SUNSTONE
ACUPUNCTURE

New Patient Intake Form

Please provide as complete information as possible, even if you do not feel certain questions pertain to your present condition. All the information you provide is confidential and is useful in determining the best treatment plan for you.

Name:_____ Today's Date:_____

Date of Birth:_____ Age:_____ Occupation: _____

Sex: M F (If there is anything about your gender that you would like me to know, please indicate): _____

Address: _____ Cell Phone: _____

City, State, Zip: _____ Work Phone: _____

E-mail:_____ Home Phone: _____

Number of Children:_____ Preferred #: Home Cell Work

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Partnership

How did you hear about us: ☐Friend/Family ☐Doctor ☐Website/Ad ☐Other: _____

Emergency Contact:_____Relationship:_____Phone: _____

Your Current Doctor(s): Name:_____ Phone #: _____

Address:_____ May we contact your Doctor: Y N

Date of last physical exam:_____Date of last blood panel:_____Diagnosis: _____

Please attach any lab work that you would like considered

Insurance:_____ Policy ID : _____

Phone #:_____Address:_____Group #:_____

Have you had acupuncture before? (If so, by what type of Practitioner?) _____

What are your primary reasons for coming in to treatment?

1 _____

2 _____

3 _____

When did you first notice this problem/How long has it been going on? _____

Have you been diagnosed with any of the following:_____

☐Hypertension
☐Autoimmune Disease
☐Epilepsy/Seizures
☐Depression/Anxiety
☐Kidney Disease
☐Emotional Disorder/Addiction/Eating Disorder
☐GERD/Reflux
☐HIV/AIDS
☐Arthritis
☐Asthma/Emphysema/COPD
☐Migraine Headaches
☐Diabetes
☐Cancer/Lymph node removal
☐Osteopenia/Osteoporosis
☐Bleeding/Clotting Disorder
☐Fibromyalgia/Chronic Fatigue Syndrome
☐High Cholesterol
☐Heart Disease
☐Stroke
☐Thyroid Disorder
☐Infertility
☐Hepatitis A/B/C

Please indicate if you have *or* are currently taking any of the following:

☐Pacemaker	☐Clotting Disorder	☐Contagious Disease
☐Sleeping Aids	☐Blood thinners (Warfarin, Coumadin etc)	☐Thyroid Medication
☐Cortisone (Steroids)	☐Diet Pills	☐Laxatives
☐Antacids (Tums, etc)	☐Pain Relievers	☐Tranquilizers/Sedatives

Please list any hospitalizations/surgeries/major injuries/accidents:

Hospitalization/Surgery/Accident	Date	Relation to health concerns

Please list all prescriptions and over-the-counter medications that you are currently taking:

Name	Dosage	Reason for taking	Date began taking

Please list all supplements, vitamins, herbs, etc. that you are currently taking:

Name	Dosage	Reason for taking	Date began taking

Approximately, how many times have you had to take antibiotics in the past ten years?_____

Please list all allergies (environmental, animal, dietary, chemical, seasonal): _____

_____.

Family Health History (Grandparents, Parents and Siblings):

☐Alcoholism	☐Drug Addiction	☐Suicide
☐Mental Illness	☐Eating Disorder	☐Depression
☐Cancer	☐Alzheimer's/Dementia	☐Arthritis
☐Parkinson's	☐Diabetes	☐Genetic Disorder/Birth Defects
☐High Blood Pressure	☐Heart Disease	☐Stroke

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☐Learning Disabilities ☐Osteoporosis ☐Infertility
☐Obesity/weight management ☐Migraine Headaches ☐Asthma

Height:_____ Weight:_____ Desired Weight: _____

DIET

Do you subscribe to a particular diet: ☐Vegan ☐Vegetarian ☐Gluten-Free ☐Paleo ☐Other:_____
How is your appetite? ☐None ☐Low ☐Normal ☐Excessive
Please list typical foods in your diet:_____
How much Alcohol intake: _____Daily _____Days/week ☐Beer ☐Wine ☐Liquor
How many OUNCES do you have DAILY: _____Water _____Soda _____Coffee/Tea
Are you always thirsty?: Y N Do you prefer: hot or cold (Circle)
Do you experience cravings? ☐Sweet ☐Spicy ☐Sour ☐Bitter ☐Raw ☐Dairy ☐Cold ☐Hot ☐Salty ☐Fried

