Arden Yingling, L.Ac., MAcOM (TX #AC01588)
9300 US 290, Austin TX 78736
512.640.9778 | arden@songbirdacupuncture.com | songbirdacupuncture.com

New Pediatric Patient Information

Child's Name _____ Today's Date _____

Birth Date _____/_____/_____ Age _____ Gender _____

Street Address _____ Apt. _____

City _____ State _____ Zip _____

Parent 1 Name and Occupation: _____

Parent 2 Name and Occupation: _____

Parents are (check one): ☐ Married ☐ Separated ☐ Divorced ☐ Other _____

Number of other children in house:_____

Parent's preferred phone _____ email _____

Pediatrician's name and phone number: _____

☐ ***I give Arden Yingling, L.Ac., permission to email me appointment notifications and occasional announcements***

How did you hear about us? _____

Emergency Contact: Name _____ Phone _____

Cancellation Policy: If you need to change or cancel your appointment, please do so with a minimum of 24 hours notice. Failure to do so will result in being charged a $40 fee.

☐ **I understand the cancellation policy.**

Signature:_____ **Date:** _____/_____/_____

(continued onto next pages)

CURRENT HEALTH HISTORY

Has your child had acupuncture before? _____ If so, for what reason? _____

_____

What is the main issue you are seeking treatment for today? _____

_____

Has your child received any other care for this issue? What diagnosis have you received, if any?

_____

_____

When did this problem begin? _____

Do you know what caused it? _____

_____

Please list any CURRENT medications/supplements your child is taking:_____

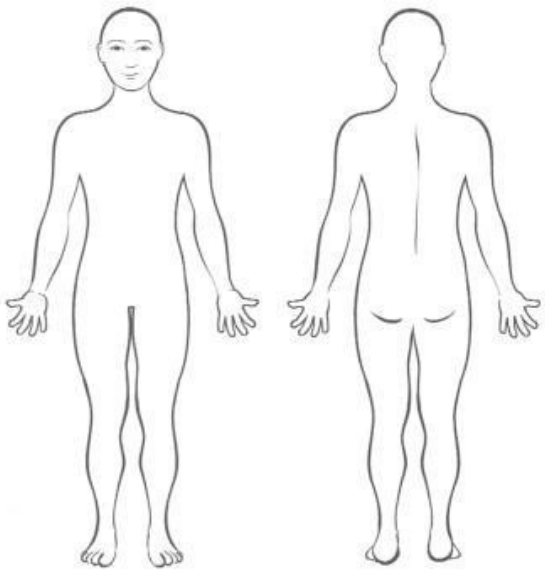
_____

Please list any PAST medications:_____

Please list any surgeries or hospitalizations, including dates:_____

_____

Please mark any areas of pain or discomfort, if that is the reason for your child's visit today:



Any issues with hearing or vision? (please describe if yes): _____

_____

Speech impediments? _____

Learning disabilities?_____

Allergies (medications/foods/chemicals/etc.):

_____

_____

_____

Typical day's diet:

Breakfast:_____

Lunch:_____

Dinner: _____

Snacks/Drinks:_____

PREVIOUS HEALTH HISTORY

Does your child get any of the following illnesses (circle best answer)?

Colds:	Regularly	Never	In the past, not currently
Ear infections:	Regularly	Never	In the past, not currently
Strep throat:	Regularly	Never	In the past, not currently
Stomach viruses:	Regularly	Never	In the past, not currently

How many times has your child taken antibiotics?_____

Has your child ever had any of the following illnesses?

Chicken pox □ Yes □ No Rubella □ Yes □ No Measles □ Yes □ No

Mumps □ Yes □ No Whooping cough □ Yes □ No

Has your child ever had a seizure? If yes, indicate date of most recent: _____

VACCINATION HISTORY

Has your child received the following vaccinations?

