Acupuncture Intake Form

Acupuncture is a safe, natural, and holistic medicine. As such, it is important for your acupuncturist to understand your primary health concerns within the context of your physical, mental, and emotional states. Thank you for taking the time to fill out this form accurately and completely.

ALL INFORMATION WILL REMAIN CONFIDENTIAL

Name_____Date of Birth_____

Address_____City_____State_____Zip_____

Cell Phone_____ Mobile Carrier:_____Opt in to text reminders? Y N

E-mail address_____

Emergency contact_____

Emergency contact address (if different) _____

Phone_____ Relationship _____

How did you hear about Whole Body Balance?_____

Please describe the reason for your visit today: _____

Is it getting better, worse, or staying the same? _____

Please list any previous treatment and outcome(s): _____

_____

What was your diagnosis? _____

Please list any current medications or supplements: _____

_____

Please list any allergies to medications, foods, or other substances:_____

_____

CURRENT PAIN OR INJURY

Location 1:_____ Severity (1-10):_____ How did it start?_____

Current treatment:_____ Is it better or worse?_____

Location 2:_____ Severity (1-10):_____ How did it start?_____

Current treatment:_____ Is it better or worse?_____

Location 3:_____ Severity (1-10):_____ How did it start?_____

Current treatment:_____ Is it better or worse?_____

FAMILY HISTORY

Please mark health issues of immediate family members and their relationship to you:

- ☐ Alcoholism/Addiction
- ☐ Arteriosclerosis
- ☐ Heart Disease
- ☐ Allergies
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Seizures
- ☐ Stroke

DIET AND LIFESTYLE

Please mark items that are a regular part of your diet and indicate how frequently they are consumed:

- ☐ Alcohol — Amount & Frequency: _____
- ☐ Nicotine — Amount & Frequency: _____
- ☐ Caffeine — Amount & Frequency: _____
- ☐ Soda/Pop — Amount & Frequency: _____
- ☐ Marijuana — Amount & Frequency: _____
- ☐ Other Drug Use — Amount & Frequency: _____
- ☐ Sweets/ Sugar — Amount & Frequency: _____

Please describe your current diet including any foods/ food groups that are specifically excluded or emphasized: _____

Please indicate how much water you consume per day: _____

On a scale of 1-10, please indicate your current stress level: _____ typical level:_____

How does stress affect you? (ie, more headaches, stomach pain, etc.) _____

MEDICAL HISTORY

Please mark current health concerns as well as significant past health issues:

Head/Brain/Face
- ☐ Hair Loss
- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Memory Loss
- ☐ Brain Injury
- ☐ Epilepsy
- ☐ Stroke
- ☐ Seizures
- ☐ Allergies:_____
- ☐ Acne
- ☐ Frequent Colds
- ☐ Sinus Trouble
- ☐ Nosebleeds
- ☐ Eyelid Twitching
- ☐ Floaters in Vision
- ☐ Glasses/Contacts
- ☐ Hearing Problems
- ☐ Dental Problems
- ☐ Jaw Pain/ TMJ

Reproductive/Hormone
- ☐ Hormone Changes
- ☐ Endocrine Disorder
- ☐ Thyroid Disorder

Sleep
- ☐ Insomnia
- ☐ Somnolence
- ☐ Night Sweats
- ☐ Vivid Dreams
- ☐ Frequent Nightmares

Chest/Circulation
- ☐ Difficulty Swallowing
- ☐ Chest Pain or Tightness
- ☐ Asthma
- ☐ Difficulty Inhaling
- ☐ Difficulty Exhaling
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Tuberculosis
- ☐ Heart Arrhythmia
- ☐ Pacemaker
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Easy Bruising
- ☐ Gout
- ☐ Reynaud's Syndrome
- ☐ Cold Hands/Feet

Nervous System
- ☐ Numbness/ Tingling
- ☐ Neuropathy
- ☐ Tremors
- ☐ Multiple Sclerosis

Mental/Emotional
- ☐ Addiction
- ☐ Mental Health Diagnosis
- ☐ Depression
- ☐ Anxiety
- ☐ Trauma

Gastrointestinal/Urinary
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Irritable Bowel
- ☐ Intestinal Parasites
- ☐ Appendicitis
- ☐ Reflux
- ☐ Abdominal Pain
- ☐ Gas/ Bloating
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Nausea/ Vomiting
- ☐ Ulcers
- ☐ Appetite Changes
- ☐ Weight Loss or Gain
- ☐ High Thirst
- ☐ Low Thirst
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Nighttime Urination
- ☐ Blood in Urine

Other
- ☐ Cancer:_____
- ☐ Excessive Sweating
- ☐ Fatigue
- ☐ Hepatitis (A, B, C)
- ☐ Mumps
- ☐ Polio
- ☐ Chicken Pox
- ☐ Shingles
- ☐ Edema or Swelling

