



Arden Yingling, L.Ac., MAcOM (TX #AC01588)  
6266 Silvermine Dr., Suite 400, Austin TX 78736  
512.640.9778 | arden@songbirdacupuncture.com | songbirdacupuncture.com

### New Patient Information

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Street Address \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Preferred Phone \_\_\_\_\_ Email \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Occupation/Employer \_\_\_\_\_

Relationship Status \_\_\_\_\_

Number of Children \_\_\_\_\_ Names/Ages of Children \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Name of OB-GYN/Midwife (if applicable): \_\_\_\_\_

Referred by \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_

**YES / NO** I give Arden Yingling, L.Ac., permission to email me appointment notifications and occasional announcements.

**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.**

**YES / NO** I understand the cancellation policy.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

*(continued onto next pages)*

**HEALTH HISTORY**

Have you had acupuncture before, and for what reason?

\_\_\_\_\_

If yes, was acupuncture beneficial? \_\_\_\_\_

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

\_\_\_\_\_

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

When did this problem begin? \_\_\_\_\_

Do you know what caused it? \_\_\_\_\_

\_\_\_\_\_

How does this issue affect your daily life?

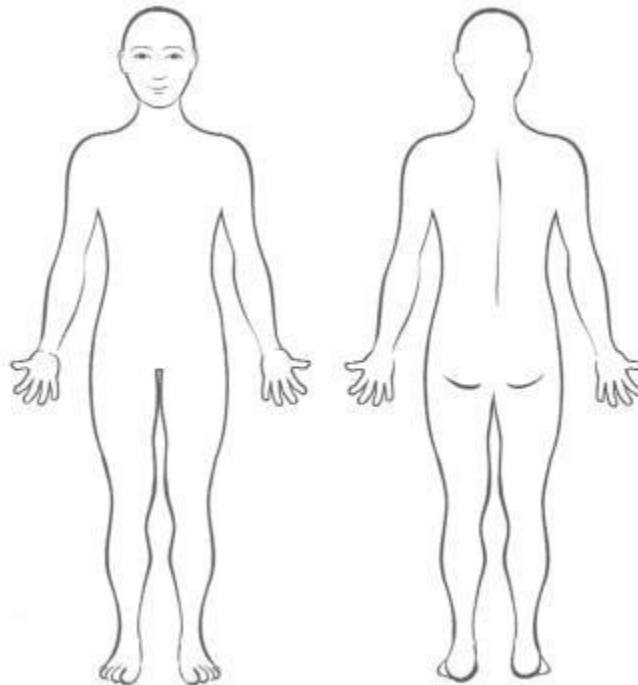
\_\_\_\_\_

Are there any other health issues you would like to work on? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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



Please **CIRCLE** any symptoms you are **CURRENTLY** experiencing or have experienced in the **RECENT** past:

**GENERAL**

Sweating easily during the day	Fevers	Unexpected weight loss/gain
Night sweating	Chills	Run hot
Fatigue	Change in appetite	Run cold
Sudden energy drop (What time of day? _____)		
Favorite time of year? _____		Worst time of year? _____

**SKIN/NAILS**

Rashes/hives	Dry skin	Bruise easily
Psoriasis	Acne	Slow wound healing
Eczema	Itching	Weak/brittle nails

**MUSCULOSKELETAL**

Neck pain/tightness	Knee pain	Hand/foot pain
Shoulder pain	Hip pain	General muscle soreness
Back pain	Leg/arm pain	Spinal curvature

**HEAD/EARS/EYES/NOSE/THROAT**

Headaches/migraines	Hearing loss	Itchy eyes
Dizziness/vertigo	Sinus pressure	Dry eyes
Earaches/pressure in the ears	Blurry vision	Teeth/jaw clenching
Ringling in the ears	Eye floaters (spots)	Difficulty swallowing

**CARDIOVASCULAR/CIRCULATORY**

Chest pain	Fainting	Cold hands & feet
Palpitations/Irregular heartbeat	High blood pressure	Blood clots
Swelling/edema	Low blood pressure	

**RESPIRATORY**

Frequent colds/flu	Chest tightness	Excess phlegm production
Seasonal/other allergies	Nasal congestion	Asthma or wheezing
Pain on inhaling	Cough	

**DIGESTIVE**

Heartburn/reflux	Constipation	Ulcer
Gallbladder problems	Diarrhea	Mucus or blood in stool
Belching	Nausea/vomiting	Sores on lips/tongue
Gas/bloating	Abdominal pain/cramps	Hemorrhoids

