1100 E. Evans Ave. Denver, CO 80210

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have questions, please ask! Thank you.

Personal Information

Name_____ Date_____
Home Address_____

City_____ State_____ Zip_____

Cell Phone _____

Email_____ Email Reminder? Y N

Occupation_____ Work Phone_____

Emergency Contact: Name_____ Phone_____

Who should we thank for referring you to our office?_____

Sex:_____ Height_____ Weight_____ Ideal Weight_____ Birthdate_____ Age_____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partnered Number of children___

Have you received acupuncture therapy before? Y N

When?_____ With whom?_____

Please indicate any significant illnesses you or a blood relative (grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer	□	□	___	Diabetes	□	□	____
Hepatitis	□	□	___	Heart Disease	□	□	____
High Blood Pressure	□	□	___	Seizures	□	□	____
Rheumatic Fever	□	□	___	Emotional Disorders	□	□	____
Infectious Diseases	□	□	___	Tuberculosis	□	□	____

Sexually Transmitted Diseases: □ Gonorrhea □ Syphilis □ AIDS □ HPV □ Chlamydia □ Herpes Date___

List all medications or supplements you are currently taking (Continue on back if necessary).

Medication	Dosage	Reason	How long	Date of last checkup

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Please indicate the use and frequency of the following:

	Yes	No	Amount		Yes	No	Amount		Yes	No	Amount
Coffee	□	□	_____	Tobacco	□	□	_____	Water Intake	□	□	_____
Recreational drugs	□	□	_____	Alcohol	□	□	_____	Soda Pop	□	□	_____

What is your main reason for seeking treatment? _____
_____

What other treatment have you sought? _____
_____

List any other health problems you have. _____
_____

List any allergies, food sensitivities or cravings. _____
_____

List any accidents, surgeries, or hospitalizations (include dates). _____
_____
_____

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Comments
Significant-Other	□	□	□	□	□	_____
Family	□	□	□	□	□	_____
Diet	□	□	□	□	□	_____
Sex	□	□	□	□	□	_____
Self	□	□	□	□	□	_____
Work	□	□	□	□	□	_____
Exercise	□	□	□	□	□	_____
Spirituality	□	□	□	□	□	_____

Women:

Are you pregnant? □ Yes □ No # of pregnancies ___ # of live births ___ #abortions ___ # miscarriages ___
Number of days between periods_____ Number of days of flow _____ Color of flow _____
Do you have clots?_____ Size _____
PMS symptoms (if yes, please list)_____
Average number of pads/tampons you use per day: Day 1 ____ Day 2____ Day 3 ____ Day 4 ____Day 5 ____
Have you been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts PID Other _____

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Symptom Survey (for everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

No mark = never experience check mark (√) = sometimes experience plus sign (+) = frequently experience

__lack of appetite
__excessive appetite
__Loose stool or diarrhea
__indigestion
__bloated after eating
__vomiting
__belching, burping
__heartburn/reflux
__feeling the retention of food in the stomach
__tendency to become obsessive in work, relationships…
_____
__insomnia, difficulty sleeping
__heart palpitations
__cold hands and feet
__nightmares
__mentally restless
__laughing for no apparent reason
__angina pains

__abdominal pain
__chest pain
__sciatic pain
__headaches
__pain or coldness in the genital area
_____
__cough
__shortness of breath
__decreased sense of smell
__nasal problems
__skin problems
__feeling of claustrophobia
__bronchitis
__colitis or diverticulitis
__constipation
__hemorrhoids
__recent use of antibiotics

__eye problems
__jaundice (yellowish eyes or skin)
__difficulty digesting oily foods
__gall stones
__light colored stool
__soft or brittle nails
__easily angered or agitated
__difficulty in making plans or decisions
__spasms or twitching of muscles
_____
__low back pain
__knee problems
__hearing impairment
__ear ringing
__kidney stones
__decreased sex drive
__hair loss
__urinary problems

__fatigue
__edema
__blood in stool
__black tarry stools
__easily bruised
__asthma
__tendency to catch colds
__intolerance to weather
__allergies
__hay fever
__dizziness
__tendency to faint easily
__high cholesterol
__sudden weight loss
__sudden weight gain

Colorado Mandatory Disclosure and Informed Consent

Pin & Tonic, LLC 1100 East Evans Ave
Denver, CO 80210

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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. All rules and regulations set forth by the Department of Health are strictly adhered to, including proper cleaning, sterilization, and sanitation of equipment and office. 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 Registrations Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-2440. 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 healthcare professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registration in the Department of Regulatory Agencies.

Clinic Fee Schedule (due at time of service)
Community Room Initial Treatment $45 Follow up: $30, 2nd visit same business week: $20, 3rd visit: $15
24 hour notice is required for change of appointment or cancellation. If you are unable to give 24 hour notice, we will do our best to fill your space but if we are unable to do so you will be charged a $20 fee for that appointment.

I hereby request and consent to the performance of acupuncture procedures by my acupuncturist (s). I have been informed 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(s) named above. I understand that there are no guarantees regarding cure of 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 provider who may be more qualified to treat me outside of these facilities. I do not expect the acupuncturist(s) to anticipate and explain all possible risks and complications, and I permit the acupuncturist(s) to determine and/or alter the course of treatment which the acupuncturist(s) 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. If you are receiving treatments from another provider for the same condition, consult your practitioner before implementing changes recommended.
I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content, and 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(s) and for any future condition(s) for which I seek treatment.
By signing below I acknowledge the receipt of HIPPA Policy

Signature of Patient or Person authorized to consent _____ Relationship or Authority of Representative _____ Date