Boulder Community Acupuncture

Confidential HEALTH HISTORY

First Name _____ Last Name _____
Address _____ City, State, Zip _____
Home Phone _____ Cell Phone _____
Email _____ Age _____ Preferred pronouns: _____
Emergency Contact_____ Home Phone _____
Have you had acupuncture before? _____ Referred by_____
What is your chief complaint at this time? How did you hear about us?_____

How long have you had this symptom? _____
Current energy level from 1-10 (1=no energy, 10=a lot of energy) _____ Stable or Fluctuates?
Sleep: Hours/night: _____ Time to bed: _____ Time to wake: _____ Trouble falling asleep:_____
Do you feel rested in the morning? _____
Current stress level: mild moderate high extreme
Do you eat 3 meals a day?
What do you eat and drink on a typical day?
Breakfast:_____
Lunch_____
Dinner_____
Snacks: _____ How much: Caffeine _____ Alcohol _____ Tobacco _____

Exercise: how many times/week? _____ Type? _____ Level: low moderate high

History of (**CIRCLE if applies**): mood swings anxiety depression abuse attempted suicide
Current (**CIRCLE if applies**): mood swings anxiety depression abuse attempted suicide

Stools: Constipation: _____ Diarrhea or loose: _____ Alternating: _____

Please check box if you currently or regularly experience these symptoms:

	Yes
Do you have frequent abdominal, rib side or breast distention and pain?	☐
Are you easily irritated, angered, or frustrated?	☐
Do you sigh a lot?	☐
Do you have floaters in your eyes?	☐
Do you have a high stress level?	☐
Do you feel better with exercise or movement?	☐
Do you have monthly PMS and breast tenderness?	☐
Are you regularly fatigued, especially after eating?	☐
Do you frequently experience abdominal bloating or gas after eating?	☐
Do you have a tendency for loose stools?	☐
Are your hands and feet usually cold?	☐
Do you have a lack of strength or feeling of heaviness in your extremities?	☐

Do you frequently feel dizzy when moving from sitting to standing positions? ☐
Do you bruise easily? ☐
Are you prone to excessive worrying? ☐

Are you regularly thirsty or have a dry mouth? ☐
Do you suffer from frequent night sweats or hot flashes? ☐
Do you have ringing in your ears? ☐
Do you have chronic low back or knee soreness? ☐
Do you have a decreased libido? ☐
Are you often fearful? ☐

Do you have chronic or troublesome insomnia? ☐
trouble falling asleep?_____waking in the night?_____what time?_____
Do you have heart palpitations? ☐
Do you have a tendency toward anxiety or panic attacks? ☐

Do you get sick easily or often? ☐
Do you have a history of asthma or breathing difficulties? ☐

Are your nails dry or brittle? ☐
Do you have excessively dry skin? ☐
Have you noticed a decrease in your night vision? ☐

If applicable, please answer the following questions:
Is your cycle regular/monthly? _____
How many days apart are your cycles? _____
Rate your menstrual flow: light moderate heavy contains clots watery bright red dark wine color
Do you have cramping? _____ mild moderate severe
How many days do you bleed? _____
Any spotting between periods? _____ Any pain at ovulation?_____
Date of last menstrual period _____
Menopause: Age of onset: _____ Hot flashes? _____ Night sweats? _____ HRT? _____

Please **CIRCLE** any conditions / illnesses you have had or currently have:

AIDS/HIV Alcoholism Allergies Asthma Autoimmune illness Type? _____
Cancer Type? _____ Diabetes Heart disease Hepatitis Type? _____ High Blood Pressure
High Cholesterol Stroke Thyroid disorder Type? _____ PACEMAKER? YES NO

List any surgeries, hospitalizations, medications, serious illnesses not covered above:

Comments, as well as anything else you would like us to know:

Disclosure Statement

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 Department of Regulatory Agencies. Inquiries should be made to: Director of Registrations, Acupuncturists Licensure, 1560 Broadway, Suite 1350, Denver, CO 80202, (303)894-7800. 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 relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

Clinic Fee Schedule (due at time of service)

Acupuncture Sliding Scale: $45.00 - $80.00*

*plus one-time $10.00 paperwork fee for the initial visit

We ask patients to give us **24 hours notice** in advance of an appointment if it is necessary to cancel/reschedule. All appointments that are canceled/rescheduled with less than 24 hours notice, as well as appointments missed without notice, will be charged $40.00 for that appointment. **Initial _____**

Insurance: We do not bill insurance. Upon request, we will provide you with a receipt for your insurance company.

Practitioner Education, Certification, and Experience

Jennifer Wyler, Dipl. O.M., L.Ac., Master of Science, Southwest Acupuncture College in Boulder, CO, 2009. NCCAOM Diplomate in Oriental Medicine issued 2009. Colorado Licensed Acupuncturist # 1583.

Stephanie Wilson Dipl. O.M., L.Ac., Master of Science, Southwest Acupuncture College, Boulder, CO, 2008. NCCAOM Diplomate in Oriental Medicine issued 2008. Colorado Licensed Acupuncturist # 1441.

Dr. Jennifer Cowing Kralowetz, Doctor of Acupuncture and Chinese Medicine, DACM, Dipl. OM., L.Ac., Master of Science, American College of Traditional Chinese Medicine, San Francisco, CA, 2013; Pacific College of Oriental Medicine, San Diego, CA, 2020 .
NCCAOM Diplomate in Oriental Medicine issued 2014. CO Licensed Acupuncturist #2598, CA #15856.

Informed Consent

I hereby request and consent to the performance of acupuncture procedures by any or all of the aforementioned acupuncturists. 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 named above. I understand that there are no guarantees regarding cure or 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 to be able to anticipate and explain all possible risks and complications, and I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist 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.

I have read or have had read to me the above consent. 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 and for any future condition(s) for which I seek treatment.

_____ _____ _____

Signature of Patient/Person authorized to consent PRINT YOUR NAME DATE