SLEEP:

Average hours of sleep per night?: _____
Do you have difficulty: ☐Falling asleep ☐Staying asleep Are you able to fall back asleep? Y N
Do you wake due to (*Check all that apply)*
☐Pain or discomfort ☐Racing thoughts ☐Worry ☐Sadness ☐Hot Flash ☐Night Sweats ☐Dreams
Other:_____
Do you wake in the night to urinate? Y N How many times per night?_____
Do you use sleep aids?_____ If yes, what _____

EXERCISE & ENERGY:

General Energy Level: *(0 is low, 6-7 is normal, 10 is high):* _____
☐Tired after eating ☐Energized after eating ☐Tired after exercising ☐Energized after exercising
How often do you exercise?_____ Type of exercise_____

EMOTIONS:

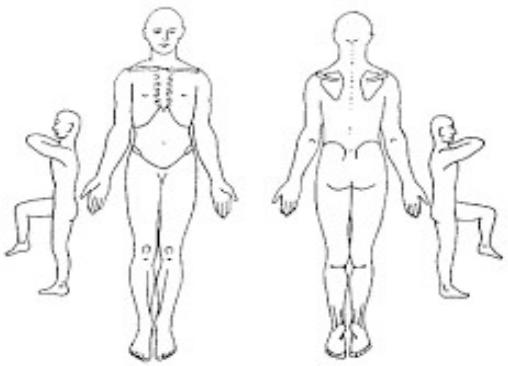
How is your stress level? *(0 is low, 10 is high)*: _____
Do you have (check all that apply):
☐Depression ☐Bad Temper ☐Frustration ☐Anger ☐Sighing ☐Worry
☐Panic attacks ☐Anxiety ☐Nervousness ☐Fear ☐Fright ☐Poor memory
☐Difficulty concentrating/Brain Fog ☐Other: _____
How does stress manifest in your body? ☐Digestive disturbances ☐Neck/shoulder tension ☐Mood changes
☐Disturbed sleep ☐Other _____

If you are experiencing pain or discomfort, please indicate where below & rate: 1 2 3 4 5 6 7 8 9 10

What makes the pain worse: _____

What makes the pain better:_____

Have you had a medical evaluation(s): ☐X-Ray ☐MRI ☐CT Scan ☐EKG ☐Ultrasound ☐Blood Test
Other:_____ Finding(s):_____



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Survey of Symptoms: Please put a check next to your current/frequent symptoms and write "*past*" next to any condition that you have experienced in the past and/or no longer experience.

Head, Neck & Eyes:

- ☐ Dizziness/Fainting/Vertigo
- ☐ Floaters/Blind Spots
- ☐ Blurry Vision/Glaucoma/Cataracts
- ☐ Neck Stiffness
- ☐ Enlarged Lymph Nodes
- ☐ Headaches/Migraines/Head Injury
- ☐ Corrected/Diminishing Vision
- ☐ TMJ/Teeth Grinding

Ears:

- ☐ Infection/Clogged/Tubes
- ☐ Ringing (High or Low)
- ☐ Decreased Hearing/Deafness

Nose, Throat & Mouth:

- ☐ Nose Bleeds
- ☐ Nasal Congestion/Pressure/Drip
- ☐ Sinus Infections
- ☐ Hay Fever/Allergies
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Mouth Sores
- ☐ Dry Mouth
- ☐ Bleeding Gums

Skin:

- ☐ Hives/Rashes/Fungus
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Night Sweating
- ☐ Excessive Sweating
- ☐ Dry Skin
- ☐ Bruise Easily

Respiratory:

- ☐ Chronic Cough
- ☐ Coughing Up Blood
- ☐ COPD/Emphysema/Smoker
- ☐ Pneumonia
- ☐ Catches Colds Easily
- ☐ Asthma/Difficulty Breathing
- ☐ Coughing Up Phlegm

