

Welcome! to International Acupuncture, practice of Dr. Susana Méndez, feel free to call me at 1.214.566.0149, prior to your first session, in case of questions. Please complete all the information, or check the answer. Bring all the paperwork the day of your first appointment. If you have medical records, please bring a copy. Payment is due at the end of each session; you will receive a super bill to present to your insurance company. Please complete the patient registration packet **prior to your appointment**.

Arbitration Agreement. By signing this form, you are acknowledging that you will read the Arbitration Agreement and are agreeing to have any issue of medical malpractice decided by a neutral arbitration and are giving up your right to a jury or court trial.

This will allow me to spend less time “taking your history” and more time strategizing with you about how best to treat your current needs(s). If you are not able to complete all components of this packet prior to your arrival, we may not be able to complete your assessment in the first visit. Therefore I will require a second visit in order to complete the evaluation and your first treatment for your need(s)

Your first visit with me will be a consultation and first treatment, we will determine if a mutual, on-going relationship would be acceptable for going on care

I am looking forward to help you find a solution to your needs by treating you directly or providing a referral

Thank you

Dr. Susana E. Méndez, MAOM, L.Ac, ADS, CAS, LCDC, ABMPP, NBCCH.
Board Certified Medical Psychotherapist / Certified Addictions Specialist.
Board Certified in Oriental Medicine (Acupuncture and Herbal Medicine)
Training Chair - NADA.

GENERAL PRACTICE INFORMATION AND POLICIES

Our Location: 14114 Dallas Parkway, Suite 245- Dallas, Texas: 75254

New Patient: Your first appointment will consist of a full assessment; the consultation fee is \$375.00.

Medical Information: Please complete the attached patient assessment completely. If you have medical records or laboratory results, please bring them with you. Laboratory results older than six months are not viable

Current Medication(s): Please bring the medications you are currently taking with you.

Medical Insurance: Please bring your current picture ID. I don't file insurance, but I will provide a super bill for you to present to your insurance company, payment remains your responsibility.

Appointment Cancellations: I see patients by appointment only. If you are unable to keep your appointment, please notify me at 214.566.0149 as soon as possible, so we are able to offer your appointment time to another patient.

Late Appointment: Please be on time for your appointment. **If you arrive more than ten (10) minutes late to an appointment I will not be able to see you.** The appointment will have to be rescheduled and you will be charged a fee of \$125.00

Appointments:

- Patient appointments are scheduled by calling at 1.214-566-0149.

Patient Information: It is **your responsibility** to let me know of any change(s) to your, address, telephone number(s), or other pertinent patient information.

Prescriptions and Prescription Refills:

- Prescriptions provided to you (herbal medicine) will be order by me directly to the manufacture. You must call them to confirm your personal information and pay them directly. Any requests for prescription refills must be by calling me at 1214-566- 0149 and we will determine if I need to see you prior to a refill

Emergency (Critical) Situations:

- If a situation poses immediate risk to health and life, call 911 and/or go to the nearest Emergency Room immediately.

Financial Policy:

- Payment is due at time of service by cash or check.
- NSF checks returned by your bank will be collected in cash only, and a fee of \$35 will be charged to you.

Patient Cancellations and Failure to Arrive for a Scheduled Appointment: A late cancellation fee of \$125.00 will be charged for any appointment **not cancelled or rescheduled 24 hours in advance**. A fee of \$175 will be charged for an appointment that has been made and **not kept (no-show)**. Please call me at 1214-566-0149 to avoid being charged for a late cancellation or a no-show appointment.

What to expect on your first TCM visit:

- Your appointment will generally last 1 ½ hours.
- As a new patient you have 2 options for paperwork:
 - You can arrive approximately 30 minutes early for your appointment and fill it out in the waiting room
 - You can download forms from our website and fill them out before your appointment.
- The New Patient paperwork includes legal forms and medical intake forms that should be read and filled out, and privacy forms that only need to be read.
- After checking in for your appointment, I will follow up on the information you provided in your intake forms during a 20-25 minute consultation..
- In addition to your paperwork and consultation, I will also examine your tongue and feel your pulse in both wrists in order to arrive at a traditional Chinese medical diagnosis.
- If you are taking any medication or herbal supplements please let me know.
- After the initial consultation, you may be asked to remove your shoes and socks and lie down. Depending on the area to receive treatment, you may be asked to remove other articles of clothing. For your comfort and convenience I offer clean medical gowns that can be worn during your treatment.
- After swabbing the various acupuncture sites with alcohol, I will insert very thin, sterile, disposable needles. Although some points are more sensitive than others, the patient will usually feel little to no sensation or discomfort. A heat lamp and/or space heater are available should you feel cold during your treatment.
- The needles will be left in for approximately 25-35 minutes. During this time I will check on you several times, Most people find acupuncture to be very relaxing; however, should you experience any pain or discomfort, please just let me know right away so adjustments can be made.
- I made recommendations for traditional Chinese herbs, dietary and/or exercise changes as part of a suggested treatment plan.

After your visit:

- Plan to take it easy after your treatment.
- Sometimes after receiving an acupuncture treatment you may feel a little lightheaded or “woozy.” If that is the case, please sit for a while in our waiting area. In a few minutes you’ll be relaxed and clear-headed.
- It’s best if you do not come to your appointment on an empty or full stomach.
- Herbal prescriptions are intended only for the person for whom they were prescribed. Do not give herbal formulas to anyone else.
- Very rarely, symptoms may become worse after an acupuncture treatment. This is often a sign that preciously dormant conditions are being awakened so that complete healing may occur. This should pass quickly. If you have any questions or concerns, please do not hesitate to contact me.

What to expect on your first counseling visit:

- Your appointment will generally last 1 ½ hours.
- As a new patient you have 2 options for paperwork:
 - You can arrive approximately 30 minutes early for your appointment and fill it out in the waiting room
 - You can download forms from our website and fill them out before your appointment.
- The New Patient paperwork includes legal forms and medical intake forms that should be read and filled out, and privacy forms that only need to be read.
- After checking in for your appointment, I will follow up on the information you provided in your intake forms during a 50-55 minute consultation. After this consultation recommendations will be given to you for care. We will discuss alternatives of care with me or a referral will be given to you

PATIENT REGISTRATION INFORMATION

DATE: _____ NAME: _____ AGE: _____ SEX: _____

BIRTHDATE: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

E-MAIL ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ SOCIAL SECURITY # _____ DRIVER'S LIC. # _____

SINGLE: ___ MARRIED: ___ DIVORCED: ___ WIDOWED: ___ OCCUPATION: _____

NAME OF SPOUSE OR NEXT OF KIN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
(If different from patient)

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMPLOYED: YES or NO EMPLOYER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

REFERRAL SOURCE: _____ PERSON RESPONSIBLE FOR PAYMENT: _____

NAME: _____ SS#: _____

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____




GUARANTOR'S FINANCIAL INFORMATION AND AGREEMENT

By signing my name to this document, I agree that I understand I am responsible for all patient charges. I agree that if I choose to pay on my account with cash, check, money order or major credit card, I will review my account and discuss any issue(s) I have **prior to payment**. I will not stop payment on any check I produce for payment of services.

I agree to keep my credit card on file for purposes of payment for services rendered, late cancellations and appointments not kept. I also agree that I will accept these charges and if I choose to pay with my credit card I will not dispute the charge with my credit card company.

MY CREDIT CARD INFORMATION IS AS FOLLOWS. All information listed on this form shall be completed

I _____ hereby authorize ***International Acupuncture*** to charge this credit card as follows:

			Card No.		Security Code	
--	---	---	----------	--	---------------	--

Expiration Date	MM	YY	In the amount of	
-----------------	----	----	------------------	--

Card Owner Billing address: _____

 (Zip code is required for billing)

Phone number: _____

On the date of _____, I _____ hereby verify that the following named authorized user is authorized to charge my credit card on my behalf. The Card Owner shall submit a photocopy of his/her valid photo identification with this form as well as a photo copy front and back of the credit card. I understand that these services are non-refundable and I will not dispute the credit card charges.

