

**Center for the Healing Arts  
Kim McLaughlin, LAc, RPh  
Barbara Borchardt, LAc  
312 W. Leuda  
Fort Worth, TX 76104  
(817) 882-9750**

Patient Name \_\_\_\_\_  
Email address \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_  
Cell. Phone \_\_\_\_\_  
Marital Status \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_  
Position \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Work phone \_\_\_\_\_  
Drug Allergies \_\_\_\_\_  
Referred by (name & phone no.) \_\_\_\_\_  
\_\_\_\_\_

**Spouse/Parental Information**

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
  
Emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone number \_\_\_\_\_

**Financial Policy**

Fees for all services and products are due at the time of service. I understand that insurance is not accepted at this office. Payment may be made in the form of cash, check, or credit card.

**Appointments**

As a courtesy to other patients, please be on time for your scheduled appointment. Should you need to cancel or reschedule, please give 24 hours notice to avoid a \$25.00 cancellation fee.

**I have read the above statement and I agree to all terms and conditions.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**Informed Consent to Treatment**

I consent to acupuncture and other procedures associated with Traditional Chinese medicine by Kim McLaughlin and/or Barbara Borchardt. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage) Chinese herbal medicine and nutritional counseling. I have been informed that acupuncture is a safe method of treatment, but it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, dizziness, or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture may include spontaneous miscarriage, nerve damage, organ puncture, or lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile, single use needles and maintains a clean safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and/or tingling of the tongue. I will notify the clinic if I am or become pregnant. I do not expect Kim McLaughlin or Barbara Borchardt to be able to anticipate and explain all possible risks and complications of treatment. And, I wish to rely on her to exercise judgment using the course of treatment that she believes at the time and based upon the facts then known, is in my best interest. I understand the clinical and administrative staff may review my medical records and lab reports, but my records will be kept confidential and will not be released without my written consent. I acknowledge and specifically state that I understand that treatment with acupuncture (like treatment by other health services) cannot and does not guarantee specific results or cures. By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, and have been told about the risks for acupuncture and other procedures, and have had the opportunity to ask questions. I intend this consent to cover the entire course of treatment of my present condition(s) for which I seek treatment.

	<b>Date</b>
<b>Print Name</b>	<b>Date</b>
<b>Signature</b> (parent if patient is a minor)	<b>Date</b>
<b>Witness</b>	<b>Date</b>

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(Pursuant to the requirements of Sections 6.11, Subsections b-d, V.A.C.S., article 4495vc governing the practice of acupuncture.)

I, \_\_\_\_\_, am notifying the Staff Acupuncturist of the Center for the Healing Arts of the following:

I have...

I have not...

been evaluated by a physician or dentist for the condition being treated within one year before the acupuncture was performed. I recognize that a physician should evaluate me for the condition being treated by the acupuncturist.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I have...

I have not...

received a referral from my chiropractor within the last thirty days for acupuncture. After being referred by a chiropractor, if after thirty days or twenty treatments, whichever comes first, no substantial improvements occur in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow this advice.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I am requesting acupuncture treatment for smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse. A licensed acupuncturist must recommend an evaluation by a licensed Texas physician or dentist, if after performing acupuncture 20 times or for two months, whichever occurs first, there is no substantial improvement of the patient's chronic pain, alcoholism or substance abuse.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I understand that I am being advised to see a physician for an evaluation of my condition, but do not choose to see one at this time. I will take responsibility for this decision.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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Patient Name: \_\_\_\_\_

Reason for today's visit

\_\_\_\_\_

Is this an emergency? Yes  No

Injury/illness date \_\_\_\_\_

Have you had similar symptoms before? Yes  No

How long have you had this condition?

\_\_\_\_\_

Is it getting progressively worse?

\_\_\_\_\_

Does this condition bother you when you

Sleep  Work  Other  \_\_\_\_\_

What seems to make this condition

better? \_\_\_\_\_

What seems to make this condition worse?

\_\_\_\_\_

Are you currently under the care of a doctor? Yes  No

If yes, please provide your doctor's name and phone number...