Gastrointestinal:

- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating
- ☐ Gas
- ☐ Heartburn
- ☐ History of Parasites
- ☐ Stomach Pain
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Celiac's Disease
- ☐ Ulcers
- ☐ Bad Breath
- ☐ Blood/black in stools
- ☐ Hemorrhoids/Hernia
- ☐ Dry, hard, difficult to pass stools
- ☐ Soft, sticky, loose stools
- ☐ Poor Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gallbladder stones/problems
- ☐ Recent Weight/ Bowel Change
- ☐ Food Cravings
- ☐ Hypoglycemia

Urinary:

- ☐ Frequent Daytime Urination
- ☐ Frequent Nighttime Urination
- ☐ UTI/Bladder/Kidney Infections
- ☐ Kidney Disease/Stones
- ☐ Weak Stream/Dribbling/Cloudy
- ☐ Recent Change in Bladder Habits

Muscle & Joints:

- ☐ Arthritis /Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Back Pain
- ☐ Muscle soreness
- ☐ Muscle Weakness/atrophy
- ☐ Joint Stiffness

Cardiovascular:

- ☐ Palpitations
- ☐ Chest Pain or Tightness
- ☐ Rapid Heart Beat
- ☐ Irregular Heart Beat/Murmur
- ☐ Anemia
- ☐ Heart Disease
- ☐ Poor Circulation/Varicose Veins
- ☐ Cold Hands/Feet/ Raynaud's
- ☐ Swelling (edema) ankles
- ☐ Stroke
- ☐ High Blood Pressure

Infection:

- ☐ HIV/AIDS
- ☐ TB (Tuberculosis)
- ☐ Hepatitis
- ☐ STDs
- ☐ Herpes

Neurological:

- ☐ Numbness/Tingling
- ☐ Seizures/Convulsions
- ☐ Tremors
- ☐ Paralysis

General:

- ☐ Fatigue
- ☐ Hair Loss
- ☐ Chills/ Aversion to Cold
- ☐ Insomnia
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Poor Memory
- ☐ Difficulty Concentrating/Brain Fog
- ☐ Jaundice
- ☐ Gout
- ☐ Hernia
- ☐ Diabetes Mellitus
- ☐ Thyroid Problems
- ☐ Cancer
- ☐ Low Libido
- ☐ **Other:** _____

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MEN: *Check all that apply*

☐Prostatitis ☐Impotence ☐Premature ejaculation ☐Penile blood/mucous discharge ☐Painful urination

Additional Information or concerns:

_____

WOMEN

	Occasional	Frequent		Occasional	Frequent
Endometriosis/PCOS			Fibrocystic Breasts		
Ovarian Cysts			Breast Cancer		
Uterine Fibroids			Breast Lumps		
Abnormal Pap Smear			Nipple Discharge		
Yeast Infections			Vaginal Discharge/Odor		
Urinary Tract Infections			Herpes/STDs		
Pain/itching of genitalia			HPV		
Genital lesions/discharge			Hysterectomy		
Pelvic Inflammatory Disease			Uterine Prolapse		

Menstruation:

Please be specific in describing your menstrual cycle (*Check all that apply)*:

# of days do you bleed:_____ **# of Days between Periods:**_____ **Bleed between Periods?** _____

Color of menstrual blood:

☐Pale/light red ☐Dark red

☐Red ☐Dark red/brown

☐Bright red ☐Clots

Amount of blood:

☐Spotting ☐Light

☐Even throughout ☐Heavy

Are your periods painful? **Before:** _____ **During:**_____ **After:**_____

Is the pain:

☐Mild/Moderate

☐Moderate/Intense

Is the pain located:

☐Low abdomen

☐Low back ☐Other

Is the quality of the pain:

☐Cramping ☐Stabbing

☐Aching ☐Dull

☐Constant ☐Burning

☐Comes & goes

	Occasional	Frequent		Occasional	Frequent
Discharge			Swollen/ painful breasts		
Headaches			Mood swings		
Nausea			Increased appetite		
Constipation			Decreased appetite		
Diarrhea			Insomnia		