 Card Owner – Original Signature

 Authorized Card user – Original Signature

 Card Owner – Print Name

 Authorized Card user – Print Name

 Card Owner – Phone number

 Authorized Card user – Phone number

Guarantor's financial information and agreement

International Acupuncture requires 24 hour notice for cancellation of an appointment. If cancellation notice is not given, it is the policy and procedure at IA to bill for no show cancellations as well as late fees. If your credit card is not on file, you will be billed.

I HAVE READ AND UNDERSTAND MY FINANCIAL RESPONSIBILITY AND I ACCEPT AND AGREE TO THE TERMS OF THIS AGREEMENT IN ITS ENTIRETY.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

CONSENT/AUTHORIZATION FOR EXCHANGE OF MEDICAL RECORDS, INSURANCE OR PATIENT INFORMATION

Patient Name: _____ Birthdate: _____ Date: _____

The patient named above authorizes Dr Susana E Mendez, to exchange medical records, or patient information. No limitation is placed on the dates, history of illness or diagnostic and therapeutic information, including treatment for alcohol/drug abuse or psychiatric treatment, unless specifically specified below.

Person or company to exchange information: _____

Address: _____

Phone #: _____ Fax #: _____

Signature of patient or legally authorized representative

Date

GENERAL CONSENT TO RELEASE INFORMATION

By your signature, you are consenting to give the individual(s) listed below information regarding your medical condition and/or financial information. You may leave any of the following information blank if you object to giving out your information. No limitation is placed on the dates, history of illness or diagnostic and therapeutic information, including treatment for alcohol/drug abuse or psychiatric treatment, unless specifically specified below. You may change this information at any time. To do so, please contact our office.

- 1. If we may inform family members or other persons about your medical condition and diagnosis, please print their names and telephone numbers:

- 2. For emergency purposes only, please print the phone number and names of the family members or persons whom we may inform about your medical condition:

- 3. Please print a phone number, if other than your home phone, where you want to receive calls regarding information for appointments, diagnoses, or other health information:

(____) _____

- 4. Please print the appropriate address if you want to use an address other than your home address to receive billing statements and/or other correspondence:

- 5. Can we leave confidential messages such as appointment reminders on your home phone, answering machine or voicemail? Or, if you gave us another phone number to call, can we do the same on that phone number?

YES _____ NO _____

- 6. If you do not have an answering machine or voicemail, can a confidential message be left at your place of employment?

YES _____ NO _____

Patient Name: _____

Patient/Guardian Signature: _____

Witness Signature: _____

COMPREHENSIVE PATIENT ASSESSMENT QUESTIONNAIRE

Name: _____ Date: _____

Presenting Information

What are the main problems that brought you my practice?

When did these problems first begin?

Please check the statement below that best describes the course of these problems since they began:

- The problems have stayed about the same since they started.
 The problems have steadily worsened since they started.
 The problems seem to come and go. By the time I feel almost back to my usual self, the problems usually come back.
 The problems have ups and downs but haven't gone away completely since they started.

Have you had a past period in which you had similar problems? If so, when?

Below are listed several areas of functioning. Please check any which have been worsened due to your current problems.

- | | |
|---|--|
| <input type="checkbox"/> My job performance | <input type="checkbox"/> My relationship with my spouse or significant other |
| <input type="checkbox"/> My relationship with my family | <input type="checkbox"/> My ability to manage my usual chores at home |
| <input type="checkbox"/> My interest in keeping up my appearance | <input type="checkbox"/> My ability to control my temper |
| <input type="checkbox"/> My ability to control my behavior (acting before I think) | |
| <input type="checkbox"/> My ability to carry out my usual leisure interests and hobbies | |
| <input type="checkbox"/> My ability to plan for my future and set goals for myself | |
| <input type="checkbox"/> My ability to carry out my usual social life with friends, activities, organizations, etc. | |
| <input type="checkbox"/> Any other way your functioning has been effected? If so, please explain _____ | |

Medical History

Who is your family doctor or "main" doctor? _____ When was your last appointment? _____
When was the last time you had lab work? _____

Please check if you have or have had (in the last three months) any of the following diseases or conditions.