MMR □ Yes □ No

DtAP □ Yes □ No

HiB □ Yes □ No

Hep A □ Yes □ No

Hep B □ Yes □ No

Chicken Pox/Varicella □ Yes □ No

Polio □ Yes □ No

Any reactions to vaccinations? If yes, please explain: _____

_____

_____

FAMILY HEALTH HISTORY (MOTHER OR FATHER)

□ Allergies □ Cancer □ Obesity □ Diabetes □ Mental Illness □ Heart Disease

□ Other _____

MOTHER'S PREGNANCY HISTORY

Age at conception of this child: _____

Medications during pregnancy: _____

Complications during pregnancy (morning sickness, gestational diabetes, pre-eclampsia, etc.):

_____

Vaginal birth? □ Yes □ No Traumatic birth? □ Yes □ No

History of postpartum depression or anxiety? _____

INFANT HEALTH HISTORY

Gestational age (number of weeks) at birth? _____

Birth weight and length? _____

Complications after delivery?_____

_____

Location of delivery? □ Hospital □ Birthing center □ Home □ Other _____

Was child breastfed? If yes, for how long?_____

At what age was solid food introduced?_____

What were first solid foods? _____

At what age did child first walk? _____ Talk? _____ Develop teeth? _____

Please check if your child has a history of any of the following conditions:

Infant jaundice	□ Yes	□ No	Frequent cavities	□ Yes	□ No
Colic	□ Yes	□ No	Very sweaty	□ Yes	□ No
Diaper rash	□ Yes	□ No	Poor sleeper	□ Yes	□ No
Eczema or psoriasis	□ Yes	□ No	Nightmares	□ Yes	□ No
Diarrhea	□ Yes	□ No	Bedwetting	□ Yes	□ No
Constipation	□ Yes	□ No	Hyperactivity	□ Yes	□ No
Picky eating	□ Yes	□ No	Frequent tantrums	□ Yes	□ No
Abdominal pain	□ Yes	□ No	Fears/phobias	□ Yes	□ No
Chronic allergies	□ Yes	□ No	Anxiety/depression	□ Yes	□ No
Asthma	□ Yes	□ No	Early puberty	□ Yes	□ No

Any particular household or school stressors your child may be experiencing? _____

_____

_____

Please list any other information or issues you would like to discuss with me today:

AUTHORIZATION FOR CARE OF A MINOR:

I hereby authorize Arden Yingling, L.Ac. and Songbird Acupuncture to administer care to my son/daughter as they deem necessary. I clearly understand that I have the right to refuse care and that I am personally responsible for all costs associated with care given. This consent expires on the patient's 18th birthday.

_____ _____

Parent or Guardian Signature **Date**

Songbird
Acupuncture

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Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by Arden Yingling, L.Ac., MAcOM.

I understand that methods or treatment may include, but are not limited to: acupuncture, moxibustion, cupping, moving cupping, electrical stimulation, acupressure, Chinese or Western herbal medicine, supplement recommendations, and nutritional counseling.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

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 condition(s) for which I seek treatment.

Patient's Name _____

Patient's/Patient Representative's Signature _____

Today's Date _____/_____/_____

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Texas Acupuncture Requirements

In the state of Texas, acupuncture and Chinese medicine is not considered "primary health care." Licensed acupuncturists are permitted to treat the following conditions without any extra evaluation or referrals.

If you are here today for any of these, please check the appropriate line below and **skip the remainder of this page.**

___Chronic Pain (over 3 months) ___Smoking addiction ___Weight loss ___Alcoholism ___Substance abuse

For all other conditions, please fill out the state required form below.

Form to be Completed by Patient, Notifying the Acupuncturist of Whether He/She Has Been Evaluated by a Physician, and Other Information.

(Pursuant to the requirements of 22 TAC §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) _____, am notifying Songbird Acupuncture of the following:

___ Yes ___ No I have been evaluated by a physician or dentist 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.

_____ (initials of patient) Date: _____

or

___ Yes ___ No I have received a referral from my chiropractor within the last 30 days for acupuncture. 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.

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

Songbird Acupuncture is not responsible for untrue statements made by patients.

Songbird Acupuncture

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HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the Songbird Acupuncture "Notice of Privacy Practices." I understand that I have the right to review "Notice of Privacy Practices" prior to signing this document.

I understand that Songbird staff members 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 voicemail or with anyone who answers the phone.

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

By signing this form, I am giving Songbird Acupuncture 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 Songbird Acupuncture will be held confidential except in the instance where my safety or the safety of others may be at risk.

_____ _____

Patient Name (print) Date

_____

Patient or Patient Representative's Signature

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Songbird Acupuncture 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 or Patient Representative's Signature Date