EAST WEST NEURO-ACUPUNCTURE

New Patient Information Form

Please help us provide you with a complete evaluation by taking time to fill out this medical questionnaire carefully. All answers are strictly confidential. Please print clearly in ink. Thank you.

Name ________________________________ Sex M ___ F___ Date ________ Email ________________

Address ______________________________ City _____________________ State _______ Zip __________

Date of Birth ______________Place of birth ______________ Age ____ Height _____ Weight_____

Telephone: Home ( ) _______________ Work ( ) _______________ Cell ( ) ______________________

_____ Single _____ Married _____ Divorced _____ Widowed _____ Living with

Education __________________________________ Occupation ____________________________________

Referred by: ____

Reason for visit today ____

Other problems ____

How long have you had this condition? ______________ Have you ever experienced this before? _______________

What seemed to be the initial cause? ____

What seems to make it better? ____

What seems to make it worse? ____

Does it bother your Sleep ___Work ___other (what?) ____

EAST WEST NEURO-ACUPUNCTURE

FAMILY HISTORY - Complete for each family member, indicating any illness they have had. Please place an 'X' in the appropriate box or boxes.

	self	mother	father	sibling	spouse	children
cancer or tumors						
diabetes						
blood or bleeding disorders/anemia						
seizures						
high blood pressure/heart disease						
allergies						
stroke						
drug abuse						
depression or mental illness						
age of death						
hepatitis						
kidney disorders						
thyroid disorders						
musculo-skeletal disorder						
blood transfusion (if before 1985)						

PERSONAL LIFESTYLE HABITS (How much, how many, or how often)

Cigarettes (packs) ______________ Coffee/Tea (cups) ______________ Alcohol (drinks per week) ______________

Marijuana ____

Other recreational drugs ____

Vitamins & herbs ____

Dietary restrictions ____

Food cravings ____

Diet: What might you eat on a typical day?

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Exercise ____________________________________ How often? ___________________________

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.) ____________________________

Please write a 'C' in the column if the medical condition is current. Write a 'P' if it is a past medical condition.

General
__ Insomnia
__ Dreams/nightmares
__ Irritability
__ Depression
__ Mood swings
__ Fatigue
__ Poor memory
__ Strongly like cold drinks
__ Strongly like hot drinks
__ Recent weight loss/gain
__ Cold hands & feet
__ Chills
__ Fever

Head & Neck
__ Headaches
__ Migraines
__ Stiff neck
__ Dizziness/nausea
__ Fainting
__ Swollen glands

Ears
__ Ear Ringing
__ Hearing Loss
__ Ear Infections
__ Earache
__ Use Hearing Aids
__ Vertigo

Eyes
__ Eyeglasses/contact lenses
__ Blurred vision
__ Poor night vision
__ Spots or floaters
__ Flashes of light
__ Eye inflammation
__ Double vision
__ Glaucoma
__ Cataracts

Nose, Throat & Mouth
__ Sinus infection
__ Hay fever/allergies
__ Frequent sore throat
__ Difficulty swallowing
__ Mouth & tongue ulcers
__ Frequent cold
__ Nosebleed
__ Dry nose/dry mouth
__ Nasal congestion
__ Loss of voice
__ Thirst
__ Excessive phlegm
__ TMJ
__ Facial pain
__ Gum problems

Skin
__ Hives
__ Rashes
__ Eczema/psoriasis
__ Night sweats
__ Excessive sweating
__ Dry skin
__ Easily bruise
__ Changes in moles, lumps
__ Itching

Respiratory
__ Difficulty breathing
__ Difficulty breathing when lying down
__ Wheezing
__ Asthma
__ Chronic cough
__ Wet cough
__ Dry cough
__ Coughing up phlegm
__ Coughing up blood
__ Shortness of breath
__ Tightness in chest
__ Pneumonia

Cardiovascular
__ High blood pressure
__ Low blood pressure
__ Chest pain
__ Palpitation
__ Rapid heartbeat
__ Irregular heartbeat
__ Poor circulation
__ Swollen ankles
__ Phlebitis
__ Anemia
__ History of heart attack

Gastrointestinal
__ Nausea
__ Indigestion
__ Stomach pain
__ Diarrhea
__ Constipation
__ Poor appetite
__ Excessive hunger
__ Vomiting
__ Gas
__ Hiccups
__ Acid regurgitation
__ Bloating
__ Bad breath
__ Laxative use
__ Bloody stool
__ Mucus in stool
__ Hemmorhoids
__ Gall bladder disorder

Musculoskeletal
__ Joint pain/disorder
__ Sore muscles
__ Weak muscles
__ Difficulty walking
__ Neck/shoulder pain
__ Upper back pain
__ Lower back pain
__ Rib pain
__ Limited range of motion
__ Other (describe)

Neurological
__ Seizures
__ Tremors
__ Numbness or tingling sensation
__ Pain
__ Paralysis
__ Poor coordination
__ Other (describe)

Genito-Urinary
__ Pain during urination
__ Frequent/urgent urination
__ Blood in urine
__ Unable to hold urine
__ Incomplete urination
__ Bedwetting
__ Increased/decreased libido
__ Kidney stones
__ Impotence
__ Premature ejaculation
__ Nocturnal emission
__ Pain/itching in genitilia
__ Lumps in testicles

Infection Screening
__ HIV risks (self or partner)
__ TB (self or household)
__ Hepatitis risk (self or partner)
__ History of STD (self or partner)
__ Gonorrhea
__ Chlamydia
__ Syphilis
__ Genital warts
__ Herpes (oral/genital)

Gynecological
__ Irregular periods
__ Vaginal infections
__ PMS
__ Menopause
__ Uterine Fibroids
__ Menstrual pain
__ Hormone Replacement Therapy
__ Number of miscarriages
__ Number of pregnancies

EAST WEST NEURO-ACUPUNCTURE

MEDICINES:

Prescription drugs you are currently taking: For what condition?

