Arden Yingling, L.Ac., MAcOM (TX #AC01588)
6626 Silvermine Dr., Suite 400, Austin TX 78736
512.640.9778 | arden@songbirdacupuncture.com | songbirdacupuncture.com

New Patient Information

Name _____ Today's Date _____

Street Address _____

City _____ State _____ Zip _____

Preferred Phone _____ May I text you? YES NO

Email _____

Birth Date _____/_____/_____

Preferred Pronouns _____

Occupation/Employer _____

Names/Ages of Children (if any) _____

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 announcements.

CANCELLATION POLICY: If you need to change or cancel your appointment, please do so with a minimum of 24 hours notice. Late cancellations or no-shows will result in being charged the full appointment fee.

YES / NO I understand the cancellation policy.

Signature:_____ Date: _____/_____/_____

HEALTH HISTORY

Please know that you can take your time with this intake form. For my files, I need all the information on Page 1, as well as all 3 consent forms signed and dated. After that, you can skip anything you'd rather not answer, and fill out as much as feels comfortable. We can also discuss things in person, if you'd prefer. Information can be shared at your pace.

What brings you in today? _____

_____

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

_____

When did this problem begin and do you know what caused it?

_____

How does this issue affect your daily life?

_____

What would it look like (what would change for you) if you reached your health goals?_____

_____

Have you had acupuncture before?

_____

Is there anything I can do to make sessions more accessible or comfortable for you?

_____

Are there any areas of your body that do NOT like to receive touch or acupuncture that you'd like me to know about?

_____

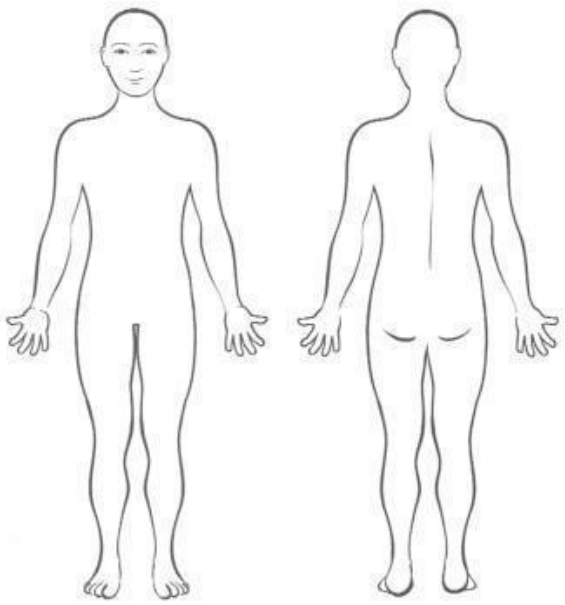
Anything else you'd like me to know about you, or are there any other issues you would like to work on?

_____

_____

_____

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 PAST THREE MONTHS:

GENERAL

Sweating easily during the day	Unexpected weight loss/gain	Run cold
Fatigue	Run hot	

Favorite time of year? _____ Worst time of year? _____

SKIN/NAILS

Rashes/hives	Dry/itchy skin	Slow wound healing
Eczema or Psoriasis	Bruise easily	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	Ringing in the ears	Eye floaters (spots)
Vertigo	Hearing loss	Dry eyes
Dizziness only when standing up	Sinus pressure	Teeth/jaw clenching
Earaches/pressure in the ears	Blurry vision	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	Cough
Seasonal/other allergies	Nasal congestion	Asthma/wheezing

DIGESTIVE

Heartburn/reflux	Diarrhea	Hemorrhoids
Gallbladder problems	Nausea/vomiting	Low appetite
Gas	Abdominal pain/cramps	Always hungry
Constipation	Ulcer	Fatigue or bloating after meals

URINARY/GENITAL

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

EMOTIONAL/PSYCHOLOGICAL

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

NEUROLOGICAL

Loss of balance/coordination	History of concussion	Areas of numbness/paralysis

GYNECOLOGICAL

Unusual vaginal discharge	Endometriosis	Hot flashes
Ovarian cysts	Fertility issues	Night sweats
Fibroid cysts	Low libido	

Have you been through menopause or are you in perimenopause? _____

Are you experiencing any perimenopause/menopausal symptoms?_____

_____

If you get a menstrual cycle, how long is it? (ex: 28 days) _____

How many days of bleeding in your cycle?_____

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

Bloating	Fatigue	Mood swings
Breast tenderness	Food cravings	
Cramping	Headache or migraine	

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)

# of pregnancies _____ # of births _____

# of miscarriages _____ # of abortions _____

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

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? _____

COVID-19

Have you had a confirmed or suspected case of COVID-19? YES NO

If you have had COVID, do you have any lingering symptoms or concerns? _____

_____

Have you received the COVID-19 vaccine?

____ One dose

____ Two doses

____ Two doses + booster

____ No, not yet

____ No, I do not plan to be vaccinated

OTHER HEALTH HISTORY

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

_____

Please circle any significant illnesses and indicate date:

Anemia	Cancer	Diabetes
Arthritis	COPD/breathing problems	Epilepsy

Heart disease	High blood pressure	Substance abuse
Hepatitis	Seizures	Thyroid disease (hypo or hyper)
HIV	Stroke	Other _____

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

_____

_____

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 disease	Stroke	

LIFESTYLE

Current medications/herbs/supplements: *(No judgement - I ask this question so that I can modify my treatment as needed in case of contraindication.)*

_____

_____

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 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 you 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

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, 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.

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, midwife, or dentist within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician, midwife, 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

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 and Date