
# Acupuncture Intake Form

Welcome to the office Whole Body Balance. Chinese Medical Diagnosis requires complete and honest answers to questions pertaining to both the body and the spiritual/ emotional state as well. Thank you for taking the time to fill out this form completely.

**ALL INFORMATION WILL REMAIN CONFIDENTIAL**

Name_____Date of Birth_____

Address_____City_____State_____Zip_____

Day Phone_____Evening Phone_____Cell_____

E-mail address_____

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How did you hear about Whole Body Balance?
Google ___ Yahoo ___ City Search___ Dex Online ___
Other Online Search or Online Yellow Pages _____ Dex Yellow Pages_____
Yellow Book Yellow Pages___ Verizon Yellow Pages____ Other_____

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In case of emergency contact_____

Address (if different from above)_____

Phone_____ Relationship_____

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Please describe the reason for your visit today (Chief Complaint)_____

_____

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

_____

Are you, or have you been, treated for this problem with any other health professionals?
_____

Has it been effective?_____

What was your diagnosis?_____

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Are you taking any medication or herbal supplements? If so, which ones? (Add dosage if known)

Are you in generally good health, or do you frequently fall ill?

What illnesses might you be prone to? (ie, frequent colds, Gastro-intestinal problems)_____

## MEDICAL HISTORY

Please circle any current health issue. For those diseases which are part of your health history, please note the year of the occurrence.

| | | |
|---|---|---|
| Allergies | Epilepsy | Polio |
| Anemia | Fatigue | Scarlet Fever |
| Appendicitis | Gout | Stroke |
| Arteriosclerosis | Heart Disease | Surgery (List): |
| Asthma | Hepatitis (A, B,C) | _____ |
| Bleeding Disorder | Hypoglycemia | _____ |
| Blood Pressure (Low or High) | Injuries | _____ |
| Cancer | Insomnia | Thyroid Disorder |
| Chicken Pox | Intestinal Parasites | Trauma (falls, accidents) |
| Diabetes | Multiple Sclerosis | Tuberculosis |
| Digestive Disorders | Mumps | Ulcers |
| Emotional Difficulties | Pacemaker | Other_____ |
| Emphysema | Weight Loss or Gain | _____ |

Do any of your family members suffer from: (Please list relationship to you)

| | | |
|---|---|---|
| Alcoholism | Arteriosclerosis | Heart Disease |
| Allergies (list) | Asthma | High Blood Pressure |
| _____ | Cancer | Seizures |
| _____ | Diabetes | Stroke |

Which of the following are part of your lifestyle? How frequently do you engage in it?

| | | |
|---|---|---|
| Alcohol | Nicotine | Exercise |
| Coffee | Recreational Drug Use | Excessive Sugar |

Do you usually eat three meals a day? _____Do you follow any particular diet?_____

On the scale of 1-10, how would you rate the level of stress in your life currently?

What is the level of stress in your life in general (1-10)?_____

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

Are there any other concerns you would like to address?_____

_____

## REVIEW OF SYSTEMS

Please fill this out carefully, even if some of the symptoms don't seem at all connected to your current issue! Place **one check** next to a symptom you have experienced, **two checks** next to a frequently occurring symptom, and **three checks** next to a symptom that is particularly distressing to you.

**Head and Face**
Headaches
Dizziness
Memory Loss
Other

**Eyes**
Blurry Vision
Eyelid Twitching
Floaters
Pain

**Nose**
Frequent Colds
Sinus Trouble
Bleeding

**Mouth**
Dental Problems
Gum Problems
Teeth Grinding/TMJ
Unusual Tastes
Other

**Throat**
Sore Throat
Hoarseness
Difficulty Swallowing
Dryness
Other

**Respiration**
Difficulty Inhaling
Difficulty Exhaling
Pain
Cough
Congestion
Shortness of Breath
Other

**Heart and Chest**
High Blood Pressure
Low Blood Pressure
Chest Pain
Chest Tightness
Difficulty Lying Down
Other

**Circulation**
Easy Bruising
Easy Bleeding
Cold Limbs-Hands or Feet
Reynaud's Syndrome

**Gastrointestinal**
Always Thirsty
Never Thirsty
Excessive Appetite
Low Appetite
Gas/Bloating
Stomach or Abdominal Pain
Nausea
Diarrhea/Loose Stools
Constipation
Rectal Bleeding
Colon Problems

