Natural Acupuncture LLC

Welcome to Our Office!

The more information we know about you and your family, the better care we can provide to you

CONFIDENTIAL

Case No: _____
Name: _____
Date: _____
Office Only

PATIENT INFORMATION:

Patient's Last Name: _____ **First Name:** _____ Middle Name: _____ Date of Birth: ___/___/_____ Age____

Sex: []Male []Female Marital Status: []Single []Married []Separated []Divorced []Widowed Height____ Weight_____

Patient's Address: _____City:_____State/Zip: _____

Home Phone: (____) _____-_____ Cell: (____) _____-_____E-mail: _____

Employer/School: _____Occupation/Grade: _____ Work Phone: _____

Who referred you to our office? []Friend_____[]Web search []Newspaper []Yellow book []Flyer []Sign []Others_____

EMERGENCY CONTACT:

Name of relative: _____Relationship to patient: _____ Phone: _____

Family Physician's Name: _____Phone: _____

1. Major complaint/Health problem:_____
2. How did this condition develop?_____
3. How long has the condition persisted_____
4. Have you been given a diagnosis for this problem? If Yes, when & what? _____
5. Have you ever received treatments for this condition? If Yes, when & what? _____
6. What were the results of the treatments?_____
7. Have you been treated by acupuncture or TCM? []Yes []No
8. Are you pregnant or suspected to be pregnant (Female only)? []Yes []No
9. Do you have clotting disorder? []Yes []No
10. Do you have diagnosed arrhythmia? []Yes []No
11. Are you carrying pace maker device? []Yes []No
12. List all the substances that you are allergic to:_____
13. List all the medications that you are currently taking:_____
14. List any major surgeries you have had(include date):_____

    _____
15. List significant trauma (auto accident, falls etc.) _____

Medical History:

[] Arthritis	[] Connective tissue disease	[] Hepatitis	[] Rheumatic fever	[] Alcohol use
[] Asthma	[] Diabetes	[] High blood pressure	[] Ruptured appendix	[] Smoking
[] Autoimmune disease	[] Gallstones	[] High cholesterols	[] Seizures	[] Drug use
[] AIDS	[] Heart disease	[] Low blood pressure	[] Thyroid disease	
[] Cancer		[] Kidney stones	[] Venereal disease	

Family/Genetic diseases: _____Others:_____

I, the undersigned, understand that the diagnosis and treatment, acupuncture/herbs/cupping etc., which I will be given by Natural Acupuncture LLC is based upon Traditional Chinese Medicine principles and natural treatment only, and does not constitute a western medical diagnosis. I understand that there is no implied or stated guarantee of success of effectiveness and there may be a skin reaction, bleeding, bruise and/or other complications not anticipated. Further, if I am concurrently undergoing western medical treatment, it is my responsibility to advise my physician of any herbs supplements I am concurrently taking. I also understand that, although the TCM treatments are generally safe, any liability, loss or damage in connection with the treatments or excises at this office is expressly disclaimed.

Patient's Signature (or Guardian): _____ Date Signed: ____/____/_____

12150 E Briarwood Avenue, Suite 140, Centennial, CO 80112
Tel: (303)898-9731 Email: mnaturalacu@gmail.com www.naturalacu.com

HEALTH HISTORY: (Please check any symptoms you currently have or have bad in the past year)

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General
[ ] Allergies
[ ] Aversion to cold
[ ] Aversion to heat
[ ] Chills
[ ] Dizziness
[ ] Excess thirst
[ ] Fatigue
[ ] Fevers
[ ] Insomnia
[ ] Lack of sweating
[ ] Low energy
[ ] Nervousness
[ ] Night sweating
[ ] Numbness
[ ] Sweat spontaneously
[ ] Weight gain
[ ]Weight loss

Head & Neck
[ ] Blurred vision
[ ] Cataract
[ ] Corrected vision
[ ] Double vision
[ ] Earache
[ ] Ear discharge
[ ] Eye pain/strain
[ ] Headache
[ ] Hearing loss
[ ] Heaviness in the head
[ ] Hoarseness
[ ] Loss of sense of smell
[ ] Nasal discharge
[ ] Nasal obstruction
[ ] Nosebleeds
[ ] phlegm in throat
[ ] Recurrent sore throat
[ ] Red/inflamed eye
[ ] Ringing in ears
[ ] Sinus problems
[ ] Sores on lips
[ ] Sores on tongue
[ ] Taste change
[ ] Teeth problems
[ ] Vision-see halos

Respiratory
[ ] Asthma
[ ] Coughing blood
[ ] Difficulty exhaling
[ ] Difficulty inhaling
[ ] Hay fever
[ ] Persistent cough
[ ] Recurrent bronchitis
[ ] Shortness of breath
[ ] Phlegm production

Cardiovascular
[ ] Chest pain
[ ] Distention in chest orhypochondrium
[ ] High blood pressure
[ ] Low blood pressure
[ ] Hypochondriac pain
[ ] Irregular heart beat
[ ] Poor circulation
[ ] Swelling of ankles
[ ] Varicose veins

