Integrative Health Inc
Experts Providing Healthcare

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:_________________

2nd 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)

- ☐ Sugar/Candy: ___________
- ☐ Cookies/Baked Goods: ___
- ☐ Reg./Diet Soda: _________
- ☐ Chocolate: _____________
- ☐ Dairy/Milk: _____________
- ☐ Cheese: _______________
- ☐ Yogurt: ________________
- ☐ Ice-Cream: _____________
- ☐ White Flour/Bread: _______
- ☐ Pasta: ________________
- ☐ Coffee: ________________
- ☐ Alcohol: _______________
- ☐ Protein 50g: ____________
- ☐ Eggs: _________________
- ☐ Dark greens: ___________
- ☐ Fruits: ________________
- ☐ Fast Food: _____________
- ☐ 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:

Service	Fee
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:________________