effects associated with herbal prescriptions.)

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(Initial) ____________ **Cupping (Myofascial Release)**:

- I understand that I may be given cupping (the application of glass or plastic cups with suction to the skin) as part of my treatment to modify or prevent pain perceptions and to normalize body's physiological functions.
- I am aware that cupping is intended to cause petechiae, and though unsightly, the petechiae are not painful and are not bruises. They are indicative of a therapeutic reaction. I understand that I may refuse treatment.

I do not expect JoNell Norcini, to be able to anticipate and explain all possible risks of treatment. I have carefully read and understand all of the above information, and I am aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent, unless in an emergency or by legal demand.

Cypress Area Acupuncture
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Clinic Policies

Schedule your appointment as "me time." This may be the only one-hour opportunity in the week that you have without interference from work and family. Be prepared to relax and quiet your mind. This will ensure the most optimum healing experience.

Arrive on time.

- Being 15 minutes late could result in a "No Show" cancellation, and a full service fee will be charged.
- Arriving a few minutes late will result in a shorter acupuncture session.
- Please text or email if you are running behind.

Eat a healthy snack or light meal prior to acupuncture.

- It is strongly advised that acupuncture sessions not be performed on an empty stomach. Please eat a healthy snack with protein 60-120 minutes prior to session.
- Acupuncture will not be given to anyone who has had an alcoholic beverage earlier that day, or who has a hangover. This will result in a "No Show" cancellation, and a full service fee will be charged.

Cell phone use is prohibited in the treatment room. Please turn off your cell phone. No texts, calls, or use of other cell phone or device.

Wear comfortable, loose clothing. The majority of acupuncture points are located from knees and elbows to the feet & hands. You are welcome to bring extra clothes to change into prior to the treatment.

Please refrain from wearing perfume or cologne & other strong scents.

- Some patients have severe reactions (allergic, asthma attacks, etc.) to scents.
- For all cigarette smokers, please wash your hands thoroughly before entering the wellness center. Please wear clothing that has not been affected by cigarette smoke.

Schedule ahead. All sessions are by appointment only. We do not accept walk-ins. If there is a time and day that work best for your schedule, please set aside that time for recurring appointments.

Please cancel your appointment if you are contagious or running fever over 100.

- *It is not advised to cancel or reschedule an appointment if you are in the early stages of an illness* (cold, flu, infection), as Chinese Medicine (acupuncture and herbal therapy) can help treat early stages of illness.
- However, if you are sick, and need to reschedule your appointment, please do so via text or email as soon as possible.
- Consider scheduling an herbal consultation with JoNell Norcini if you feel ill, as there are herbal therapies that can help treat you. The herbs can be picked up from the clinic.

I do hereby voluntarily consent to be treated with Acupuncture by Nationally Board Certified & State Licensed Acupuncturist & Herbalist, JoNell Norcini. I have read and understand the policies set forth by Cypress Area Acupuncture.

Signature ________________________________ Date: ____________________________

Print Name ____

Cypress Area Acupuncture - Financial Policies 2023

Please read each section thoroughly before initialing beside it. By initialing, you agree and understand each policy.

(Initial) _____________ Cypress Area Acupuncture requires payment for your treatment ***at the time of service.***

(Initial) _____________ **Cash and check payments are preferred**; however, Zelle, VENMO, debit and credit cards, Health Savings Accounts & Flex Spending are also accepted.

(Initial) _____________ **Returned Checks**: If your check is returned, then a $25 fee will be charged in addition to the cost of treatment.

(Initial) _____________ **Missed Appointments**:

- ***Please provide at least a 48-hour notice if you need to cancel or reschedule your appointment.***
- If an appointment is missed or canceled within less than 48 hours of the scheduled appointment, the entire cost of the appointment will be charged.
- For patients who have purchased pre-paid packages, a deduction of 1 treatment will be made for each missed, late-canceled, or rescheduled appointment if notification is not given within 48-hour period.

(Initial) _____________ **Acupuncture Packages:**

- ***All Therapeutic packages must be paid in full, prior to scheduling the first treatment.*** Clients who purchase packages are provided with priority scheduling for all services.
- ***Therapeutic Packages are non-transferrable, non-refundable, and must be used within 6 months of purchase.***
- All unused treatments will be forfeited.

(Initial) _____________ All herbs, supplements, health & beauty products are sold separately from acupuncture sessions.

Acupuncture Services and Prices:

Service	Duration	Price
Initial Consultation with Acupuncture *	(60-90 minutes)	$145
Follow-Up Acupuncture Treatment *	(60 minutes)	$95
Micro Needling *	(90 minutes)	$350
Herbal Consultation	(30 minutes)	$50
Mei Zen Cosmetic – 10 treatments *		$1700
Cosmetic/red light add on to follow up treatment		$55

Therapeutic Acupuncture Packages *

6 Treatments **$510** **Saves $60** **Expires 6 months**

*** All treatments include infrared heat and crystal mat therapy.**

I have thoroughly read and understand the financial policies set out by Cypress Area Acupuncture.

(Signature) ____