Gastrointestinal
[ ] Abdominal pain
[ ] Belching
[ ] Black stools
[ ] Bloating
[ ] Bloody stools
[ ] Constipation
[ ] Diarrhea/loose stools
[ ] Difficulty swallowing
[ ] Gas
[ ] Heartburn/reflux
[ ] Hemorrhoids
[ ] Indigestion
[ ] Poor appetite
[ ] Nausea
[ ] Stomachache
[ ] Vomiting
[ ] Vomiting blood

Diet/Lifestyle
[ ] Drink alcohol
[ ] Drink coffee
[ ] Eat much fried foods
[ ] Eat much meat
[ ] Eat a lot of sweets
[ ] Exercise excessively
[ ] Exercise regularly
[ ] Healthy diet
[ ] Smoke cigarettes
[ ] Take melatonin
[ ] Take steroids
[ ] Use drugs
[ ] Vegetarian

Weight
[ ] Normal of height
[ ] Underweight
[ ] Overweight
[ ] Very overweight

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Genitourinary
[ ] Blood in urine
[ ] Burning urination
[ ] Cloudy urine
[ ] Dark urine
[ ] Dilute urine
[ ] Frequent urination
[ ] Poor bladder control
[ ] Profuse urine
[ ] Scanty urine
[ ] Urgency to urinate

Musculoskeletal Pain, weakness, numbness
in [ ] All over weakness
[ ] Arms
[ ] Broken bones
[ ] Cold limbs
[ ] Feet
[ ] Hands
[ ] Hips
[ ] Joints
[ ] Knee problems
[ ] Lack of strength
[ ] Legs
[ ] Low back pain
[ ] Pain all over
[ ] Neck
[ ] Shoulders

Skin
[ ] Acne
[ ] Bags under eyes
[ ] Blood not clotting
[ ] Brittle nails
[ ] Broken blood vessels
[ ] Bruise easily
[ ] Dark circles around eyes
[ ] Discoloration
[ ] Dry brittle hair
[ ] Dry skin
[ ] Hair falling out
[ ] Lumps in groin
[ ] Lumps underarm
[ ] Premature gray hair
[ ] Thick skin
[ ] Thin skin

Neurologic
[ ] Convulsions
[ ] Drowsiness
[ ] Fainting
[ ] Handwriting change
[ ] Paralysis
[ ] Recent clumsiness
[ ] Seizures
[ ] Stroke
[ ] Tremor
[ ] Vertigo

Emotional
[ ] Anxiety
[ ] Cry uncontrollably
[ ] Difficulty expressing emotions
[ ] Feel sad a lot
[ ] Forgetful
[ ] Insomnia
[ ] Irritability
[ ] Mind not clear
[ ] Much fear
[ ] Often feel angry
[ ] Terrors
[ ] Troubling dreams
[ ] Unrestrained joy

Men Only
[ ] Genital pain
[ ] Genital sores
[ ] Impotence
[ ] Low sexual energy
[ ] Lump in testicles
[ ] Penis discharge
[ ] Nocturnal emission

Women Only
[ ] Abnormal pap smear
[ ] Bleed between periods
[ ] Breast limps
[ ] Contraceptives
[ ] Endometriosis
[ ] Facial hair
[ ] Heavy periods
[ ] Irregular periods
[ ] Loss of head hair
[ ] Low sexual energy
[ ] Maybe pregnant
[ ] Menopausal
[ ] Painful periods
[ ] Premenstrual tension
[ ] Sores on genitalia
[ ] Uterine prolapse
[ ] Vaginal discharges
[ ] <25 days cycle
[ ] >35 days cycle

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COLORADO MANDATORY DISCLOSURE STATEMENT

Natural Acupuncture LLC
The Pricing and Cancellation Policy

Welcome to our office. To familiarize you with our unique services and to assure receiving the very best care available for your condition. Please read the following and sign below after you have had any questions answered and have understood this statement to your satisfaction.

Payment is required at time of your visit.

Pricing

$135 for initial visit, including consultation and a full session acupuncture treatment.
$95 for follow-up acupuncture treatment
$65 for initial cupping treatment
$60 for follow-up cupping treatment
$55 for initial herbal consultation
$45 for follow-up herbal consultation
$45 for initial ear acupuncture or ear seed
$35 for follow-up ear acupuncture or ear seed
$135 for initial facial acupuncture
$100 for follow-up facial acupuncture

*All expenses for herbs and supplements are in addition to the cost of treatment.
**Cost of herbs and supplements are vary according to your condition.

Cancellation Policy

In order to provide timely treatments for all our clients. If you need to cancel an appointment, please do so a minimum of 24 hours in advance. Otherwise, you will be charged a $45.00 no show fee or less than 24 hours cancellation fee which will be collected at the time of your next treatment.

Your cooperation and consideration are greatly appreciated.

This office complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needle and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized. In professional relations, sexual intimacy is never appropriate and should be reported to the Director of the Registration, Colorado Department of Regulatory Agencies.

I have read and understand above statement and the practice's financial policy. I certify that I have had an opportunity to fully understand above information, and I freely seek the services offered. I also understand and agree that such terms may be amended by the practice from time to time.

Patient's Signature_____ Date_____

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