

# New Patient Intake Form

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Marital Status:    S    M    D    W Gender:    M    F

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Occupation: \_\_\_\_\_ Referred By: \_\_\_\_\_

Best Phone to reach you: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Email Address (Print Clearly): \_\_\_\_\_ Subscribe to my seasonal e-newsletter: Yes / No

Emergency Contact Name/Phone: \_\_\_\_\_

Have you had acupuncture before?    Y    N Chinese Herbal Medicine?    Y    N

Reason for visit today: \_\_\_\_\_

How long have you had this condition? \_\_\_\_ Is it getting worse? \_\_\_\_ Does it bother you:    Sleep    Work    Other: \_\_\_\_\_

What seemed to be the initial cause? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Are you under the care of a physician now?    Y    N If yes, for what? \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

If you want me to discuss your case with your physician, sign here to give consent: \_\_\_\_\_

Other current therapies: \_\_\_\_\_

Family Medical History:

<u>  </u> Allergies	<u>  </u> Alcoholism	<u>  </u> Diabetes	<u>  </u> High Blood Pressure	<u>  </u> Seizures
<u>  </u> Asthma	<u>  </u> Addictions - other	<u>  </u> Heart Disease	<u>  </u> Mental Disorders	<u>  </u> Stroke
<u>  </u> Arteriosclerosis	<u>  </u> Cancer	<u>  </u> Other: _____		

Your Past Medical History (check any you currently have or have had in the past):

<u>  </u> AIDS/HIV	<u>  </u> Cancer	<u>  </u> Heart Disease	<u>  </u> Pacemaker	<u>  </u> Stroke
<u>  </u> Alcoholism	<u>  </u> Chicken Pox	<u>  </u> Hepatitis	<u>  </u> Pleurisy	<u>  </u> Thyroid disorders
<u>  </u> Allergies	<u>  </u> Diabetes	<u>  </u> Herpes	<u>  </u> Pneumonia	<u>  </u> Tuberculosis
<u>  </u> Appendicitis	<u>  </u> Emphysema	<u>  </u> High blood pressure	<u>  </u> Polio	<u>  </u> Typhoid fever
<u>  </u> Arteriosclerosis	<u>  </u> Epilepsy	<u>  </u> Measles	<u>  </u> Rheumatic fever	<u>  </u> Ulcers
<u>  </u> Asthma	<u>  </u> Goiter	<u>  </u> Multiple Sclerosis	<u>  </u> Scarlet fever	<u>  </u> Venereal disease
<u>  </u> Birth Trauma (own birth)	<u>  </u> Gout	<u>  </u> Mumps	<u>  </u> Seizures	<u>  </u> Whooping cough
<u>  </u> Other: _____				

   Surgery (please list): \_\_\_\_\_

   Major Trauma (car, fall, etc; list): \_\_\_\_\_

Your Lifestyle

   Alcohol    Migraines    Stress    Tobacco    Drugs    Occupational Hazards

Regular Exercise - Type and Frequency: \_\_\_\_\_

Your Diet

Appetite:    Low    Normal    High    Coffee    Soft Drinks    Artificial Sweetener    Sugar    Salty foods

   Thirst for water # glasses per day: \_\_\_\_\_

## Average Daily Menu

Morning

Snack

Noon

Snack

Evening

Snack

### Head, Eyes, Ears, Nose, Throat

☐ Glasses      ☐ Night blindness  
☐ Eye strain      ☐ Glaucoma  
☐ Eye pain      ☐ Cataracts  
☐ Red eyes      ☐ Teeth problems  
☐ Itchy eyes      ☐ Grinding teeth  
☐ Spots in eyes      ☐ TMJ  
☐ Poor vision      ☐ Facial pain  
☐ Blurred vision      ☐ Gum problems

☐ Sores on lips/tongue  
☐ Dry mouth  
☐ Excessive phlegm  
☐ Sinus problems  
☐ Excessive phlegm  
Color of phlegm: \_\_\_\_\_

☐ Recurrent sore throat  
☐ Swollen glands  
☐ Lumps in throat  
☐ Enlarged thyroid  
☐ Nose bleeds  
☐ Ringing in ears  
☐ Poor hearing  
☐ Earaches

☐ Headaches  
☐ Migraines  
☐ Concussion  
☐ Other head/neck problems: \_\_\_\_\_

