

PATIENT HISTORY

This clinic specializes in acupuncture and herbal care. We ask you to fill out this form for either consultation or examination purposes. Examinations are done routinely to determine the nature and extent of the problem. The acupuncturist will explain the level of examination necessary for your type of condition.

NAME _____ DATE _____
 ADDRESS _____ CITY _____ STATE _____
 ZIP _____ PHONE _____ WORK _____ CELL _____
 E-MAIL _____ BIRTHDATE _____ MARITAL STATUS _____
 NO.OFCHILDREN _____ OCCUPATION _____
 EMPLOYER _____
 PRIMARY PHYSICIAN (Name & No.): _____ REFERRED BY _____
 EMERGENCY CONTACT (Name & No.): _____

PURPOSE FOR COMING _____
 SECONDARY COMPLAINT _____ DOCTOR'S DIAGNOSIS _____

How did this condition develop? _____

When was the first time you were aware of this condition? _____

What type of service do you desire?

- ___ 1) Temporary relief of symptoms/pain control
- ___ 2) Eradication of tendencies causing condition
- ___ 3) Balanced optimum health—elimination of root cause of problem, if possible
- ___ 4) Maintenance care—regular balancing to keep in good health

Have you ever received treatment for this condition? ___ Yes ___ No

If so, where _____

By Whom: _____

What were the results of treatment? _____

Has the condition been getting ___ better, ___ worse, or ___ staying the same?

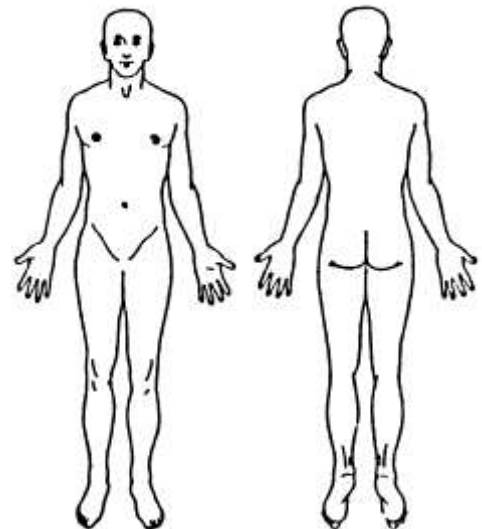
Has this condition affected your ___ home life, ___ work, ___ social life,
 ___ ability to exercise, ___ rest, or ___ sleep?

This is not a detailed history. Please circle all of the conditions below that apply to you.

Tendency to faint, tendency to bruise or discolor easily, tendency to bleed for a long time, hepatitis, AIDS, high blood pressure, heart problems, respiratory problems, treated by acupuncture before, presently using other therapies, past surgeries, taking medications, hungry at present time, exhausted at present time, nervous at present time.

☯ Please note that occasionally some people experience minor bleeding or a tiny bruising from gently piercing the skin. This does not adversely affect your health; on the contrary, it can promote healing.

If you are in pain, please mark the exact location of your pain on the figure below. Describe the type, frequency, intensity and duration of your pain, as well as any activity that brings on or aggravates the pain. (i.e. sharp abdominal pain, every 30 seconds, for the last two hours when standing or sitting.



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Current prescribed medication (i.e. hormones): _____

Over-the-counter: _____

GENERAL HEALTH: (check any that apply)

Chronic Fatigue _____ Irritability _____ Shortness of Breath _____ Headaches _____ Bone Pain _____ Poor Memory _____

Have you experienced unintentional weight loss or gain of 10 pounds or more in the last three months?

FAMILY MEDICAL HISTORY: (check any that apply)

Breast or other cancers _____ Cardiovascular Disease _____ Osteoporosis _____ Obesity _____ Alcoholism _____

Mental Illness/Depression _____ Alzheimer's _____ Diabetes _____ Arthritis _____ Stroke _____

LIFESTYLE AND DIET:

Rate the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) _____ Identify the major causes

WHAT YOU EAT: (check any that apply)

Sweets, sodas, ice cream _____ Fried foods _____ Whole grains, legumes, cereals _____ Fruits/vegetables _____

List your 4 favorite foods: _____

DO YOU: (check any that apply)

Diet frequently _____ Skip meals _____ How many meals do you eat per day _____ Dine out regularly _____

Use tobacco/smoke cigarettes _____ How many cigarettes per day _____ Exposed to passive smoke _____

Drink coffee _____ No. of cups per day _____ Strong _____ Mild _____ Decaffeinated _____

Eat chocolate _____ Drink alcohol _____ How many oz. per day/week _____ Preference _____

