NEW PATIENT INTAKE FORM

Welcome to **Boost**Acupuncture. Chinese Medical Diagnosis requires complete and honest answers to questions pertaining to both the body and the spiritual/ emotional state. Thank you for taking the time to fill out this form completely.

ALL INFORMATION WILL REMAIN CONFIDENTIAL

_____ _____
Name *Age*

_____ _____
Occupation *Date Of Birth*

_____
Address

_____ _____ _____
City *State* *Zip Code*

_____ _____
Phone *Cell Phone*

_____
Email

_____
Best Way To Contact You

IN CASE OF EMERGENCY CONTACT:

_____ _____
Name *Relationship* *Phone*

_____
Address If Different From Above

_____ _____
Primary Care Physician *Phone*

_____
Physician's Address

How did you hear about **Boost**Acupuncture? _____

May we send you text message appointment reminders? ____ No ___Yes _____
(*Cell Phone #)*

May we contact you by email? _____ No ___Yes

PLEASE DESCRIBE THE REASON FOR YOUR VISIT TODAY (CHIEF COMPLAINT)

_____

_____

When did you first notice this problem? _____

How did it originally occur? _____

How has it progressed recently? ___Same ___ Improving ___Getting Worse

How frequent is it? ___Constant ___Frequent ___ Occasional___ Intermittent

Describe the pain: ___Sharp ___Dull ___Numbness ___Tingling ___Aching ___Burning ___

___Stabbing ___Throbbing ___ Distending ___Other: _____

Does anything relieve the problem? (Movement, sitting, heat, cold, etc.) If so please list. ___No ____Yes:

_____

Does anything make the problem worse? (Movement, cold, damp weather, etc.) If so please list. ___No
Yes: _____

What does this problem prevent you from doing or enjoying? _____

_____

On a scale of 1 to 10, 1 being minor and 10 being extreme, how would you rate this problem?

1 2 3 4 5 6 7 8 9 10

Are you, or have you been, treated for this by any other health care professionals?

_____

Has it been effective? _____

What was your diagnosis? _____

Have you been treated for any *other* health conditions in the past year? (List) _____

_____

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

_____

Please list any medications, dietary, or herbal supplements and dosage if known: _____

_____

What illnesses might you be prone to? (i.e. frequent colds, bronchitis, gastro-intestinal?) _____

_____

MEDICAL HISTORY

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

Allergies (List)

_____

_____

Anemia
Appendicitis
Arteriosclerosis
Asthma
Bleeding Disorder
High Blood Pressure
Low Blood Pressure
Cancer
Chicken Pox
Diabetes
Digestive Disorders
Emotional Difficulties
Emphysema
Epilepsy
Fatigue
Gout
Heart Disease
Hepatitis (A, B, C)
Hypoglycemia
Injuries
Insomnia
Intestinal Parasites
Multiple Sclerosis
Mumps
Pacemaker
Polio
Scarlet Fever
Stroke

Surgeries (List)

_____

_____

Thyroid Disorder
Trauma (falls, accidents)

_____

_____

Tuberculosis
Ulcers
Weight Loss or Gain
Other (including auto accidents):

_____

_____

Please indicate any conditions that run in your family and whether your family member is the **G**randparent, **F**ather, **M**other, **B**rother, **S**ister)

___Alcoholism
___Allergies (list)

_____

_____

___Arteriosclerosis
___Asthma
___Heart Disease
___Lung Disease
___High Blood Pressure
___Cancer
___Kidney Disease
___Liver Disease
___Seizures
___Diabetes
___Stroke
___Mental Illness
___Other: _____

LIFESTYLE:

How frequently do you engage in?

Alcohol _____ Caffeine _____

Nicotine _____ Excessive Sugar _____

Exercise _____
Recreational Drug Use _____

What percentage of the day are you:

_____ Lifting _____ Bending

_____Sitting _____Working at a Computer

How many meals do you usually eat each 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? (i.e., more headaches, stomach pain, etc.) _____

_____

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

Fluttering

Palpitations

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/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

Sweaty Palms

Sweaty Feet

Sweaty Chest
Other

Neurological

Nervousness/Anxiety
Tremors
Numbness or Tingling

Lack of Coordination

Nerve Pain

Other

Sleep

Insomnia

Drowsiness

Excessive Dreaming

Waking Easily

Other

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? _____

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? _____

NATURE OF YOUR PERIODS:

____Short (Less than 28 days) ____ Long (35+ days) ____ Varied ____ Regular

Painful:____ Before ____ During ____ After

Quantity: ____Heavy ____Light ____Very little

Do you have clots? ____ Early in the cycle ____ Throughout the Cycle Relative to the blood that comes from a wound, is your menstrual blood:

____The same color ____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? _____

_____

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 (circle):

Reduced Libido	Urinary Frequency	Genital/ Testicular pain
Excessive Libido	Premature Ejaculation	
Impotence	Discharge	