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Over-the-counter medication you are currently taking: For what condition?

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

MAJOR HOSPITALIZATIONS If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

Date of last physical examination: ______________________________

Name & address of physician ______________________________

Phone number of physician ______________________________

Have you ever been treated with acupuncture &/ or Chinese herbal medicine before?YesNo

EAST WEST NEURO-ACUPUNCTURE

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

In the course of providing service to you, we create, receive, and store health information that identifies you. It is sometimes necessary to use and disclose this health information in order to treat you, obtain payment, and conduct healthcare operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. Please feel free to refer to this Notice or to request a copy of this Notice prior to signing this consent.

The use and disclosure of your health information for **treatment purposes** not only includes care and services provided here, but also disclosures as may be necessary or appropriate for you to receive follow-up or emergency care from another health professional.

The use and disclosure of your health information for **payment purposes** includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination for benefits, and payment; and our submission of your health information to auditors hired by third-party payers and insurers.

The use and disclosure of your health information for **healthcare operations** includes quality assessment and improvement activities as well as evaluating practitioners and conducting training programs. A complete list is provided in our Notice of Privacy Practices.

Our Notice of Privacy Practices will be updated if our policies change. You may get an updated copy here at our office.

You can revoke this consent in writing at any time unless we have already treated you, sought payment for services, or performed healthcare operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

We can decline to serve you if you elect not to sign this consent form. Signing this consent signifies that you have been given the opportunity to read our Notice of Privacy Practices and/or given a copy of it if you desire one.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

Name (printed)____

Signature____ Date_____________

(If applicable) Personal Representative's Name___________________________________

Relationship to Patient____

EAST WEST NEURO-ACUPUNCTURE

DISCLAIMER

Traditional Chinese Medicine and Homeopathy is an ancient method of health care that seeks to identify and resolve patterns of disharmony in the body. It views each patient as unique.

Because each patient is unique, a few individuals may experience adverse reactions during or after their acupuncture treatment. These symptoms may include nausea, discomfort, fainting, redness and bruising. There may also occur interaction from herbs and homeopathic remedies. This occurrence is rare, but there is no guarantee.

East West Neuro-Acupuncture will work with you to resolve the problem as feasibly possible, but cannot be held accountable for any of the aforementioned conditions resulting from treatment. Your acknowledgement and understanding concerning this matter is greatly appreciated.

APPOINTMENT COMMITMENT

Here at East West Neuro-Acupuncture, we take particular pride in our commitment and consistent attention to each individual patient. Part of that includes reserving the utmost respect for our patients' time by refraining from overbooking our clinic. While this practice helps to ensure satisfying treatments, this policy is also difficult to maintain when last minute cancellations are made. When a patient cancels their appointment with less than 24 hours advance notice, it is almost impossible to fill that appointment void last minute. As a result, certain related business costs will never be recovered. We employ a cancellation policy so that the frequency of these cancellations is minumized.

NOTE: The following applies to any and all appointments made at East West Neuro-Acupuncture.

If for any reason you are unable to keep your appointment, please call the clinic 48 hours in advance to cancel. If you notify the clinic the day of your appointment to cancel, you will be charged 50% of the standard treatment fees. If you do not call or there is a no-show, you may be charged 75% of the standard treatment fees. If you are late for you appointment, your treatment time may be shortened so as not to interfere with another patient's scheduled treatment.

Thank you very much for your cooperation and understanding.

Signature:____ **Date:**________________

EAST WEST NEURO-ACUPUNCTURE

This disclosure is in compliance with the State of Colorado, Department of Regulatory Agencies, Senate Bill 9. All rules and regulations set forth by the Department of Health are strictly adhered to by this clinic, including proper cleaning and sterilization of equipment and office. The practice of Acupuncture is regulated by the Department of Regulatory Agencies. Any complaints should be directed to the Investigation section of the Division of Registrations within the Department of Regulatory Agencies located at:

1525 Sherman Street Rm 132
Denver, CO 80203
(303) 866-5696

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 and may terminate therapy at any time. In a professional setting, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registration within the Department of Regulatory Agencies.

EAST WEST NEURO-ACUPUNCTURE
Tamara L. Pollack, Dipl. Ac. (NCCA)

Education
Colorado School of Traditional Chinese Medicine
3-year Program - Certified Acupuncturist 1996

Professional Organizations
Acupuncturist Association of Colorado 1996

Professional Licenses and Certifications
National Committee for the Certification of Acupuncturists and Herbalists
Certified Acupuncturist - Dipl. Ac. (NCCA) Active status since 1996
Certified Herbalist - Dipl. H. (NCCA)
Colorado State Registered License

I have read and understand the above.

Signed____________________________________ Date_____________________________