Name \_\_\_\_\_

Phone number \_\_\_\_\_

Is this a job related accident? Yes  No  If so, the date of  
injury \_\_\_\_\_

Is your visit due to injuries sustained in a motor vehicle accident? Yes  No

If so, the date of injury \_\_\_\_\_

Have you ever experienced acupuncture before? ? Yes  No

Have you ever experienced Chinese Herbal Medicine before? Yes  No

**Patient Name:** \_\_\_\_\_

**Past Medical History**

Check any of the following conditions you currently have or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> AIDS/HIV                         | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Alcoholism                       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Allergies                        | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Typhoid Fever     |
| <input type="checkbox"/> Appendicitis                     | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Arteriosclerosis                 | <input type="checkbox"/> Gout                | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Venereal Disease  |
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Polio              | <input type="checkbox"/> Whooping Cough    |
| <input type="checkbox"/> Birth Trauma<br>(your own birth) | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Other (specify)   |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Scarlet Fever      | _____                                      |
| <input type="checkbox"/> Chicken Pox                      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures           | _____                                      |
|   | <input type="checkbox"/> Measles             | <input type="checkbox"/> Stroke             | _____                                      |

**List medications you are currently taking:**

Medications Strength How many per day For how long

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**List substances or medications you are allergic to:**

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**List any major surgeries you have had:**

Date Problem

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**List significant trauma you have had (auto accident, falls, etc.):**

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**List significant family history:**

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**Your Diet**

- |  |                                      |                                     |                             |
|--|--------------------------------------|-------------------------------------|-----------------------------|
| Appetite   | <input type="checkbox"/> Coffee      | <input type="checkbox"/> Sugar      | Thirst for water:           |
| <input type="checkbox"/> High <input type="checkbox"/> Low | <input type="checkbox"/> Soft drinks | <input type="checkbox"/> Salty food | # of glasses per day: _____ |

Vitamins taken in the past two months:

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**Your Lifestyle**

- |                                    |   |   |
|------------------------------------|---|---|
| <input type="checkbox"/> Alcohol   | <input type="checkbox"/> Drugs                | <input type="checkbox"/> Regular Exercise |
| <input type="checkbox"/> Tobacco   | <input type="checkbox"/> Stress               | Type: _____ Frequency: _____              |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Occupational Hazards | Type: _____ Frequency: _____              |

**General Symptoms**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Poor appetite             | <input type="checkbox"/> Poor sleep            | <input type="checkbox"/> Cold hands or feet  | <input type="checkbox"/> Sweats easily              |
| <input type="checkbox"/> Heavy appetite            | <input type="checkbox"/> Healthy sleep         | <input type="checkbox"/> Poor circulation    | <input type="checkbox"/> Muscle cramps              |
| <input type="checkbox"/> Strongly like cold drinks | <input type="checkbox"/> Dream-disturbed sleep | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Vertigo or dizziness       |
| <input type="checkbox"/> Strongly like hot drinks  | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Fever               | <input type="checkbox"/> Bleed or bruise easily     |
| <input type="checkbox"/> Recent weight loss        | <input type="checkbox"/> Lack of strength      | <input type="checkbox"/> Chills              | <input type="checkbox"/> Peculiar taste (describe): |
| <input type="checkbox"/> Recent weight gain        | <input type="checkbox"/> Bodily heaviness      | <input type="checkbox"/> Night sweats        | _____   |

**Head, Eyes, Ears, Nose, and Throat**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Glasses         | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Excessive Saliva      | <input type="checkbox"/> Nose bleeds            |
| <input type="checkbox"/> Eye strain      | <input type="checkbox"/> Cataracts               | <input type="checkbox"/> Sinus problems        | <input type="checkbox"/> Ringing in ears        |
| <input type="checkbox"/> Eye pain        | <input type="checkbox"/> Teeth problems          | <input type="checkbox"/> Excessive phlegm      | <input type="checkbox"/> Poor hearing           |
| <input type="checkbox"/> Red eyes        | <input type="checkbox"/> Grind teeth             | <input type="checkbox"/> Color of phlegm:      | <input type="checkbox"/> Earaches               |
| <input type="checkbox"/> Itchy eyes      | <input type="checkbox"/> TMJ                     | _____  | <input type="checkbox"/> Headaches              |
| <input type="checkbox"/> Spots in eyes   | <input type="checkbox"/> Facial pain             | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Migraines              |
| <input type="checkbox"/> Poor vision     | <input type="checkbox"/> Gum problems            | <input type="checkbox"/> Swollen glands        | <input type="checkbox"/> Concussions            |
| <input type="checkbox"/> Blurred vision  | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Lumps in throat       | <input type="checkbox"/> Other head/neck issues |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Dry mouth               | <input type="checkbox"/> Enlarged thyroid      | _____   |