Any other concerns? _____

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

_____ _____

Patient's or Guardian's signature *Date*

BoostAcupuncture, LLC

Pain, Recovery, Wellness, and Cosmetic Rejuvenation

Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and other Oriental Medicine procedures by the below named licensed acupuncturist. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, nausea, tingling, pain or discomfort, miscarriage, pneumothorax, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand there is a risk of suffering burns from heat lamps. I understand that the acupuncturist may not be able to fully anticipate and explain all the risks and complications associated with my treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs/Nutritional Supplements: I understand that substances from the Oriental Materia Medica and/or nutritional supplements may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from using these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems which I associate with these substances, I should suspend taking them and inform my acupuncturist as soon as possible*.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

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I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss any emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _____ initials

I understand that all payments for services rendered are due at the time of treatment. I agree to pay all charges incurred for services rendered, over and above insurance coverage. _____ initials

I understand that I will be charged $50 for any missed or forgotten appointments without 24-hour notice of cancellation. _____ initials

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment:

_____ _____

Patient or Guardian Signature *Date*

_____ _____

Printed Name *Date of Birth*

_____

Address

_____ _____ _____ _____

City *State* *Zip Code* *Phone*

To be completed by the patient's representative if the patient is a **minor or physically/legally incapacitated**.

_____

Name of Patient

_____

Patient's Representative *Relationship of Authority of Patient*

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use your health information for treatment or disclose it to a physician or other health care provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the Federal Privacy Rules for its payment activities.
Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include: quality assessment and improvement activities, reviewing competence of healthcare professionals, evaluation practitioner/provider relationships, conducting training programs, accreditation, certification, and credentialing or licensing activities. We may also disclose your information to another healthcare provider or organization that is subject to the Federal Privacy Rules and that has a relationship with you to support some of their health care operations.
On Your Authorization: You may give us written authorization to use your health care information or disclose it to anyone for any purpose. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.
Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your health care or with payment for your health care. Before we disclose your health information, we will provide you with an opportunity to object to our use or disclosure. If you are not present or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We will also use our experience and professional judgment to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, or similar forms of health information.
Courtesy Calls & Appointment Reminders: We may use or disclose your health information to provide you with appointments reminders, courtesy calls, etc. via voicemail, email, postcards, and letters.
Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law
- For public health activities (disease/statistic & child abuse reporting, work-related illness or injury)
- To report abuse, neglect, or domestic violence
- In response to court and administrative orders and other lawful processes

YOUR RIGHTS - You Have The Right To:

- Request a copy of our Privacy Practices Notice at any time
- Look at and obtain a copy of your health information
- Deny courtesy calls, emails, or letters sent by our office
- Request a restriction on certain uses and disclosures of your health care information
- Receive confidential communications regarding your health information
- Revoke authorizations that you made previously in regards to your protected health information

OUR RESPONSIBILITIES - We Have The Right To:

- Maintain the privacy of your health information as required by federal and state law
- Provide you with a notice of our Duties and Privacy Practices
- Abide by the terms of this notice

BoostAcupuncture, LLC

Pain, Recovery, Wellness, and Cosmetic Rejuvenation

Acknowledgement of Privacy Practices & Consent to Treat

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party payer can verify that services be billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I have read the Notice of Privacy Practices, have had the opportunity to ask questions regarding its content and meaning and fully understand its content and implication.

I understand that I have the right to review the notice prior to signing this consent.

I understand that the organization reserves the right to change their notices and practices and prior to implementation and will mail a copy of any revised notice to the address I have provided.

I understand that I have the right to object to the use of my health information for directory purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operation and that the organization is not required to agree to restrictions.

I understand that I may revoke this consent in writing, except to the extent that organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

I, _____, hereby acknowledge that I read and reviewed a copy of Notice of Privacy Practices and fully understand this consent form. I am consenting to the use and/or disclosure of my health information to treat me and arrange for my medical care. I am consenting to be treated.

_____

Signature of Patient or Legal Representative

_____

Printed Name of Patient *Date*

BoostAcupuncture, LLC

Pain, Recovery, Wellness, and Cosmetic Rejuvenation

COLORADO MANDATORY DISCLOSURE STATEMENT

BoostAcupuncture, LLC
2770 Dagny Way, Ste 210; Lafayette, CO 80026 303-601-5380

Education and Experience

Julie Johns earned her Master of Science, Acupuncture degree from Colorado School of Traditional Chinese Medicine in April 2015. The three-year program consists of 2,265 hours of education, including 525 hours of clinical practice. Julie's training includes adjunctive therapies such as moxibustion, tui na, cupping, auriculotherapy, and dietary and lifestyle recommendations. Julie is also trained in cosmetic acupuncture for face and neck.

The National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) certifies Julie as a Diplomate in Acupuncture, May 2015. This includes certification in Clean Needle Technique. Julie is a member of the Acupuncture Association of Colorado and the American Association of Oriental Medicine. She is a licensed acupuncturist in Colorado. None of these licenses, certificates, or registrations have ever been suspended or revoked.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule

Initial Consultation and Treatment (75 min)	$120
Follow-Up Treatment	$ 95
20 min auricular stress treatment	$ 35
20 min cupping	$ 35

Topical herbal remedies are an additional charge

Patient's Rights and Responsibilities

- 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 Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Professions and Occupations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturist Licensure Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202; (303) 894-7800; dora_acupunctureboard@state.co.us

I have read and understand this document.

_____ _____

Patient or Guardian Signature *Date*