Please provide details (if needed) regarding items marked above: _____

_____

Please list any other health concerns not listed above: _____

_____

REPRODUCTIVE HEALTH HISTORY

Please complete the questions/ mark boxes that relate to your reproductive system:

- ☐ Genital Pain
- ☐ Lower Abdominal Pain
- ☐ Abnormal Discharge
- ☐ History of STD/STI
- ☐ Current STD/STI
- ☐ Excessive Libido
- ☐ Decreased Libido
- ☐ Impotence
- ☐ Infertility
- ☐ Urinary Frequency
- ☐ Urinary Incontinence

Please complete the following questions if you menstruate:

First day of last period: _____ Currently pregnant: Y N Unsure

Number of pregnancies: _____ Births: _____ Miscarriages/ Terminations _____

Stillbirths: _____Current birth control method (if applicable): _____

Date of last pap test:_____ Date of last clinical breast exam: _____

Age of first menses_____ Age of menopause (if applicable):_____

Bleeding between periods: Y N Bleeding after intercourse: Y N

Please describe your menstrual cycle and flow:

- ☐ Short (Under 28 days)
- ☐ Long (Over 28 days)
- ☐ Irregular (21-60 days)
- ☐ Regular (27-29 days)
- ☐ Painful Before
- ☐ Painful During
- ☐ Painful After
- ☐ Heavy Flow
- ☐ Light Flow
- ☐ Short Flow (1-3 days)
- ☐ Long Flow (7-9 days)
- ☐ Clots Present
- ☐ Light Red Color
- ☐ Dark Crimson Color
- ☐ Brownish Color
- ☐ Purplish Color
- ☐ Fatigue Before
- ☐ Fatigue After

Please describe any pre-menstrual symptoms you experience:

- ☐ Irritability/Anger/Rage
- ☐ Depression/ Crying
- ☐ Anxiety
- ☐ Headaches/migraines
- ☐ Digestive Upset
- ☐ Breast Tenderness
- ☐ Insomnia
- ☐ Cravings:_____
- ☐ Other:_____

Please list any other reproductive concerns: _____

I have provided correct and complete information to the best of my knowledge.

_____ _____

Patient's or Guardian's signature Date

COLORADO MANDATORY DISCLOSURE STATEMENT

Anne Devereux, L.Ac., MSOM
Whole Body Balance, Inc.
2995 Baseline Rd., Ste. 110
Boulder CO 80303
(303) 444-0192

EDUCATION AND EXPERIENCE

Anne Devereux earned her Master of Science in Oriental Medicine degree from Southwest Acupuncture College in August 2012. This four-year program consists of 3,092.5 hours of didactic and clinical education. She was certified as a Diplomate in Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in July 2012, which includes certification in Acupuncture, Chinese Herbology, and Clean Needle Technique. Anne's training includes adjunctive therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy, electrical stimulation (e-stim), and dietary/lifestyle recommendations. Anne is a member of the Acupuncture Association of Colorado. Anne is a licensed acupuncturist in the state of Colorado. Her acupuncture license, certificates, or registrations have never been suspended or revoked.

This clinic uses only single-use, disposable, factory-sterilized needles, and complies with the rules and regulations promulgated by the Colorado Department of Public Health and Environment concerning proper cleaning and sanitation measures.

FEE SCHEDULE:

Initial Consultation and Treatment	$120.00 + cost of herbs
Fertility Consultation and Treatment	$140.00 + cost of herbs
Follow up treatment	$79.00 + cost of herbs
Monthly Maintenance plan treatment	$64.00 + cost of herbs

I understand that if I need to cancel or reschedule an appointment for any reason, I will give at least 24 hours notice or be responsible for the full session fee.

PATIENT'S RIGHTS

- -The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known
- -The patient may seek a second opinion from another health care professional or may terminate therapy at any time.
- -In a Professional Relationship, sexual intimacy is never appropriate and should be immediately reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of Acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1340, Denver, CO. 80202. Tel (303) 894-7851.

I have read and understand this document.

_____ _____

Patient's or Guardian's signature Date

FINANCIAL POLICY

Thank you for choosing Whole Body Balance, Inc. We are committed to providing safe and effective health care. Please understand that payment is considered part of your care. The following is a statement of our financial policy, which you must sign prior to receiving care.

Please note that it is ultimately your responsibility to understand what services are covered under your insurance policy. Please check your insurance policy to determine your coverage.

If you have insurance benefits, we are happy to process your insurance claims. To prevent any misunderstandings about your insurance coverage and our billing / collections procedure, we would like to inform our patients that we cannot render services under the ASSUMPTION that we will be reimbursed by your insurance company. **Please understand that you will be fully responsible for all professional services that your insurance company does not pay.**

Whole Body Balance is committed to providing the best care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

It is our policy to:
1. Collect all co-pays at the time services are rendered.
2. Collect full payment for cash patients the day services are rendered. If payment is not collected on the day of service, the time of service discount will no longer apply and you will be billed the full standard fee.
3. Charge a late fee if payment is not received by the due date on the statement.
4. Charge a $25 late fee on all returned checks.
5. Charge for missed appointments at the rate of a normal office visit if the visit is not canceled 24 hours prior to the appointment time. (Please help us serve you better by keeping scheduled appointments.)