### Respiratory

☐ Difficulty breathing when  
    lying down  
☐ Shortness of breath

☐ Tight chest  
☐ Asthma/whooping

☐ Cough: \_\_\_\_\_  
Wet or Dry? \_\_\_\_\_  
Thick or thin? \_\_\_\_\_

Color of phlegm: \_\_\_\_\_

☐ Coughing blood  
☐ Pneumonia

### Cardiovascular

☐ High blood pressure  
☐ Blood clots

☐ Low blood pressure  
☐ Fainting

☐ Chest pain  
☐ Difficulty breathing

☐ Tachycardia  
☐ Heart palpitations

☐ Phlebitis  
☐ Irregular heartbeat

### Gastrointestinal

☐ Nausea  
☐ Vomiting  
☐ Acid regurgitation  
☐ Bloating

☐ Diarrhea  
☐ Constipation  
☐ Laxative use  
☐ Intestinal pain/cramping

Bowel movements:

Frequency: \_\_\_\_\_

Color: \_\_\_\_\_

Texture/Form: \_\_\_\_\_

Odor: \_\_\_\_\_

### Skin and Hair

☐ Rashes      ☐ Hives      ☐ Eczema      ☐ Psoriasis      ☐ Other hair/skin problems: \_\_\_\_\_

### Genito-Urinary

☐ Pain on urination  
☐ Frequent urination

☐ Urgent urination  
☐ Bedwetting

☐ Wake to urinate  
☐ Increased libido

☐ Decreased libido  
☐ Other: \_\_\_\_\_

### Gynecology

☐ Age menses began  
Length of cycle (day 1 to day 1): \_\_\_\_\_  
Duration of flow: \_\_\_\_\_  
☐ Vaginal discharge  
(color: \_\_\_\_\_)

☐ Irregular menses  
☐ Painful period  
☐ PMS  
☐ Vaginal sores  
☐ Vaginal odor

☐ Clots  
☐ Breast lumps  
# Pregnancies: \_\_\_\_\_  
# Live births: \_\_\_\_\_  
# Premature births: \_\_\_\_\_

Age at menopause: \_\_\_\_\_  
Date of last PAP: \_\_\_\_\_  
Date last period began: \_\_\_\_\_

### Neuropsychological

☐ Depression      ☐ Irritability  
☐ Anxiety      ☐ Easily stressed

☐ Abuse survivor  
☐ Considered/attempted suicide

☐ Seeing a therapist

Other: \_\_\_\_\_

Is there anything else I need to know about treating you?

## Medications and Supplements

Please provide a full and complete list of all medications, vitamins and supplements including dosage. Please also indicate the reason you are on the medication or supplement. You may further list any concerns you have. Is the medication working as well as you would like or causing any side effects of concern.

Today's Date: \_\_\_\_\_

[illegible]

## Colorado Mandatory Disclosure Statement

### Education and Experience

Tina Laue, L.Ac. earned her Master of Science degree in Traditional Chinese Medicine from the Colorado School of Traditional Chinese Medicine in December, 2007. This program consists of 2,850 hours of education including 560 hours of clinical internship treating the public. She was certified as a Diplomate in Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in 2008. This includes certification in Clean Needle Technique and Chinese Herbology. Tina has also completed a three year internship in Five Element Acupuncture with Judi Terill (J.R. Worlsey -> Warren Bellows -> Judi Terrill). Tina's training includes adjunctive therapies such as moxibustion, tui na, gua sha, acupressure, cupping, auriculotherapy, shonishin, diet, and lifestyle recommendations. She is a Licensed Acupuncturist in Colorado. Her license has never been suspended or revoked.

This clinic complies with the rules and regulations set for 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 used.

### Cancellation Policy

Please cancel by noon the day before your appointment or you are responsible for \$50 of the total fee. This fee is due in 30 days. This fee may be waived in an emergency at Good Needles Acupuncture and Chinese Herbal Medicine's sole discretion. \_\_\_\_\_ Initial

### Fee Schedule

Initial Intake and Consultation.....	\$165
Follow up Treatment on same diagnosis, standard session .....	\$70
Follow up Treatment on same diagnosis, Five Element/Emotional session.....	\$111
Plus 30/60/90 (additional minutes).....	\$30/\$60/\$90

\*Any herbs are at an additional fee.

\*If Cost is a concern a lower fee may be approved and a Financial Hardship Agreement signed.

### Patient's Rights

1.) The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. 2.) The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. 3.) 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. If you have comments, questions, or complaints, contact: Director of Registrations, Acupuncturist's Licensure, 1560 Broadway, Suite 1350, Denver, Colorado 80202 or call them at 303-894-7800.

I have read and understand this document.

