Community Acupuncture Clinic
Health History Questionnaire

*All medical history information is confidential referred by*_____
*Name*_____ *today's date*_____
*Phone number home*_____*cell*_____*e-mail*_____
*Date of birth*_____ *mailing address*_____
*Your medical doctor's name and phone number*_____
*Contact name and phone number in case of emergency*_____
Major complaint, reason for visit
1)
2)
3)

What initiates your symptoms?

What makes them better? *What makes them worse?*

Personal history
Check any illness or conditions you have had in the past
Aids/HIV___ Bleed easily ___ Heart disease ___ MS ___ Shingles ___ Alcoholism ___
Cancer ___ Hepatitis ___ Night sweats ___ Stroke ___ Allergies ___ High blood pressure ___
Thyroid disorder ___ Anemia ___ Diabetes ___ Pneumonia ___ TB ___
Antibiotic use Date_____ Frequency___ Reason _____epilepsy___ Kidney disease ___
Ulcers ___ Asthma what kind_____ Mental disorder ___ Rheumatic fever ___ Vascular disease ___
*Herpes ___ Other*_____

*Do you eve a pace maker ___ yes ___no blood type*_____

List any surgeries, serious illnesses, broken bones, Hospitalizations, etc.:

Date and result of last medical test

Date	*test*	*result*	*date*	*test*	*result*
_____	*Cholesterol*	____	_____	*pap smear*	_____
_____	*Hepatitis*	____	_____	*physical*	_____
_____	*HIV test*	____	_____	*PSA*	_____

*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, since when

Supplements (list all you are taking)

Typical food intake
Breakfast_____
Lunch_____
Dinner, time you eat dinner_____
Snacks_____
Treats_____
Caffeine tobacco alcohol

After eating do you have fatigue bloating gas smelly gas burping pain other
Allergies, food sensitivities, and substances you are allergic, sensitive to

Stools. *How many bowl movements do you have a day____ week ____*
Consistency of bowls hard___ loose____ diarrhea_____ cramping___ deer pebbles____
sticky___ pencil like____
Color: brown____ light_____ yellow_____ green_____
Alternating loose and constipated_____

Sleep*: hours time to bed time to wake time to get up rested am?*
Trouble falling asleep Trouble staying asleep dreaming palpitations

Exercise*: type how often energy level*

Women
Pregnant length of cycle days of bleeding pain, before during after
Clots flow color PMS irritable breast tender sad
Cravings fatigue birth control pregnancies birth's
Miscarriages vaginal discharge yeast infections menopause
Hot flushes night sweats

Headache : location how often pain sharp dull

Dizziness numbness tingling

Eyes: red itchy watery blurry floaters other

Ears: ringing throat swollen glands sore phlegm

Neck shoulder: tension knee: pain back pain low middle upper

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

Acupuncture clinic disclosure statement & informed consent

This disclosure statement is in compliance with the State of Colorado, Department of Regulatory Agencies, and Colorado State 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 Department of Regulatory Agencies regulates the practice of acupuncture. Inquiries should be made to: Director of Registrations, Acupuncturists Licensure, 1560 Broadway, Suite 1350, Denver, CO 80202, 303 894 7800. Patients are instilled 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 if the Division of Registration in the Department of Regulatory Agencies. Private session initial appointment $140
Acupuncture and Cranial Sacral session $85 Community Clinic Fee $50 if you need the sliding scales please talk to me before the session Sliding scale: $50 to $25. $10 fee for initial visit Herbal supplements are charges in addition. UNOPENED herbs have a 14day return policy. Initial_____

We do not bill insurances, except for automobile accidents. The sliding scale pricing does not apply if we bill insurance, but is offered for payment at the time of service, cash or checks. If you need a receipt, and will be reimbursed for the treatment, please pay the full amount.

We have a 24hour cancellation policy. Missed appointments may be charged in full **Initial_____**

Practitioner Education, Certification, and Experience
Samhitta Jones L.Ac, MS, MT, Cranial Sacral Therapist
Diploma in Traditional Chinese Medicine from Colorado School of Traditional Chinese Medicine in Denver, CO in 1998.
Master's Degree in Chinese Medicine from South West Acupuncture College Boulder, 2006, Colorado Licensed Acupuncturist (#496)
Nationally Certified Massage Therapist 1995, Cranial Sacral Therapist since 1993.
Private practice in Acupuncture since 1998

Informed Consent
I hereby request and consent to acupuncture procedures by Samhitta Jones L.Ac. 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 the 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 inform the acupuncturist. I have discussed the nature and purpose of my treatment with Samhitta Jones. I understand that there are no guarantees regarding cure or improvement of my condition, that there may be limitations to the care provided and that in my best interest I may be referred to another health care provider to treat me outside these facilities. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications, and permit her to determine and alter the course of treatment with the acupuncturist judges to be in my best interest based upon the facts then known. I understand that I have the choice to accept or reject treatment at any time.

I have read the above consent. I have also had the opportunity to ask a question about its content, and by signing it below I arguer 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 _____