**Patient Name:** \_\_\_\_\_

**Respiratory**

- Pneumonia
- Shortness of breath
- Cough Color of phlegm: \_\_\_\_\_
- Difficulty breathing when lying down
- Tight chest Wet or dry? \_\_\_\_\_
- Asthma/wheezing Thick or thin? \_\_\_\_\_
- Coughing blood

**Cardiovascular**

- High blood pressure
- Fainting
- Tachycardia
- Irregular heartbeat
- Low blood pressure
- Chest pain
- Heart palpitations
- Blood clots
- Difficulty breathing
- Phlebitis

**Gastrointestinal**

- Nausea
- Bad breath
- Intestinal pain or cramping Bowel movements:
- Vomiting
- Diarrhea
- Itchy anus Frequency: \_\_\_\_\_
- Acid regurgitation
- Constipation
- Burning anus Color: \_\_\_\_\_
- Gas
- Laxative use
- Rectal pain Odor: \_\_\_\_\_
- Hiccups
- Black stools
- Hemorrhoids Texture/form: \_\_\_\_\_
- Bloating
- Mucous stools
- Anal fissures \_\_\_\_\_

**Musculoskeletal**

- Neck/shoulder pain
- Lower back pain
- Limited range of motion
- Other (describe): \_\_\_\_\_
- Muscle pain
- Joint pain
- Limited use
- Upper back pain
- Rib pain

**Skin and Hair**

- Rashes
- Psoriasis
- Hair loss
- Other hair/skin \_\_\_\_\_
- Hives
- Acne
- Change in hair/skin texture \_\_\_\_\_
- Ulceration
- Dandruff
- Fungal infection \_\_\_\_\_
- Eczema
- Itching \_\_\_\_\_

**Neuropsychological**

- Seizures
- Depression
- Abuse survivor
- Numbness
- Anxiety
- Considered/attempted suicide
- Tics
- Irritability
- Seeing therapist
- Poor memory
- Easily stressed
- Other (specify): \_\_\_\_\_

**Genitourinary**

- Pain on urination
- Incontinent
- Wake to urinate
- Impotence
- Frequent urination
- Incomplete urination
- Increased libido
- Premature ejaculation
- Urgent urination
- Venereal disease
- Decreased libido
- Nocturnal emission
- Blood in urine
- Bedwetting
- Kidney stones
- Other: \_\_\_\_\_

**Gynecological**

- Age menses began: \_\_\_\_\_
- Irregular periods
- Date of last PAP: \_\_\_\_\_
- # of pregnancies: \_\_\_\_\_
- Length of cycle (day 1 to day 1)
- Painful period
- # of live births: \_\_\_\_\_
- Vaginal odor
- Clots
- # of premature births: \_\_\_\_\_
- Duration of flow: \_\_\_\_\_
- Vaginal sores
- Age at menopause: \_\_\_\_\_
- Date last period began: \_\_\_\_\_
- Vaginal discharge
- PMS
- Breast lumps
- \_\_\_\_\_
- Color: \_\_\_\_\_

Are there any other health concerns we have not addressed that you would like to add?

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**Acknowledgement of Review of  
Notice of Privacy Practices**

I, \_\_\_\_\_ have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

**DISCLOSURE OF PATIENT INFORMATION**

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

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

Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Please print the telephone number where you want to receive calls about your appointments, lab, and x-rays results, or other health care information if other than your home or work number (such as a cell phone number\*): \_\_\_\_\_

\* I am fully aware that a cell phone is not a secure and private line.

Patient name \_\_\_\_\_

Please print \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian signature