Exercise daily _____ How many times per week/activity _____

DO YOU RESTRICT YOUR INTAKE OR AVOID COMPLETELY: (check any that apply)

Dietary fat _____ Dairy products _____ Animal protein _____ Salt _____ Fiber _____ All animal foods _____

PREVENTION HEALING WELLBEING

The Acupuncture Clinic
www.NasAcupuncture.com (719)634-1669
2020 W. Colorado Ave., Suite B-204, Colorado Springs, CO 80904



 CHINESE MEDICINE

 THE

 ACUPUNCTURE

 WOMEN'S HEALTH SCREEN

GYNECOLOGICAL HISTORY: (check any that apply)

Date of last gynecological exam (PAP, mammogram) _____ Results _____ Age of first period _____

Date of last menstrual cycle _____ Length of cycle _____ Interval of time between cycles _____

Any recent changes in normal menstrual flow _____ Form of birth control _____

No. of children ____ No. of pregnancies ____ C-section ____ Surgical menopause/date _____

Other surgeries _____

Endometriosis Infertility Fibrocystic Breasts Fibroids/Ovarian Cancer Reproductive Cancer Vaginal Infections

Vaginal Candidacies Genital Herpes Pelvic Inflammatory Disease

Part 1

Check the symptoms you experience regularly one **to two weeks before** your period:

1. ____ Anxiety
2. ____ Irritability
3. ____ Nervous Tension
4. ____ Aggressive or hostile towards family or friends
5. ____ Engage in self-destructive behavior
6. ____ Weight gain
7. ____ Water retention
8. ____ Abdominal bloating
9. ____ Tender, swollen and/or painful breasts
10. ____ Breast lumps increase in size and tenderness
11. ____ Discharge from nipples
12. ____ Craving for sweets
13. ____ Increased appetite
14. ____ Heart palpitations
15. ____ Fatigue
16. ____ Headaches
17. ____ Shaky or clumsy
18. ____ Depressed
19. ____ Withdrawn
20. ____ Confused
21. ____ Insomnia/difficulty sleeping

Part 2

Check the symptoms and/or behaviors that occur **during your period** with a frequency or intensity that affects our daily activities:

1. ____ Cramping in lower abdomen or pelvic area
2. ____ Sharp intermittent pain
3. ____ Dull aching pain
4. ____ Upset stomach

(Part 2, continued)

5. ____ Diarrhea
6. ____ Nausea or vomiting
7. ____ Low back aches
8. ____ Headaches
9. ____ Difficulty concentrating
10. ____ Accident prone
11. ____ Unusual fatigue (napping)
12. ____ Decreased productivity
13. ____ Weight gain
14. ____ Painful and/or swollen breasts
15. ____ Irritability
16. ____ Mood swings
17. ____ Depression
18. ____ Painful intercourse

Part 3

Check off any of the following statements **that describe** your menstrual cycle, energy level or reproductive function:

1. ____ Heavy prolonged menstrual bleeding/clotting
2. ____ Menstrual bleeding that lasts longer than 5 days
3. ____ Absence of periods for 3 months or more
4. ____ Vaginal itching, burning, dryness
5. ____ Menstruation that occurs too frequently (every 21-24 days)
6. ____ Irregular periods (once every 3 to 6 months)
7. ____ Frequently skip periods
8. ____ Menstrual cycle every 36 days or longer
9. ____ Unusually light or heavy periods
10. ____ Unusually light menstrual flow – spotting
11. ____ Menses last 3 days and are light
12. ____ Bleeding or spotting between a period
13. ____ Frequent urination

14. ____ Bleeding between periods - light/staining
15. ____ Bleeding between periods - heavy and/or clots
16. ____ Abnormal vaginal discharge

Part 4

Check any of the following symptoms if they occur **throughout the month** with an intensity or frequency that affects your ability to perform your daily activities or feel good about yourself.

1. ____ Decline of vital energy and sense of well-being
2. ____ Hot flashes
3. ____ Night sweats
4. ____ Spontaneous sweating
5. ____ Chills
6. ____ Depressed
7. ____ Irritable
8. ____ Anxiety
9. ____ Anger
10. ____ Mood Swings
11. ____ Headaches
12. ____ Forgetful
13. ____ Difficulty concentrating
14. ____ Difficulty sleeping
15. ____ Urinary problems
16. ____ Vaginal problems
17. ____ Dry skin
18. ____ Bleeding between periods
19. ____ Irregular periods
20. ____ Stopped menstruating
21. ____ Joint and muscle pain
22. ____ Change in sexual desire
23. ____ Difficulty with orgasm
24. ____ Painful intercourse
25. ____ Loss of muscle tone
26. ____ Vaginal bleeding
27. ____ Vaginal bleeding after sex
28. ____ Vaginal discharge

PREVENTION HEALING WELLBEING



MEDICAL HISTORY

Please list any significant illnesses, surgeries, or accidents.

