

New Patient Intake Form

Today's Date: _____

Name: _____ Marital Status: S M D W Gender: M F

Street: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Age: ____ Occupation: _____ Referred By: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ht: _____ Wt: _____

Email Address: _____ Subscribe to my seasonal e-newsletter: Yes / No

Emergency Contact Name/Phone: _____

Have you had acupuncture before? Y N Chinese Herbal Medicine? Y N

Reason for visit today: _____

How long have you had this condition? ____ Is it getting worse? ____ Does it bother your: Sleep Work Other: _____

What seemed to be the initial cause? _____

What makes it better? _____

What makes it worse? _____

Are you under the care of a physician now? Y N If yes, for what? _____

Physician's Name: _____ Physician's Phone: _____

If you want me to discuss your case with your physician, sign here to give consent: _____

Other current therapies: _____

Family Medical History:

Allergies Alcoholism Diabetes High Blood Pressure Seizures
 Asthma Addictions – other Heart Disease Mental Disorders Stroke
 Arteriosclerosis Cancer Other: _____

Your Past Medical History (check any you currently have or have had in the past):

AIDS/HIV Cancer Heart Disease Pacemaker Stroke
 Alcoholism Chicken Pox Hepatitis Pleurisy Thyroid disorders
 Allergies Diabetes Herpes Pneumonia Tuberculosis
 Appendicitis Emphysema High blood pressure Polio Typhoid fever
 Arteriosclerosis Epilepsy Measles Rheumatic fever Ulcers
 Asthma Goiter Multiple Sclerosis Scarlet fever Venereal disease
 Brith Trauma (own birth) Gout Mumps Seizures Whooping cough
Other: _____

____ Surgery (please list): _____

____ Major Trauma (car, fall, etc; list): _____

Your Lifestyle

Alcohol Migraines Stress Tobacco Drugs Occupational Hazards

Regular Exercise – Type and Frequency: _____

Your Diet

Appetite: Low High Coffee Soft Drinks Artificial Sweetener Sugar Salty foods
 Thirst for water # glasses per day: _____

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Head, Eyes, Ears, Nose, Throat

<input type="checkbox"/> Glasses	<input type="checkbox"/> Night blindness	<input type="checkbox"/> Sores on lips/tongue	<input type="checkbox"/> Recurrent sore throat	<input type="checkbox"/> Headaches
<input type="checkbox"/> Eye strain	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Migraines
<input type="checkbox"/> Eye pain	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Excessive phlegm	<input type="checkbox"/> Lumps in throat	<input type="checkbox"/> Concussion
<input type="checkbox"/> Red eyes	<input type="checkbox"/> Teeth problems	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Enlarged thyroid	<input type="checkbox"/> Other head/neck problems: _____
<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Excessive phlegm	<input type="checkbox"/> Nose bleeds	_____
<input type="checkbox"/> Spots in eyes	<input type="checkbox"/> TMJ	Color of phlegm: _____	<input type="checkbox"/> Ringing in ears	_____
<input type="checkbox"/> Poor vision	<input type="checkbox"/> Facial pain	_____	<input type="checkbox"/> Poor hearing	_____
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Gum problems		<input type="checkbox"/> Earaches	

Respiratory

<input type="checkbox"/> Difficulty breathing when lying down	<input type="checkbox"/> Tight chest	<input type="checkbox"/> Cough: _____	Color of phlegm: _____	<input type="checkbox"/> Coughing blood
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Asthma/wheezing	Wet or Dry? _____		<input type="checkbox"/> Pneumonia
		Thick or thin? _____		

Cardiovascular

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Tachycardia	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Fainting	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Irregular heartbeat

Gastrointestinal

<input type="checkbox"/> Nausea	<input type="checkbox"/> Diarrhea	Bowel movements: _____		
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Constipation	Frequency: _____	Texture/Form: _____	
<input type="checkbox"/> Acid regurgitation	<input type="checkbox"/> Laxative use	Color: _____	Odor: _____	
<input type="checkbox"/> Bloating	<input type="checkbox"/> Intestinal pain/cramping			

Skin and Hair

<input type="checkbox"/> Rashes	<input type="checkbox"/> Hives	<input type="checkbox"/> Eczema	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Other hair/skin problems: _____
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Genito-Urinary

<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Urgent urination	<input type="checkbox"/> Wake to urinate	<input type="checkbox"/> Decreased libido	
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Increased libido	<input type="checkbox"/> Other: _____	

Gynecology

<input type="checkbox"/> Age menses began	<input type="checkbox"/> Irregular menses	<input type="checkbox"/> Clots	Age at menopause: _____
Length of cycle (day 1 to day 1): _____	<input type="checkbox"/> Painful period	<input type="checkbox"/> Breast lumps	Date of last PAP: _____
Duration of flow: _____	<input type="checkbox"/> PMS	# Pregnancies: _____	Date last period began: _____
<input type="checkbox"/> Vaginal discharge (color: _____)	<input type="checkbox"/> Vaginal sores	# Live births: _____	
	<input type="checkbox"/> Vaginal odor	# Premature births: _____	

Neuropsychological

<input type="checkbox"/> Depression	<input type="checkbox"/> Irritability	<input type="checkbox"/> Abuse survivor	<input type="checkbox"/> Seeing a therapist	Other: _____
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Easily stressed	<input type="checkbox"/> Considered/attempted suicide		_____

Is there anything else I need to know about treating you?

