

## Acupuncture Questionnaire and Consents

5191 S. Yosemite St., Suite B, Greenwood Village, CO 80111

This questionnaire is in addition to the initial intake form (which must have been completed within the last two years).

### Patient Contact Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female If minor, name of parent: \_\_\_\_\_

Cell #(\_\_\_\_\_) \_\_\_\_\_

Complete the information below if it has changed since completing the initial intake form:

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Married or have a life partner?  Yes  No Significant other's name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

2<sup>nd</sup> Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

---

**Primary reason for today's visit:** \_\_\_\_\_

When and how did this start? \_\_\_\_\_

Describe the worst it can be: \_\_\_\_\_

What treatments have you already tried? \_\_\_\_\_

Did you get temporary relief? \_\_\_\_\_ Did it fix the problem? \_\_\_\_\_ Any side effects? \_\_\_\_\_

How does this affect your life? \_\_\_\_\_

**Second reason for today's visit:** \_\_\_\_\_

When and how did this start? \_\_\_\_\_

Describe the worst it can be: \_\_\_\_\_

What treatments have you already tried? \_\_\_\_\_

Did you get temporary relief? \_\_\_\_\_ Did it fix the problem? \_\_\_\_\_ Any side effects? \_\_\_\_\_

How does this affect your life? \_\_\_\_\_

On a scale of 1-10, rate your commitment to getting rid of the problem(s) and feeling better: \_\_\_\_\_

Have you had acupuncture before?  NO  YES: When & Who: \_\_\_\_\_

Any concerns or fears of needles?  NO  YES: What? \_\_\_\_\_

What are the goals of your acupuncture visit?

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

SUPPLEMENTS	PURPOSE	HOW LONG

**Diet** (check all that apply and write how much per day/week)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Sugar/Candy: _____         | <input type="checkbox"/> Yogurt: _____            | <input type="checkbox"/> Protein 50g: _____          |
| <input type="checkbox"/> Cookies/Baked Goods: _____ | <input type="checkbox"/> Ice-Cream: _____         | <input type="checkbox"/> Eggs: _____                 |
| <input type="checkbox"/> Reg./Diet Soda: _____      | <input type="checkbox"/> White Flour/Bread: _____ | <input type="checkbox"/> Dark greens: _____          |
| <input type="checkbox"/> Chocolate: _____           | <input type="checkbox"/> Pasta: _____             | <input type="checkbox"/> Fruits: _____               |
| <input type="checkbox"/> Dairy/Milk: _____          | <input type="checkbox"/> Coffee: _____            | <input type="checkbox"/> Fast Food: _____            |
| <input type="checkbox"/> Cheese: _____              | <input type="checkbox"/> Alcohol: _____           | <input type="checkbox"/> Do you eat breakfast? _____ |

**Only mark CURRENT SYMPTOMS you have on a 1-5 severity rate (5 being the worst).**

**LIVER / GALLBLADDER**

- \_\_\_\_\_ Irritability / Anger
- \_\_\_\_\_ Depression / Stress
- \_\_\_\_\_ Headaches / Migraines
- \_\_\_\_\_ Visual Problems
- \_\_\_\_\_ Red / Dry / Itchy Eyes
- \_\_\_\_\_ Gall Stones
- \_\_\_\_\_ Dizziness
- \_\_\_\_\_ Blurred Vision
- \_\_\_\_\_ Feeling of Lump in Throat
- \_\_\_\_\_ Clenching of Teeth at Night
- \_\_\_\_\_ Muscle Cramping / Twitching
- \_\_\_\_\_ Tension
- \_\_\_\_\_ Joints/Neck/Shoulder Pain/Tight
- \_\_\_\_\_ Poor Circulation
- \_\_\_\_\_ Soft / Brittle Nails
- \_\_\_\_\_ Emotional Eater

**KIDNEY / URINARY BLADDER**

- \_\_\_\_\_ Urinary Problems
- \_\_\_\_\_ Bladder Infection
- \_\_\_\_\_ Lack of Bladder Control
- \_\_\_\_\_ Weakness / Pain in Lower Back
- \_\_\_\_\_ Decrease Bone Density
- \_\_\_\_\_ Feel Cold Easily
- \_\_\_\_\_ Low Sex Drive
- \_\_\_\_\_ Excess Sexual Desire
- \_\_\_\_\_ Poor Memory
- \_\_\_\_\_ Loss of Hair
- \_\_\_\_\_ Hearing Problems
- \_\_\_\_\_ Cavities
- \_\_\_\_\_ Craving / Avoiding Salty Foods
- \_\_\_\_\_ Fear
- \_\_\_\_\_ Hot Flush / Night Sweating

**HEART / SMALL INTESTINES**

- \_\_\_\_\_ Heart Palpitations
- \_\_\_\_\_ Chest Pain
- \_\_\_\_\_ Insomnia / Sleep Problems
- \_\_\_\_\_ Easily Startled
- \_\_\_\_\_ Restlessness / Agitation
- \_\_\_\_\_ Vivid Dreams
- \_\_\_\_\_ Lack of Joy in Life