- General** Poor appetite Poor sleep Fatigue Fevers Chills Night sweats Sweat easily Tremors Cravings
 Change in appetite Poor balance Bleed or bruise easily Localized weakness Weight loss Weight gain
 Peculiar tastes Desire hot food Desire cold food Strong thirst (cold or hot drinks)
 Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____

- Skin & hair** Rashes Ulcerations Hives Itching Eczema Pimples Acne Dandruff Dry skin Recent moles Loss of hair
 Purpura Change in hair or skin texture Other?

Musculoskeletal Joint disorders Muscle weakness Pain/soreness in the muscles Tremors
 Cold hands/feet Difficulty walking Swelling of hands/feet Spinal curvature Back pain Hernia
 Numbness Tingling Paralysis Neck tightness Neck pain Shoulder pain
 Hand/wrist pain Hip pain Knee pain Joint Sprain Other? _____

Head, eyes, ears, nose, and throat Dizziness Concussions Migraines Glasses/lens Eye strain Eye pain Color blindness
 Night blindness Poor vision Cataracts Blurry vision Earaches Ringing in ears
 Poor hearing Spots in front of eyes Sinus problems Nose bleeding Sore throat Grinding teeth Teeth problems
 Facial pain Jaw clicks Sores on lips/tongue Difficulty swallowing Other?

Cardiovascular High blood pressure Low blood pressure Chest pain
 Palpitation Fainting Phlebitis Irregular heartbeat Rapid heartbeat Varicose veins Other?

Respiratory Cough Coughing blood Wheezing Difficulty breathing Bronchitis Pneumonia Chest pain
 Production of phlegm – What color? _____

Gastrointestinal Nausea Vomiting Diarrhea Constipation Gas Belching Black stools Blood in stools Indigestion
 Bad breath Rectal pain Hemorrhoids Abdominal pain/cramps Gallbladder problems Parasites Chronic laxative use
Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____

Genito-urinary Painful urination Frequent urination Blood in urine Urgency to urinate Kidney stones Unable to hold urine
 Dribbling Pause of flow Frequent urinary tract infection Genital pain Genital itching Genital rashes STD Other?

Male Prostate problems Discharge Erectile dysfunction Ejaculation problems
 Frequent seminal emission Fertility problems Painful/swollen testicles other

Female Frequent vaginal infections Pelvic infection Endometriosis
 Vaginal/genital discharge Fibroids Ovarian cysts Irregular periods
 Clots Pain/cramps prior/during periods Breast tenderness Breast Lumps
 Fertility Problems Hot flashes Moodiness related to periods

_____ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions _____ Premature births _____
C-section _____ Difficult delivery

First date of last period _____ Age of first period _____ Duration of periods _____ days, cycle _____ days

Do you practice birth control ? Yes No. If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long _____

Adult Patient Parent or Guardian Spouse

Please mark the areas on your body where you feel the sensations described blow, using the appropriate symbol

How long do you have this symptom? _____ Years _____ Months _____ Weeks

Is this the first episode of this symptom: _____ yes _____ No

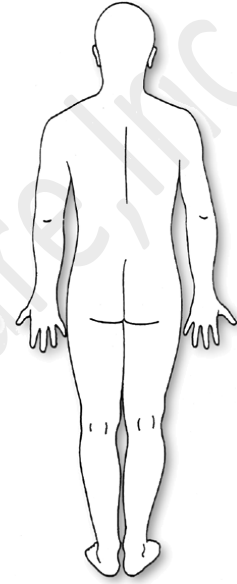
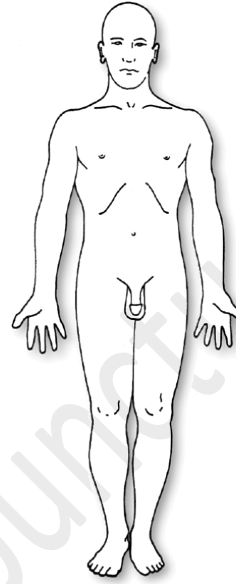
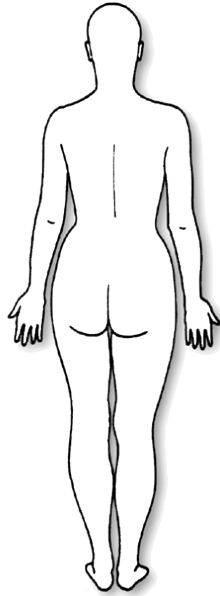
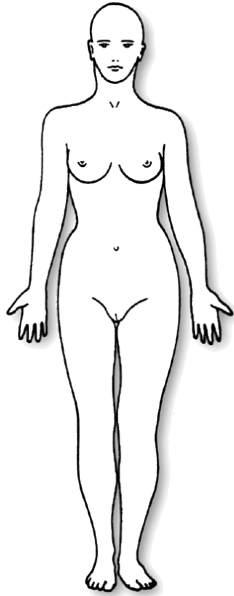
Use the letters below to indicate the type and location of your sensations RIGHT NOW