\_\_\_\_\_  
Patient or Guardian's Signature

\_\_\_\_\_  
Date

## Consent to Receive Treatment

*By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist and herbalist at Good Needles. 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.*

**Acupuncture:** I understand that acupuncture is performed by the insertion of sterile, single-use 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, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture 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. 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.

**Moxibustion/Direct Moxibustion:** Moxa is the furry underside of the leaf of the plant mugwort or artemesia vulgaris. It is used to add heat to the body or to move energy in the channels. Moxa is selected because it burns at a nice even pace and does not have intense heat to it. It is applied indirectly, on top of the needles, in the form of stick-on moxa cones, or directly to the skin. I understand that there is a risk of burns and I am free to refuse this treatment. It may also be irritating to people with asthma or allergies and I will communicate to my practitioner if this product irritates me.

**Chinese Herbs:** I understand that substances from the Oriental Materia Medica 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 taking 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 call the Chinese Medical Clinic as soon as possible.*

**Acupressure/Tui-Na Massage/Shonishin:** I understand that I may also be given acupressure/tui-na massage/shonishin 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. This is the application of an electric current to the needles. 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.

**Gua Sha:** I understand that I may be offered Gua Sha to help normalize the body's physiological functions or to modify or prevent pain perception. I understand that certain adverse side effects could result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that I may refuse this therapy.

**Cupping:** I understand that I may be offered cupping, which is the application of suction using glass cups for the purpose of relieving pain, increasing energy, breaking up stagnation, and treating disease conditions. This therapy leaves bruises which may be quite dark. I need to protect the area for the next 48 hours from excessive or prolonged exposure to wind, sun, or direct spray from a shower. (A quick shower is fine.) This is because the pores are opened and may be quite sensitive. I understand that I will be asked each time this therapy is applied if I want it and that I may refuse it.

**Ear Seeds:** I understand that I may be offered ear seeds, which are seeds taped on an auricular acupuncture point in the ear. I understand that the ear has a minimal blood supply and that an inflammation of the outer ear is very serious. I agree if I receive ear seeds to remove them if they irritate or bother me. I agree to keep my ears clean and to remove them after the time frame discussed with my practitioner. I understand that if the outer ear becomes infected due to my negligence in removing these seeds in a timely manner, that I need to seek western medical care and am fully responsible for the charges. I understand that I may refuse this therapy.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. 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. (If I ask for and receive a more detailed explanation, both practitioner and patient will initial next to item:) I give my permission and consent to treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Treatments from outside the Acupuncture and Chinese Medicine Box:**

I strive to offer competent, professional services and to integrate the full scope of my capabilities, skill and knowledge. As with all of my services, I will explain what I am doing and you will be verbally asked to consent to anything I do at the time of treatment. You are always free to decline any of the services I provide that you are not comfortable with. Please be aware that the items below are outside the scope of my malpractice insurance and that any issues arising from working with the items below need to be settled by arbitration.

#### **Reiki:**

Tina Laue, L.Ac. is also certified in Reiki, the flow of universal healing energy.

#### **Young Living Oils/Aromatherapy/The Raindrop Technique:**

Tina Laue, L.Ac. also incorporates aromatherapy, oils on the skin, and an immune supporting technique known as the Raindrop Technique into her practice.

- I understand that if I consent to use essential oils in conjunction with my treatment that Tina Laue, L.Ac. does her best to use them safely and appropriately. Possible side effects may be a topical skin rash. I agree to inform Tina Laue, L.Ac. of any concerns or issues that may arise.

#### **Energy Work/Intuitive Work:**

Tina Laue, L.Ac. uses her gifts of intuition and her ability to sense energies within the body. Occasionally a session may open into deeper layers. It is Tina's intention to use her full range of skills as a healer in an integrated and safe way. It is her belief that only those people who are ready or choose to experience mystical or higher level spiritual experiences invite them.

-I understand that I am responsible for things from within my psyche that may come up during healing sessions with Tina Laue, L.Ac. I further understand and accept responsibility to communicate with Tina Laue, L.Ac. about any concerns, fears, or challenges that arise during or after treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### **Agreement to arbitration:**

I understand that Reiki, Essential Oils, and Energy Work fall outside the scope of practice covered by Tina Laue, L.Ac.'s Malpractice Insurance. I agree that if I agree verbally and on this form to receive these treatments, that any issues or concerns that may arise, including those that cause me to seek medical care or miss work, will be worked out by arbitration.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Acknowledgement of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for the office of Good Needles Acupuncture and Chinese Herbal Medicine, detailing how my information may be used and disclosed as permitted under federal and state law.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Patient: \_\_\_\_\_

Relationship: \_\_\_\_\_