**LUNG / LARGE INTESTINE**

- \_\_\_\_\_ Dry Cough
- \_\_\_\_\_ Cough with Sputum
- \_\_\_\_\_ Nasal Discharge
- \_\_\_\_\_ Post-Nasal Drip
- \_\_\_\_\_ Sinus Infection / Congestion
- \_\_\_\_\_ Itchy, Red or Painful Throat
- \_\_\_\_\_ Dry Mouth / Throat / Nose
- \_\_\_\_\_ Skin Rashes / Hives
- \_\_\_\_\_ Snoring
- \_\_\_\_\_ Grief / Sadness
- \_\_\_\_\_ Shortness of Breath
- \_\_\_\_\_ Allergies / Asthma
- \_\_\_\_\_ Low Resistance to Colds or Flu
- \_\_\_\_\_ Sneezing
- \_\_\_\_\_ Mild Fever Comes & Goes
- \_\_\_\_\_ Smoke Cigarettes

**SPLEEN / STOMACH**

- \_\_\_\_\_ Heaviness Anywhere in Body
- \_\_\_\_\_ Fatigue / Worse After Eating
- \_\_\_\_\_ Hard to Get Up in the Morning
- \_\_\_\_\_ Edema (Swelling)
- \_\_\_\_\_ Muscles Feel Tired Often
- \_\_\_\_\_ Easily Bruising & Bleeding
- \_\_\_\_\_ Bad Breath
- \_\_\_\_\_ Decreased / Increased Appetite
- \_\_\_\_\_ Crave Sweets
- \_\_\_\_\_ Hypoglycemia
- \_\_\_\_\_ Difficulty Digesting Oily Foods
- \_\_\_\_\_ Nausea / Vomiting
- \_\_\_\_\_ Gas / Belching
- \_\_\_\_\_ Insulin Sensitivity
- \_\_\_\_\_ Hemorrhoids
- \_\_\_\_\_ Constipation
- \_\_\_\_\_ Diarrhea
- \_\_\_\_\_ Abdominal Pain
- \_\_\_\_\_ Indigestion / Heartburn
- \_\_\_\_\_ Over-Thinking
- \_\_\_\_\_ Tendency to Gain Weight
- \_\_\_\_\_ Brain Foggy

# Colorado Mandatory Disclosure and Consent Form for Acupuncture

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body by well-trained, licensed acupuncturists. Acupressure, acupuncture, moxibustion, cupping, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. The client shall not construe therapies and advice offered to be a diagnosis or treatment of any disease or injury.

I understand that complications may result from acupuncture treatment. Among these possible complications are areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to acupuncture. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia or coumadin use. Please use caution when walking barefoot in the treatment room. I, the patient, further understand and agree to hold harmless, indemnify, and protect against court action the individual acupuncturist/therapist, as well as the management and owners of this clinic, in the event of accidental injury on these premises.

We gladly accept automotive, workers' compensation, and major medical insurance as payment. Insurance coverage depends on your plan. Please call your insurance company beforehand to determine your acupuncture benefits.

## Colorado law requires all acupuncturists to provide the following information to clients on their first visit:

### Education, Experience, Degrees, Certificates, Credentials, Licenses, Certificates, and Registrations:

Your provider has been licensed by the state of Colorado, which requires that they graduate from an approved institution (a four year program), and pass the National Board Exam (NCCAOM) for acupuncture and oriental medicine. They have never had any license, registration, or certification issued by any local, state, or national healthcare agency, revoked or suspended.

### Cash Fee Schedule:

Initial Acupuncture Treatment (incl. exam).....	\$150.00
Follow-up Acupuncture Treatment.....	\$95.00
5-visit Family Plan.....	\$450.00
10-visit Family Plan.....	\$850.00
Membership (1 yr).....	\$80/ follow-up (\$960/year) - with select providers

### Insurance Fee Schedule:

Based on benefit coverage & allowed amount determined by the insurance company.

All fees are due on the service date; prices are subject to change. Family plan refunds: total paid less than \$95 per treatment received. There are no expiration dates on family plans. See the contract for Membership details. Any questions about billing should be discussed with your provider.

This office complies with all rules and regulations promulgated by the Colorado Department of Health related to the proper cleaning and sterilization of needles used in acupuncture practice and the sanitation of acupuncture offices. This office uses only single-use disposable needles and disposes of them in a manner consistent with OSHA and Colorado State regulations. We are trained in recommending and applying adjunctive therapies and herbs as defined by traditional Oriental medicine concepts.

Each patient who visits this office is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Divisions of Registrations in the Department of Regulatory Agencies: The Colorado Department of Regulatory Agencies regulates the practice of acupuncture. Send inquiries to the attention of: Director of the Division of Registrations 1560 Broadway, Suite 1545 Denver, CO 80202. Phone: (303) 894-2464. Each patient may seek a second opinion from another healthcare professional or terminate therapy anytime. If you have any questions about any part of your treatments, billing statements, etc., please ask the office manager and tell your provider.

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient.

Patient's Name (Print): \_\_\_\_\_

Signature of patient or legal guardian \_\_\_\_\_ Date: \_\_\_\_\_