Key: A= Ache P = Pins and Needles
 B = Burning S= Stabbing
 N = Numbness O= Other

Scale 1 to 10: _____

1= No pain - 10 = Excruciating

1----2---3---4---5---6---7---8----9---10--- more.



Comments:

Current Medications – Please list any medications you are currently taking:

Medication	Dose (mg)	Times per day	When you started this medication (mo/yr)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

* Please list any medication allergies: _____

Past Psychiatric Medications - Please list any medications that you previously took on a regular basis but are not taking now.

Medication	Dose (mg)	Times per day	When you started this medication (mo/yr)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

Psychiatric History

Have you ever attempted Suicide? ___Yes ___ No If yes, please state when and what type of treatment(s) you experienced:

Have you had psychological testing in the past? ___Yes ___ No When_____ Where_____ Can you provide a copy?_____

Past Mental Health History - Please list any previous psychiatrists, psychologists or therapists you have seen:

Name of Person Seen	Dates Seen (mo/yr-mo/yr)	Medications Prescribed	Reasons Seen	Hospitalized? (Yes/No-Where)
1.				
2.				
3.				
4.				

Family History

List any blood-relatives (parents, siblings, grandparents, aunts, uncles, cousins, etc.) who have any history of any emotional problems (depression, manic-depression, anxiety, schizophrenia, drug/alcohol abuse, suicide)

Relation (Father, Aunt, Daughter, etc.)	Father/Mother's Side of Family	Problem (Depression, Alcoholism, etc.)	Ever Hospitalized? (yes/no)	Medications They Took (If known)
1.				
2.				
3.				
4.				

Substance Use

Have you ever had treatment for substance use? _____ Yes _____ No

If yes, where and when? _____

Alcohol

When was the last time you drank anything containing alcohol?

How many days per month do you drink?

How many drinks do you have in an average week?

What is your typical pattern of alcohol use?

_____ Everyday _____ Most Days _____ Weekends _____ Payday Binges

Where, and with whom, do you usually drink?

What type of alcohol do you usually have (i.e., beer, wine, liquor)?

Have you ever felt you were drinking too much?

Have you ever tried unsuccessfully to stop drinking?

What is the longest period (specify days, months or years) that you have ever had without drinking alcohol?

Have you ever had any of the following physical withdrawal symptoms when abstaining from alcohol?

Shakes or Tremors Hallucinations Insomnia Restlessness
 Seizures Night Sweats Vomiting Blood Other (specify): _____

Have you ever had any of the following problems related to your alcohol use?

Liver problems Pancreatitis Other (specify) _____ First Time? _____

Drugs

Have you ever used any of the following?

Substance	Yes or No?	If yes, when was the last time?	Have you ever felt you had a problem with these drugs? (Yes or No)
Marijuana			
Cocaine			
Crack			
Amphetamine			
LSD			
PCP			
Heroin			
Prescription Drugs?			
Other (Please specify)			

What is your typical pattern of drug use? Everyday Most days Weekends Payday binges

Have you ever had any of the following physical withdrawal symptoms when you abruptly stopped using drugs?

Fever Craving Excess Sweating Cramping
 Insomnia Restlessness Other (specify) _____

Have you ever had any of the following medical problems related to your drug use?