**URINARY/GENITAL**

Difficulty urinating	Urgent/freq. urination	Frequent UTIs
Pain upon urination	Blood in urine	Genital pain

**EMOTIONAL/PSYCHOLOGICAL**

Anxiety	Suicidal thoughts	Trouble falling asleep
Depression	Frequent crying	Trouble staying asleep
Irritability/anger	Susceptible to stress	Vivid/disturbing dreams
Worry a lot	Difficulty concentrating or poor memory	History of abuse/trauma

**NEUROLOGICAL**

Loss of balance/coordination	History of concussion	Areas of numbness/paralysis
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**FOR WOMEN ONLY:**

Unusual vaginal discharge	Endometriosis	Night sweating
Ovarian cysts	Fertility issues	
Fibroid cysts	Hot flashes	

Age at first menses \_\_\_\_\_ # of days in a typical cycle \_\_\_\_\_ # of days of bleeding \_\_\_\_\_

# of pregnancies \_\_\_\_\_ # of births \_\_\_\_\_

# of miscarriages \_\_\_\_\_ # of abortions \_\_\_\_\_

Have you been through menopause? Age? \_\_\_\_\_

Do you practice birth control? If yes, what type and for how long? \_\_\_\_\_

Do you regularly experience PMS? If yes, please circle any symptoms you experience regularly:

Acne	Cramping	Headache or migraine
Bloating	Diarrhea	Irritability
Breast tenderness	Fatigue	
Constipation	Food cravings	

Do you have any clotting with your period? YES / NO

Do you have spotting before or between periods? YES / NO

Is your menstrual flow usually LIGHT / MEDIUM / HEAVY (circle one)

Are you now or are you currently trying to become pregnant? \_\_\_\_\_

If you are pregnant, when is your estimated due date? \_\_\_\_\_

Are you currently breastfeeding? \_\_\_\_\_

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## LIFESTYLE

Current medications/herbs/supplements:

\_\_\_\_\_  
\_\_\_\_\_

Do you follow any certain way of eating? (Vegetarian, vegan, gluten-free, dairy-free, paleo, etc.)

\_\_\_\_\_  
\_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_

Do you exercise? What and how often? \_\_\_\_\_

\_\_\_\_\_

Do you drink coffee or caffeinated tea? If yes, how much? \_\_\_\_\_

Do you eat sugar regularly? \_\_\_\_\_

Do you use tobacco? If so, how often? \_\_\_\_\_

Do you drink alcohol? If so, how many drinks/week? \_\_\_\_\_

Do you spend time outside? \_\_\_\_\_

Do you have supportive relationships in your life? \_\_\_\_\_

Do you enjoy your job (if employed outside the home)? \_\_\_\_\_

What do feel needs to happen for you to get better?

\_\_\_\_\_  
\_\_\_\_\_

How much change are you willing to make at this time for improving your health? (circle one)

MINIMAL

SOME

AS MUCH AS RECOMMENDED

**OTHER MEDICAL HISTORY**

Are you currently taking any of the following medications? (circle if yes)

Advil/Motrin/Ibuprofen	Bayer/Aspirin	Prednisone/Prednisolone
Aleve/Naproxen	Prilosec or other acid reducer	Coumadin/Warfarin

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

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Have you ever had a seizure? If yes, indicate date of most recent: \_\_\_\_\_

**Please circle any significant illnesses and indicate date:**

Anemia	Epilepsy	Stroke
Arthritis	Heart disease	Substance abuse
Cancer	Hepatitis	Thyroid disease (hypo or hyper)
COPD/breathing problems	HIV	Tuberculosis
Diabetes	High blood pressure	Other _____

Please list any major surgeries/hospitalizations or significant trauma and approximate dates:

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**FAMILY MEDICAL HISTORY (circle if your parents, siblings, or other immediate family have experienced)**

Asthma	Hepatitis	Substance abuse
Cancer	High blood pressure	Emotional disorders
Diabetes	Seizures	Other _____
Heart attack	Stroke	

**Please list any other relevant information or issues you would like to discuss:**



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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, the use of medical aromatherapy, 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 recognize that there is no guarantee of any particular outcome from acupuncture. 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.***

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#### **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 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.*





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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 Signature

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### 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's Signature \_\_\_\_\_  
Date