**Urination**
Frequent
Difficult
Painful
Nocturnal
Bleeding
Other

**Skin**
Acne
Dryness
Moles that Change
Lumps
Excessive Sweating
Night Sweats
Rarely Sweat
Other

**Neurological**
Nervousness/Anxiety
Tremors
Numbness or Tingling
Lack of Coordination
Nerve Pain
Other

**Sleep**
Insomnia
Drowsiness
Excessive Dreaming
Waking Easily
Other

**Pain - Please Describe**
_____
_____
_____
_____

Are there any other health concerns you'd like to address?
_____
_____

**WOMEN ONLY**

Are you, or could you be pregnant?_____ If so, how far along?_____

Number of pregnancies_____ Births_____ Abortions_____Miscarriages_____

What form of birth control do you use?_____

Do you have regular PAP smears?_____ How Often? _____

Age of first menses_____ Age of menopause, if applicable_____

Do you bleed between periods?_____ Do you bleed after intercourse?_____

Have you ever had any gynecological surgeries or any abnormal findings on any tests?__

_____

Are your periods uncomfortable or painful, either emotionally or physically?_____

**Are your periods:**

Short (Less than 28 days)_____Long (28+ days)_____Varied_____ Regular_____

Painful? If so, Before_____ During_____ After_____

Do you bleed heavily?_____ Lightly?_____ Very little?_____

Do you have clots ?_____ Early in the cycle?_____ or throughout?_____

Relative to the blood that comes from a wound, is your menstrual blood: The same color_____More pale_____ Purple_____ More Red_____ More Brown_____

How many days do you bleed?_____

Do you have any of the following Pre-Menstrual Symptoms? (Emotions are not judged in Chinese Medicine, they are neither good nor bad. They are, however, important diagnostic tools. Please answer honestly.)

Irritability____ Depression_____ Crying_____ Rage_____ Nausea_____

Cravings, and if so for what?_____Breast Tenderness_____

Any other symptoms around the time of your period?_____

_____

Are you experiencing any low or high sexual desires?_____ Do you have any concerns surrounding this?_____

Do you have any other gynecological concerns or complaints?_____

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

_____ _____

Patient's or Guardian's signature Date

**MEN ONLY**

Do you experience any of the following:

Reduced Libido_____ Excessive Libido_____ Impotence_____

Urinary Frequency_____ Premature Ejaculation_____ Discharge_____

Genital/ Testicular pain_____

Any other 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

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

**EDUCATION AND EXPERIENCE**

**Amy Dickinson** graduated from Five Branches College of Traditional Chinese Medicine in June, 2003. This four year program consists of 2,800 hours of education, with a curriculum strongly emphasizing the use of herbs and herbal formulas as well as acupuncture. Following graduation, Amy did an intensive study program associated with the Zhejiang Provincial Hospital of Traditional Chinese Medicine. Amy was awarded a Diploma in Acupuncture by the National Council of Colleges for Acupuncture and Oriental Medicine (NCCAOM) in July, 2003. Included in this certification is a course in Clean Needle Technique, and First Aid/CPR. None of these licenses have ever been suspended or revoked.
Amy's education also included adjunct therapies including moxibustion, cupping, gua'sha, tuina, auriculotherapy, electro-acupuncture, and lifestyle and nutritional counseling. Amy is a member of the American College of Sports medicine and the American Acupuncture Council.

**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 | $75.00 + cost of herbs |
| Monthly Maintenance plan treatment | $64.00 + cost of herbs |

I understand that if I need to 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

# 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 Amy Dickinson, L.Ac., and or 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

Amy Dickinson, L. Ac., MTCM
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(303) 444-0192
www.wholebodybalance.com

**What to Expect from your first treatment**

Welcome to my office! You are in for what I hope will be a relaxing and enjoyable experience.

Your comfort and safety are my greatest concern. Please let me know at any time if I can make you more comfortable. You are welcome to ask questions at any time, and let me know if you don't understand the answer! Chinese Medicine is a different way of looking at the body. If the explanations are not clear, the fault is mine, not yours.

Please wear comfortable clothes. You will probably remain dressed, depending on the issue that we are addressing, but you may be required to remove some articles of clothing. Loose clothes are best.

Do not come in overly full or very hungry. If you are coming in for a pain condition, please do not take pain medication prior to your treatment- IF YOU CAN STAND IT. Do not force yourself to be miserable, but we can evaluate the efficacy of the treatment best if you are not 'under the influence'. Again, do not make yourself suffer needlessly, this is only a suggestion.

Please be prepared to disclose any medications or supplements you are taking. Your condition may require herbs. Usually herbs can be used in conjunction with pharmaceuticals, but they can interact. It is imperative that you give me the information to prevent this. Your safety is my highest concern.

Occasionally, a person may feel lightheaded after a treatment. This is a result of your body's energies readjusting themselves, you will return to normal within a few minutes. You can wait for this to pass in the treatment or waiting room.

Most people find their acupuncture treatments very relaxing and enjoyable. I look forward to working with you soon.

Amy and Anne