Chest Pain or Discomfort Problems with Breathing Weight Loss Seizures

Please check any of the following relating to your alcohol or drug use:

- Yes No I've felt alcohol or drugs were causing a problem for me
- Yes No I've felt guilty about my use
- Yes No Others have annoyed me by talking about or criticizing my use
- Yes No I've had a desire (or made unsuccessful efforts) to cut down or control my use
- Yes No I've tried unsuccessfully to control my use
- Yes No I've used alcohol or drugs more often or in larger amounts than I intended
- Yes No I've had to increase my use of alcohol or drugs to get the desired effect

_____ Yes _____ No I've had problems with withdrawal (shakes, nervousness, insomnia, etc.) when I've cut down or stopped using alcohol and/or drugs
_____ Yes _____ No I've been to a meeting of Alcoholics Anonymous or Narcotics Anonymous
_____ Yes _____ No Have you ever attended meetings on a regular basis of at least 1/week for 3 months?
_____ Yes _____ No Are you still attending meetings regularly?
How many meetings per week do you usually attend? _____
What was the date of your last meeting? _____
Why did you stop attending regularly? _____

Do you smoke cigarettes or use any tobacco products? _____ YES _____ NO If yes, what and how often?

Are you intending to quit soon? _____ YES _____ NO

Educational History

How well did you like school? _____ What kind of grades did you make in school? _____

Describe your social life at school (circle one): active, normal, loner, other (explain: _____)

What things got you in trouble at school?

Did you attend college? _____ Where? _____

What was your major? _____

What is your highest educational level or degree attained? _____

Social History

Family Background and Childhood History

What is your current age? _____ Were you adopted? _____ Where were you raised? _____

Please list any siblings and their age(s): _____

What was your father's occupation? _____ What was your mother's occupation? _____

Parental Background

Did your parents divorce? _____ If so, how old were you when they divorced? _____ If your parents divorced, who raised you?
_____ How old were you when your father remarried? _____ When your mother remarried? _____

Describe your father and your relationship with him: _____

Describe your mother and your relationship with her: _____

What things did you get into trouble for at home? _____

How was discipline handled at home? _____

How old are your parents currently? Dad _____ Mom _____ How old were you when you left home? _____

Were you ever physically or sexually abused? _____ If so, at what age(s)? _____

Has anyone in your immediate family died? _____ Who and when? _____ Reason _____

Occupational History

Are you currently working? ___ Yes ___ No

How long have you been in your present position? _____

What is your occupation? _____ Where do you work? _____

Where have you worked before and how long (summary only)? _____

Have you ever been in the military? ___ Yes ___ No (If no, then skip this section and move on to symptom checklist)

Branch _____ Date entered _____ Date discharged _____

Type of discharge _____ Rank at discharge _____

Location of service _____

Did you have any psychological problems related to combat experience? ___ Yes ___ No

Do you have a service-connected disability? If so, specify: _____

Legal Information

Have you ever been stopped by the police for driving under the influence of alcohol or drugs? ___ Yes ___ No

If yes, how many times have you been stopped? _____

Have you ever been charged with or convicted of a DUI/DWI, public intoxication or other substance related crime? ___ Yes ___ No

If yes, list each time: _____

Have you ever received convictions for any crime? ___ Yes ___ No

If yes, for what crimes? _____

Have you ever spent time in jail and/or prison? ___ Yes ___ No

If yes, for how long? _____

Are you currently on probation or parole? ___ Yes ___ No

If yes, for what convictions? _____ Condition(s) of Probation _____

Marital and Family History

Are you currently ___ Married ___ Divorced ___ Single ___ Widowed How long? _____

If married, what is your spouse's occupation? _____ Where employed? _____

Describe your relationship with your spouse or significant other: _____

Have you had any prior marriages? _____ If so, how many? _____ For how long? _____

Do you have any children? _____ Ages? _____

List everyone who currently lives at home: _____

Do you attend church? _____ Where? _____ How often? _____

Symptom Checklist

Please check any of the following that may have been particularly stressful to you in the last several weeks:

- | | |
|---|---|
| <input type="checkbox"/> Job related stress
<input type="checkbox"/> Death or loss of loved one
<input type="checkbox"/> Conflict with children
<input type="checkbox"/> Conflict with parents or extended family
<input type="checkbox"/> Financial pressure | <input type="checkbox"/> Marital conflict
<input type="checkbox"/> Move/Loss of contact with friends or family
<input type="checkbox"/> Children with behavior problems
<input type="checkbox"/> Family member with an alcohol or drug problem |
|---|---|