Reproductive and Gynecological:

___# of Pregnancies ___# of Births/C-Sections ___# Premature Births

___Miscarriages ___Terminated Pregnancies ___Age at Menarche

___Last Menses ___Last Pap Smear ___Age at Menopause

___Absence of Periods ___Irregular Periods ___Painful Periods/PMS Symptoms

___Excess Facial Hair ___Infertility

Other: _____

Do you use birth control? Y N **What type?**_____ **Are you currently trying to get pregnant?** Y N

Are you Pregnant? Y N **If so how many months:**_____

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Is there anything else that you would like us to know?

_____
_____
_____.

Thank you for taking the time to answer these questions, we appreciate your time and effort.

I certify that the information that I have provided above is correct and accurate to the best of my knowledge. I understand that the diagnosis and treatment plan that will be given by Sunstone Acupuncture is based upon Traditional Chinese medical principles and natural treatment only, and does not constitute a western medical diagnosis. I understand that if no substantial improvement is made in the condition in which I am seeking consultation, I am to seek advice from a western medical doctor. Further, if I am concurrently undergoing western medical treatments, it is my responsibility to advise my physician of any herbal supplements that I am concurrently taking.

_____ _____ _____

Patient's (or Patient's Representative's) Signature **Patient's Name** **Date**

_____ _____

Patient Representative's Name **Representative's Relationship to Patient**

_____ _____

Practitioner's Signature **Date**

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Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by *Sunstone Acupuncture* for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at *Sunstone Acupuncture* may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. *Sunstone Acupuncture* is not required to agree to the restrictions that I may request. However, if *Sunstone Acupuncture* agrees to a restriction that I request, the restriction is binding upon *Sunstone Acupuncture*.

I have the right to revoke this consent, in writing, at any time except to the extent that *Sunstone Acupuncture* has taken action in reliance on this consent.

My identifiable health information means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review *Sunstone Acupuncture's* Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of *Sunstone Acupuncture*. The Notice of Privacy Practices is also provided at the front desk and on the organization's web site at www.SunstoneDenver.com This Notice of Privacy Practices also describes my rights and the duties of my practitioners and *Sunstone Acupuncture* with respect to my identifiable health information.

Sunstone Acupuncture reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name and Relationship

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This disclosure statement is in compliance with the State of Colorado Department of Regulatory Agencies, Colorado Statute Title 12 Article 29.5. This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of supplies and proper disposal of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized. The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have any comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, CO 80202. Tel: 303.894.2440. 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 from another healthcare professional or may terminate therapy at any time. In a professional relationship, sexual intimacy in never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

Fee Schedule (due at time of service):
Acupuncture
First Visit $90
Follow up Visit $75

Education and Experience
Jennie Smith, LAc. earned her degree at Colorado School of Traditional Chinese Medicine. The 28 month accelerated, M.S.Ac. degree program is approved by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM)
and the Colorado Commission on Higher Education (CCHE). Jennie was certified as a Diplomate in Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in December 2015. Jennie's training includes adjunctive therapies such as moxibustion, tui na, cupping, gua sha, auriculo-therapy, and dietary and lifestyle recommendations. Jennie is a registered licensed acupuncturist in the state of Colorado. Her license has never been suspended or revoked.

Informed Consent
I hereby request and consent to the performance of acupuncture procedures by Jennie Smith. I understand 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. 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 provided who may be more qualified 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 I permit the acupuncturist to determine and/or alter the course of treatment which she 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. 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 conditions for which I seek treatment.

Name_____

Signature_____

Date_____

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Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,
This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:
• Limited access to facilities where information is stored.
• Policies and procedures for handling information.
• Requirements for third parties to contractually comply with privacy laws.
• All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:
In administering your health care, we gather and maintain information that may include non-public personal information.:
• About your financial transactions with us (billing transactions).
• From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
• From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g.* requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).
We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 970.201.4732