Age 0-6:

Age 7 – 12:

Age 13 – 20:

Age 21 – 30:

Age 31 – 40:

Age 41 to present:

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CONSENT FOR TREATMENT

Consent for Acupuncture Care: I, the undersigned am aware of both the benefits and risks of acupuncture treatment and give my consent for treatment. I fully understand that there is no implied or stated guarantee of success of effectiveness of a specific treatment or series of treatments. I further understand that the services from this clinic are alternative approaches of my personal choice to support my optimal health; the services are not intending to change or replace any procedure and medication from my physician. And I am aware of that I may seek a second opinion from another health care professional or may terminate therapy at any time.

Patient/Responsible Party Signature: _____ **Date** _____

It is Agreed with regard to medical care and services the ATTENDING ACUPUNCTURIST will provide services to the patient to the best of his/her skill and knowledge of medical care in the light of circumstances, which is possible and practical. The PATIENT will cooperate fully with the acupuncturist by following his/her instructions.

It is also Agreed: I agree to hold harmless this acupuncturist or to present any issue or concerns of medical malpractice by letter to the acupuncturist and, if taken further, it will be decided by neutral arbitration; and therewith give up my right to jury or court trial should an issue arise. Because of the differences in human consultation and response, I understand that there is no way possible to warrant the outcome of such medical care and service.

Patient/Responsible Party Signature: _____ **Date** _____

I understand that insurance benefits are a contract between the patient and the insurance carrier; I am responsible for paying all charges, including co-payments and deductible at the time of service. I am also aware that if insurance does not cover services, or if the physician does not accept assignment, I am responsible for the charges. I authorize payment of insurance benefits directly to The Acupuncture Clinic. I hereby authorize release of medical information needed to complete insurance company claim inquiries, including release of information to the medical billing firm.

Patient/Responsible Party Signature: _____ **Date** _____

Disclosure Form: By signing below, I acknowledge having read the Disclosure Form and I have had the opportunity to ask questions.

Patient/Responsible Party Signature: _____ **Date** _____

Notice of Privacy Practices: By signing below, I acknowledge having read the Notice of Privacy Practices. (Patient may request a copy of Notice of Privacy Practices for their records.)

Patient/Responsible Party Signature: _____ **Date** _____

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FINANCIAL POLICY

Thank you for choosing us as a health care provider. We are committed to your treatment being successful. An understanding of our financial policy is a very important part of your care.

Late Policy: All efforts are made to keep our schedules on time; if you are more than 15 minutes late, every effort will be made to fit you into the schedule; however, there is no guarantee that you will be seen immediately.

Missed Appointments: It is required that patients attend all scheduled appointments. If a patient is unable to keep a scheduled appointment, the patient is required to call and cancel the appointment at least 24 hours in advance. **Failure to cancel an appointment within 24 hours will result in the assessment of a \$25.00 fee.** This fee is due when billed or at the patient’s next appointment, whichever comes first.

Payment Policy: Patients are responsible for any and all fees incurred as a result of treatment, regardless of insurance coverage. This includes, but is not limited to, payment of co-payments at the time of service, and full financial responsibility for any balance due after the insurance pays or denies claims submitted. Balances are due upon notification. Balances over thirty (30) days old will accrue a 1.5% interest per month. Insurance benefits are a matter between you and your insurance company. You are ultimately responsible for payment on your account.

If your account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, you will be responsible for all costs of collection, including, but not limited to interest, rebilling fees, court costs, attorney fees and collection agency costs.

Pre-Authorization & Referrals: If your insurance requires referrals or pre-authorization for the coverage of Acupuncture treatment(s), it is your responsibility to request such authorization from your doctor, before your Acupuncture visit.

Payment may be made by cash, checks, Visa or MasterCard.

There is a \$20 fee for any checks returned by the bank.

By signing below, I acknowledge that I have read and understand the Financial Policy.

Patient/Responsible Party Signature: _____ Date: _____

As a courtesy, we place Reminder Calls to patients the business day before their appointment. All efforts are made to either speak with patient, or leave a message with Appointment Date & Time. Please indicate if you wish to receive these Reminder Calls and if so, which phone number you wish for us to use:

- Yes**, I wish to receive Appointment Reminder Calls at this phone number: _____
- No**, I do not wish to receive Appointment Reminder Calls

☉ We send out holiday and birthday gift certificate, as well as other promotion notes via E-mail, if you wish to receive these, please **print** your E-mail here _____

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