Please check any of the following symptoms which occur for most of the day, nearly every day, for periods longer than several days at a time:

Recent	Past		If recent, when was the last episode?	How frequently do you experience episodes?
<input type="checkbox"/>	<input type="checkbox"/>	Depressed or sad mood	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Loss of interest or pleasure in things I'm normally interested in	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty falling asleep	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty staying asleep or waking up too early	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping too much	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Increased appetite/Weight gain (____ lbs.)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Decreased appetite/Weight loss (____ lbs.)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue/Poor energy level	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Decreased activity (work, social, physical, sexual)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Poor concentration or slowed thinking	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of suicide	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive feelings of guilt or worthlessness	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Decreased sex drive or interest	_____	_____

Please check any of the following symptoms which have occurred for more days than not for months at a time:

Recent	Past		If recent, when was the last episode?	How frequently do you experience episodes?
<input type="checkbox"/>	<input type="checkbox"/>	Excessive anxiety or worry for no good reason	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Trembling, twitching or feeling "shaky"	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Muscle tension or muscle aches	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Easily fatigued	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or lightheadedness	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Nausea, diarrhea or other stomach problems	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Feeling keyed up or on the edge	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Irritability	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Trouble falling or staying asleep	_____	_____

Panic attacks (any period of extreme, increased anxiety lasting from a few minutes up to several hours) with any of the following symptoms:

Recent	Past		If recent, when was the last episode?	How frequently do you experience episodes?
<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks/anxiety attacks	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Persistent worry that I will have a panic attack	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart pounding or racing heart	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Trembling or shaking	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sweating	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Choking	_____	_____

Symptom Checklist (continued)

<input type="checkbox"/>	<input type="checkbox"/>	Nausea or stomach problems	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of unreality	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling sensations	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Feeling of smothering or shortness of breath	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Fear of dying	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Fear of going crazy or doing something uncontrolled	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chest pains or discomfort	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness, unsteady feelings or faintness	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Avoiding situations or places that may cause panic	<input type="text"/>	<input type="text"/>

Please check any of the following symptoms which have occurred for most of the day, for more than four days at a time: **(Bipolar)**

Recent	Past		If recent, when was the last episode?	How frequently do you experience episodes?
<input type="checkbox"/>	<input type="checkbox"/>	Euphoric or "high" mood	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Irritable mood (getting angry easily)	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Decreased need for sleep without feeling tired	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Increased energy level	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Increased activity (work, social, physical, sexual)	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts speeded up or racing thoughts	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Much increased talkativeness or being much more socially outgoing	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Making decisions too impulsively	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Going on spending sprees	<input type="text"/>	<input type="text"/>

Have you ever experienced any of the following symptoms?

Recent	Past		If recent, when was the last episode?	How frequently do you experience episodes?
<input type="checkbox"/>	<input type="checkbox"/>	Hearing voices that sound real even though they are not actually there	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Vivid voices in my head that do not seem like my ideas	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Feeling that others might be putting thoughts in my head	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Feeling others might be able to read my thoughts	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Others feeling I am too suspicious or paranoid	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Feeling others might be talking about me	<input type="text"/>	<input type="text"/>

Please check any of the following disturbances in eating habits or maintaining your normal weight that you have experienced:

Recent	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Insistence on maintaining body weight below expected for age and height
<input type="checkbox"/>	<input type="checkbox"/>	Intense fear of gaining weight or becoming fat even though underweight
<input type="checkbox"/>	<input type="checkbox"/>	I feel "fat" even when others see me as underweight
<input type="checkbox"/>	<input type="checkbox"/>	Eating binges
<input type="checkbox"/>	<input type="checkbox"/>	Feeling of lack of control of eating during eating binges
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting or using laxatives to prevent weight gain
<input type="checkbox"/>	<input type="checkbox"/>	Being overly concerned about body weight and shape

Please check any of the following disturbances that apply to you:

