Medical Acupuncture of Austin
Michael D. Martin, MD

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Dear New Patient,

Thank you for choosing Medical Acupuncture of Austin. This letter is to introduce you to my practice and to provide you with information on my office policies.

- Enclosed is a health questionnaire which must be completed and returned as soon as possible. This will allow me to familiarize myself with your health history prior to your first visit and will enable me to spend more time focusing on your primary areas of concern when we meet.

- We ask you to do your best to fill out all the requested information completely and accurately. If you have questions or need assistance completing your paperwork, you may call or come by our office and we will be happy to assist you.

- Please return the New Patient forms to my staff at your earliest convenience. Once we receive your completed paperwork, you will be contacted within 48 hours to schedule your initial appointment.

- There are several options available to return completed paperwork to our office – fax, email, mail, or personal delivery:

Address:	Medical Acupuncture of Austin 4501 Spicewood Springs Road, Suite #1030 Austin, TX 78759
Fax:	844-712-3807
Email:	info@MDacupunctureATX.com (Please call 512-342-1912 to verify receipt of paperwork)

If you do not receive a call from a staff member within 48 hours of returning your paperwork, please call us to schedule your appointment.

- If you are not familiar with our location, you can find directions on our website www.MDacupunctureATX.com. We ask that you **arrive 20 minutes early** for your first appointment to complete some additional forms. Please expect to spend from 60 to 90 minutes at our office for your initial consultation.

- If you need to reschedule or cancel an appointment, we ask that you contact us by telephone and give us at least 24 hours notice. Failure to do so will result in a $45 missed appointment fee.

- Please note that payment is due at the time of services. We accept Visa, MasterCard, Discover, and American Express. We **do not bill insurance companies**, but will provide you with a statement of services if you wish to submit it to your carrier. Please be aware that many insurance carriers do not reimburse for acupuncture. **Medicare does not cover acupuncture** and Medicare patients are seen by private contract only.

- Please contact us if you have any questions about the above.

Acknowledgement: I have read and understand the above information concerning my initial appointment.

Patient (Responsible Party) Signature: _____

Print Patient Name: _____

Acupuncture Health Questionnaire

Name _____ Date _____

Date of Birth _____ Sex (M/F) _____ Contact Phone Number _____

Emergency Contact Person _____ Emergency Contact phone number _____

Please tell us more about yourself by completing the following questions. I understand that this time consuming but it will allow me to serve you better at your initial visit. Be honest. Your answers are strictly confidential.

A. Please describe the reason for your visit

_____

_____

_____

_____

If your primary reason for seeing me is a pain issue, then please complete section B,

Otherwise, skip to section C.

B. Pain Questions

1. Location of pain-_____
2. Quality of pain (for example: sharp, dull, aching, stabbing, burning, nagging, throbbing, etc)

   _____
3. Please circle the number that best describes your pain
   (0 = no pain, 10 = Worst pain imaginable)

   At its **worst** in the last month:
   1 2 3 4 5 6 7 8 9 10

   At its **least** in the last month:
   1 2 3 4 5 6 7 8 9 10

   On **average** during the last month:
   1 2 3 4 5 6 7 8 9 10
4. What makes your pain better? For example: Lying down, sitting, stretching, activity, heat, cold, medication (if the latter, what medication helps?), etc.

   _____
5. What makes your pain worse? For example: Standing, lifting, sitting, walking, etc.

   _____

C. Do you suffer from any of the following? (circle those that apply)

Difficulty falling asleep	Difficulty staying asleep
Sleeping too much	Feeling excessively sleepy during the day
Fainting spells	Unintentional loss of weight
Frequent or severe headaches	Loss of appetite
Shortness of breath	Chronic cough
Chest pains	Palpitations
Recurrent abdominal pain	Constipation
Diarrhea	Bleeding with bowel movements
Frequent urination	Blood in the urine
Weak urine stream	Poor bladder control/urinary leakage
Sadness	Feeling anxious or nervous a lot

D. Past Medical History
Do you have a history of any of the following? Circle any that apply and provide details please.

Heart Problems _____
Pacemaker _____
Diabetes _____
High Blood pressure _____
Cancer _____
Kidney stones/Kidney problems _____
Lung Problems _____
Other _____

E. Past Surgical History- Please list any major surgeries with approximate dates

_____
_____
_____

F. Females- pregnancy and menstrual history
How many times have you been pregnant? _____
How many abortions or miscarriages? _____
Number of living children? _____
Last menstrual period? _____
Do you have problems with irregular periods or very heavy periods? Yes / No
If yes, please describe:

Are you currently pregnant or do you suspect you might be pregnant? Yes/No

Family History – Please circle any of the following diseases that have occurred in family members (including mother, father, grandparents, brothers, sisters and children)

High blood pressure Heart attack Stroke Kidney failure

Colon cancer Breast cancer Prostate cancer Uterine cancer

Ovarian cancer Diabetes Alcoholism Chemical dependency

Other (please list)

G. Health Habits

1. Do you smoke cigarettes or use any form of tobacco? Yes / No
   If yes, how much and for how long? _____

2. Do you drink any alcohol? Yes / No
   If yes, what is your average amount per day, week, or month? _____

3. Do you use any recreational or illegal drugs? Yes / No
   If so, what type and how often? _____

4. Do you drink caffeinated coffee or tea? Yes / No
   If so, how much per day? _____

5. Do you drink soft drinks? Yes / No
   If so, how often? _____

6. Do you exercise? Yes / No
   If so, what type and how often? _____

H. Personal History

1. Are you married? Yes / No
   If so, for how long? _____
2. Employment- Are you currently working? Yes / No
   If yes, what type of work? _____
   Do you enjoy your job? _____

I. Medications- List all current medications and dosages (including supplements and any non-prescription medications you take regularly)

_____

_____

_____

_____

_____

_____

Medication Allergies - _____