Whole Body Balance accepts cash, checks, and most major credit cards.

ASSIGNMENT OF INSURANCE PROCEEDS

If you have insurance, please sign this assignment of benefits agreement. By agreeing to this assignment, we will direct your insurance company to make any payments for your chiropractic, physiotherapy, physical rehabilitation, diagnostic testing, or any other reimbursable treatment or evaluations you receive to our clinic directly.

In exchange for services and supplies rendered, I do assign to Whole Body Balance, Inc., any insurance proceeds, including accident and health insurance benefits and bodily injury claim awards up to the amount of any unpaid balance with interest as allowed by law.

_____ Patient Initials

_____ _____

Patient's or Guardian's signature Date

STATEMENT OF INFORMED CONSENT

I hereby request and consent to the performance of acupuncture and other treatments within the scope of practice of an acupuncturist to be performed by Anne Devereux, L.Ac. representing Whole Body Balance, on me (or, if the patient is a minor, on the patient named below, for whom I am legally responsible).

I understand that there are minor risks associated with acupuncture treatment, including, but not limited to, slight bleeding and/or bruising of the skin. I understand that the risk of infection is negligible when using single use, disposable needles.

I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture. I understand that results are not guaranteed.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications. I wish to rely on the acupuncturist to exercise good judgment during the course of the procedure, based on the facts then know, and act in my best interest.

I have read the above consent, or have had it read to me. I have had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend for this consent form to cover the entire course of treatment for my present condition, as well as any future conditions for which I may seek treatment.

Following your treatment:

1) Occasionally, a person may feel light headed after an acupuncture treatment. If this happens to you, please sit for a while in the designated area. You'll feel fine in a few minutes.
2) Herbs prescribed for the patient are intended for his or her use only, and should not be used by those for whom they are not dispensed.

Please sign and date below to indicate that you have read and understand this form.

_____ _____

Patient Signature (or Guardian, if minor) Date

_____

Printed Name

WHAT TO EXPECT FROM YOUR FIRST ACUPUNCTURE TREATMENT

Many people feel excited and perhaps a little bit nervous prior to their first acupuncture treatment. Please be aware that acupuncture is not only safe and effective, but also very relaxing. Many patients feel calm and centered after acupuncture, sometimes even blissful or euphoric. If we are working on a sports injury or musculoskeletal pain, it is possible that you may feel a little bit sore for 24 hours after acupuncture. This is a natural and healthy response to muscular release and repair.

Your initial visit will consist of four main parts. The first part will include completing new patient paperwork such as consent and medical history forms.

The next part of your visit includes a discussion of your medical history and health care goals with our acupuncturist. S/he will then formulate a diagnosis and treatment plan and perform the next part of your visit, which is the acupuncture treatment. Most treatments include about 10-20 thin, sterile, single-use needles inserted shallowly into the body at specific points. If we are working on musculoskeletal pain or injury, the needles may be inserted around the area of injury or into the target tissue.

After the acupuncture needles have been inserted, you will likely rest for 10-30 minutes with the needles retained. The needles will then be removed. The final part of your visit includes a discussion of expected results and the creation of a follow-up plan.

In some cases, the acupuncturist will opt to use his/her hands rather than needles, using Chinese and Japanese styles of bodywork such as shiatsu and tui na. This may feel like "acupressure." In other cases, the acupuncturist may use very mild electrical stimulation with the acupuncture needles. If this is indicated, s/he will describe the process for you prior to beginning.

Your comfort and safety are very important to us. Please inform the acupuncturist or other staff if you have any questions or concerns, or are uncomfortable at any point. We welcome questions, and are happy to discuss or explain any part of the acupuncture treatment at any point.

Please wear comfortable clothes. Most acupuncture treatments include working from the knees to feet and from the elbows to hands. It is also important for the acupuncturist to access specific areas of injury or pain, therefore loose clothing, tank tops, and/or shorts may be helpful. Sheets and drapes are always available as well.

Occasionally, a person may feel lightheaded after a treatment. This is often either the result of your body responding to treatment and/or being too hungry at the time of your visit. If this occurs, please notify your acupuncturist immediately and s/he will treat you accordingly. Thank you!

RELEASE OF MEDICAL RECORDS

Patient Information

Full name:_____

Date of birth:_____Phone number:_____

Address:_____

Please list or describe the specific medical records to be released including any relevant dates of service or a date range during which care was received: _____

_____

_____

_____

_____

_____

Provider Information

Name of **releasing** health care provider:_____

Name of office or practice:_____

Address:_____

Phone number:_____Fax number:_____

Name of **receiving** health care provider:_____

Name of office or practice:_____

Address:_____

Phone number:_____Fax number:_____

Patient Signature:_____

Date:_____