Recent	Past	
<input type="checkbox"/>	<input type="checkbox"/>	I tend to do things on impulse which end up being damaging to me or others
<input type="checkbox"/>	<input type="checkbox"/>	I have mood swings (depression, irritability, anxiety, anger) lasting up to several hours
<input type="checkbox"/>	<input type="checkbox"/>	I have tried to commit suicide
<input type="checkbox"/>	<input type="checkbox"/>	I have made cuts, burns, or other injuries to myself without wanting to kill myself
<input type="checkbox"/>	<input type="checkbox"/>	My relationships always seem to work out wrong
<input type="checkbox"/>	<input type="checkbox"/>	My mood often shifts from being overconfident to having very low self esteem

- I have a hard time sympathizing with others' physical or emotional pain
- I often feel others do not understand me
- I tend to get very hurt or angry when I am criticized or rejected by someone
- I tend to need a lot of reassurance or approval from others
- I am very concerned about my appearance
- Others often expect too much of me

Please check any of the following problems relating to past severe trauma or stress that apply to you:

Recent Past

- I have had an experience that was so traumatic that nearly anyone would have been seriously stressed by it
- I have a history of relatives hurting me physically or touching me in sexual areas
- I have memories of a stressful event that I have trouble putting out of my head
- I sometimes have flashbacks of past events, or I act or feel as though I am re-living a stressful event

Please check any of the following obsessions or compulsions that apply to you:

Recent Past

- Excessive doubting or repeated, forced unreasonable thoughts, images, or sounds that I cannot get out of my head
- Urges to check things, wash things, or count repeatedly
- Excessive concern about coming in contact with germs or dirt
- Excessive concern with right/wrong or morality
- Excessive need for things to be exact or symmetrical

I have completed this form correctly to the best of my knowledge.

Signature: _____ **Date:** _____

Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Daytime Phone #: _____ Cell Phone#: _____

Information Released To: Dr Susana E Mendez, L. Ac, CAS, LCDC -

From: _____

Please Release the Following:

_____ Problem List _____ X-Ray Reports _____ Progress Notes _____ X-Ray Films _____ History/Physical Exam

_____ EKG Reports _____ Lab Reports _____ Other Diagnostic Reports (Specify) _____

Immunizations _____ Other (Specify) _____

Including information (if applicable) pertaining to:

_____ Mental Health _____ Drug/Alcohol _____ HIV/AIDS _____ Communicable Treatment

Purpose of Need for Disclosure:

_____ Continued Patient Care _____ Insurance Claim/Application _____ Disability Determination _____ Other
(Specify) _____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

Signature of Patient or Legal Representative Date _____ Relationship to Patient Witness _____

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold Dr. Susana E Mendez, Lac, CAS, LCDC, liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative Date _____ Relationship to Patient Witness _____

Date request completed _____ # pages copied _____ Initials _____

Notice To the Patient:

(Pursuant to the requirements of sections 183.6 (e) of this title (relating to Denial of License, Discipline of Licensee) and TEX.OOC.CODE ANN. 205.351 governing the practice of acupuncture)

I (patient's name) _____ am notifying Dr. Susana E Méndez, L.Ac, LCDC of the following:

_____ YES _____ NO : I have been evaluated by a physician or dentist for the condition being treated within the 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 Dr. Susana Méndez, L.AC _____ (initial of the patient)
Date _____

_____ YES _____ NO . I have received a referral from my Chiropractor within 30 days for acupuncture

After being referred by a Chiropractor, if after 120 days or 30 treatments whichever comes first no substantial improvement occurs in the condition being treated, I do understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

Patient Signature _____ Date _____

Optional Form to be completed by patient, attesting that the acupuncturist has referred him/.her

(Pursuant to the requirements of sections 183.6 (e) of this title (relating to Denial of License, Discipline of Licensee) and TEX.OOC.CODE ANN. 205.351 governing the practice of acupuncture)

Susana Méndez, L. Ac, LCDC has referred me to see a physician. It is my responsibility and choice whether to follow his or her advice.

Patient Signature _____ Date _____

Acupuncturist _____ Date _____

Dr. Susana E. Méndez, MAOM, L.AC, LCDC, ABMPP, CAS, ADS