Community Acupuncture Clinic

HEALTH HISTORY QUESTIONNAIRE

All Medical History information is confidential. **Referred by: __________**

Name: ____________________________________ Today's Date: ______________________
Phone number: _____________________________ Date of Birth: __________________________
Mailing address: ____

Major Complaint: What is your primary reason for this visit?

1)

2)

3)

What initiates your symptoms? ____

What makes them better? ______________________ What makes them worse? ________________

Your medical doctor's name and phone number ____
Contact name and phone number in case of emergency ______________________________________

PERSONAL HISTORY

Check any illnesses or conditions you have or have had in the past:

AIDS/HIV	Bleed Easily	Heart Disease	Multiple Sclerosis	Shingles
Alcoholism	Cancer	Hepatitis	Night Sweats	Stroke
Allergies	Chicken Pox	High Blood Pressure	Pertussis/Whooping Cough	Thyroid Disorders
Anemia	Diabetes	Jaundice	Pneumonia	Tuberculosis
Antibiotic Use	Epilepsy	Kidney Disease	Polio	Ulcers
Asthma	Glaucoma	Mental Disorder	Rheumatic Fever	Vascular Disease

Other: ____

Do you have a PACEMAKER? Yes No
List any surgeries, serious illnesses, broken bones, hospitalizations, etc.: ________________________
____
____

♦ List the Date and Results of last medical test:

Date	Test	Result	Date	Test	Result
	Cholesterol			Pap Smear	
	Hepatitis			Physical	
	HIV test			PSA (prostate)	

Emotions: History of: Mood swings ________Anxiety ________ Depression ________
Irritability ________ Abuse ________ Attempted suicide ________
Current Stress Level : mild moderate high extreme

Current Medications (list all you are taking):

____

Supplements (list all you are taking):

____

Typical Food Intake:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Treats: ____

Caffeine:_________________ Tobacco:______________ Alcohol:______________________

After eating do you have: Fatigue Bloating Gas Burping Pain Other:_______________

Allergies: List any drugs, foods, or other substance you are allergic/hypersensitive to:

____

Stools: Constipation:______________ Diarrhea:______________ Alternating:_____________

Sleep: Hours/night:______ Time to bed:______ Time to wake:______ Rested in a.m.:__________

Trouble falling asleep _______________Palpitations:__________________________

Exercise: Type:_______________________ How often:___________ Energy Level:____________

Energy best at what time of day ______________

<u>Women</u>

DLMP:___________ Pregnant? Y N Length of Cycle:_________ #Days Bleeding:_________

Pain:___________________________________ Clots:_______________ Flow:_________________

Color:___________ PMS:__________________ Irritable:__________ Mood Swings:__________

Breasts Tender:___________ Cravings:_________________ Fatigue:______________________

Birth Control:_________________________ Pregnancies:______ Births:_____ Miscarriages:____

Menarche Age:_______ Vaginal Discharge:_____________ Hx Yeast Infxn's:_________________

Menopause: Age at Onset:_____ Hot Flashes:_____________ Night Sweats:__________________

<u>Body System Review</u>

Headache: Location:________________ How often:____________ Type of Pain:_______________

Dizziness:________ Numbness/Tingling:________ Eyes**:** Red:_____ Itchy:_____ Watery:_____

Blurry:_____ Floaters:______ ↓Night Vision:______________ Glasses:______________________

Ears**:** Ringing:______ Pitch:______ Other:_________________

Throat**:** Swollen glands/Sore throat:______________________________

Neck/Shoulder Tension:________________ Joint Pain: Knees:___________ other:_______________

Low Back Pain:______________________ Shortness of Breath:_____________________________

Comments (anything else you would like to tell us):

Patient Signature: ____ Date: ______________

Acupuncture Clinic Disclosure Statement & Informed Consent

This disclosure statement is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Statute Title 12 Article 29.5. All rules and regulations set forth by the Department of Health are strictly adhered to, including proper cleaning, sterilization, and sanitation of equipment and office. The practice of acupuncture is regulated by the Department of Regulatory Agencies. Inquiries should be made to: Director of Registrations, Acupuncturists Licensure, 1560 Broadway, Suite 1350, Denver, CO 80202, (303)894-7800. Patients are entitled to receive information about the methods of therapy, techniques used, and the duration of therapy, if known. Patients may seek a second opinion and may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

Clinic Fee Schedule (due at time of service)

Sliding Scale: $25.00 - $40.00

$10.00 Paperwork Fee for the initial visit

The Community Acupuncture Clinic aims to make acupuncture affordable for you to receive treatment as often and for as long as needed.

The Community Acupuncture Clinic does not accept patients who want to be treated for substance abuse. We are happy to refer you to acupuncture practitioners and other local resources who are equipped to do so.

Insurance: We do not bill insurance. Upon request, we will provide you with a receipt for your insurance company

We ask our patients to give us 24 hours notice in advance of an appointment if it is necessary to cancel/reschedule. All appointments that are cancelled/rescheduled with less than 24 hours notice and appointments missed without notice will be charged the full regular fee for that appointment.

Practitioner Education, Certification, and Experience

Samhitta Jones, Dipl. Ac., L.Ac., Master's degree in Chinese Medicine from Southwest Acupuncture College Diploma in Traditional Chinese Medicine from Colorado School of Traditional Chinese Medicine in Denver, CO in 1998. NCCAOM Diplomate in Acupuncture issued in 1998. Colorado Licensed Acupuncturist (#496). Private practice in acupuncture since 1998. Also, CranioSacral practitioner since 1989. Nationally certified in Massage Therapy 1995.

Informed Consent

I hereby request and consent to the performance of acupuncture procedures by my acupuncturist, Samhitta Jones. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including discomfort, pain, dizziness, bruising, or numbness at site of procedure. Unusual and rare risks of acupuncture include nerve damage, organ puncture including lung puncture, infection, and spontaneous miscarriage. Other side effects and risks may occur. If I suspect that I am pregnant, I will immediately inform the acupuncturist.

I have discussed the nature and purpose of my treatment with the acupuncturist(s) named above. I understand that there are no guarantees regarding cure or improvement of my condition. I understand that there may be limitations to the care provided and that in my best interest I may be referred to another acupuncture practitioner or other healthcare provider who may be more qualified to treat me outside of these facilities. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications, and I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist judges to be in my best interests based upon the facts then known. I understand that I have the choice to accept or reject treatment at any time.

I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition(s) for which I seek treatment.

______________________________	______________________________	__________
Signature of Patient or Person authorized to consent	Relationship or Authority of Representative	Date