Colorado Mandatory Disclosure Statement

Education and Experience

Tina Laue earned her Master of Science degree in Traditional Chinese Medicine from the Colorado School of Traditional Chinese Medicine in December, 2007. This program consists of 2,850 hours of education including 560 hours of clinical internship treating the public. She was certified as a Diplomate in Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in 2008. This includes certification in Clean Needle Technique and Chinese Herbology. Tina is also completing a 3 year internship in 5 Element Acupuncture with Judi Terrill (J.R. Worsley -> Warren Bellows -> Judi Terrill). Tina's training includes adjunctive therapies such as moxibustion, tui na, gua sha, acupressure, cupping, auriculotherapy, shonishin, diet, and lifestyle recommendations. She is a Licensed Acupuncturist in Colorado. Her license has never been suspended or revoked. This clinic complies with the rules and regulations set forth by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single use, disposable, factory-sterilized needles are used.

Cancellation Policy

You are responsible for the full fee for scheduled service unless you provide me with 24 hour notice to cancel or reschedule. This fee is due in 30 days.

Fee Schedule

Initial Intake, Consultation and Treatment (1½ - 2 hours).....	\$100
Follow-up Treatment (1 - 1½ hours).....	\$70
Follow-up Herbal Consult only (½ hour).....	\$50
Acupuncture Happy Hour Stress Relief.....	\$10
Initial Shonishin Intake and Treatment (1 hour).....	\$60
Follow-up Shonishin Treatment (½ hour).....	\$35
Missed Appointment Fee.....	Full Fee for Scheduled Service

*Any herbs are an additional fee. Services may be discounted for seniors, students, and those in need.

Packages: Combine your Follow-up Care and Save Money!

Adults: 3 Sessions - \$195, 6 Sessions - \$360, 9 Sessions - \$495

Children: Shonishin Wellness Package – 10 sessions - \$250

Package prices must be paid in full up front and expire one year from the date of purchase.

One package session is forfeit if you fail to give 24 hour notice for cancellation.

Patient's Rights

1.) The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. 2.) The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. 3.) 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 (DORA). 4.) The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact:

Director of Registrations, Acupuncturists Licensure, 1560 Broadway, Suite 1350, Denver, Colorado 80202 or call them at 303-894-7800.

I have read and understand this document.

Patient or Guardian's Signature

Date

Consent to Receive Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist and herbalist at Good Needles. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Acupuncture: I understand that acupuncture is performed by the insertion of sterile, single-use needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time. I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Moxibustion/Direct Moxibustion: Moxa is the furry underside of the leaf of the plant mugwort or artemisia vulgaris. It is used to add heat to the body or to move energy in the channels. Moxa is selected because it burns at a nice even pace and does not have intense heat to it. It is applied indirectly, on top of the needles, in the form of stick-on moxa cones, or directly to the skin. I understand that there is a risk of burns and I am free to refuse this treatment. It may also be irritating to people with asthma or allergies and I will communicate to my practitioner if this product irritates me.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Chinese Medical Clinic as soon as possible.*

Acupressure/Tui-Na Massage/Shonishin: I understand that I may also be given acupressure/tui-na massage/shonishin as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. This is the application of an electric current to the needles. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Gua Sha: I understand that I may be offered Gua Sha to help normalize the body's physiological functions or to modify or prevent pain perception. I understand that certain adverse side effects could result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that I may refuse this therapy.

Cupping: I understand that I may be offered cupping, which is the application of suction using glass cups for the purpose of relieving pain, increasing energy, breaking up stagnation, and treating disease conditions. This therapy leaves bruises which may be quite dark. I need to protect the area for the next 48 hours from excessive or prolonged exposure to wind, sun, or direct spray from a shower. (A quick shower is fine.) This is because the pores are opened and may be quite sensitive. I understand that I will be asked each time this therapy is applied if I want it and that I may refuse it.

Ear Seeds: I understand that I may be offered ear seeds, which are seeds taped on an auricular acupuncture point in the ear. I understand that the ear has a minimal blood supply and that an inflammation of the outer ear is very serious. I agree if I receive ear seeds to remove them if they irritate or bother me. I agree to keep my ears clean and to remove them after the time frame discussed with my practitioner. I understand that if the outer ear becomes infected due to my negligence in removing these seeds in a timely manner, that I need to seek western medical care and am fully responsible for the charges. I understand that I may refuse this therapy.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. (If I ask for and receive a more detailed explanation, both practitioner and patient will initial next to item.) I give my permission and consent to treatment.

Signature: _____ **Date:** _____