Acupuncture Therapy Clinic LLC
Katie Thomas, LAc
Patient Health History

Name: _____ Date: _____
(first) (middle) (last)

Parent/Guardian's Name:_____ Date: _____

Address: _____City: _____ State: _____ Zip Code:_____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Date of Birth: _____Age: ____ Gender: M/F Marital status: _____Social Security: _____

Emergency Contact: _____ Relationship:_____ Phone: _____

Employer: _____ Occupation: _____

Email: _____ I would like to receive informational updates/ newsletter Yes: ____ No: ____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. All information collected on this form is confidential, protected health information. Thank you.

Primary Care Physician: _____ Physician Tel. Number: _____
Specialist Physician(s): _____ Specialist(s) Tel. Number: _____

INSURANCE INFORMATION

Do you have a personal, group health, workman's comp, or accident insurance? _____
Company/Plan Name: _____ Address: _____
Subscriber Name: _____ Group #: _____ ID #: _____

Has your case been referred to an attorney? Y N

Please identify the health concerns that have brought you to see Katie Thomas, LAc, in order of importance below:

Condition	**Past Treatment**
a. _____	_____
How does this condition affect you?	_____
b. _____	_____
How does this condition affect you?	_____
c. _____	_____
How does this condition affect you?	_____

1. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

2. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

3. Do you have any reason to believe you may be pregnant? Y N

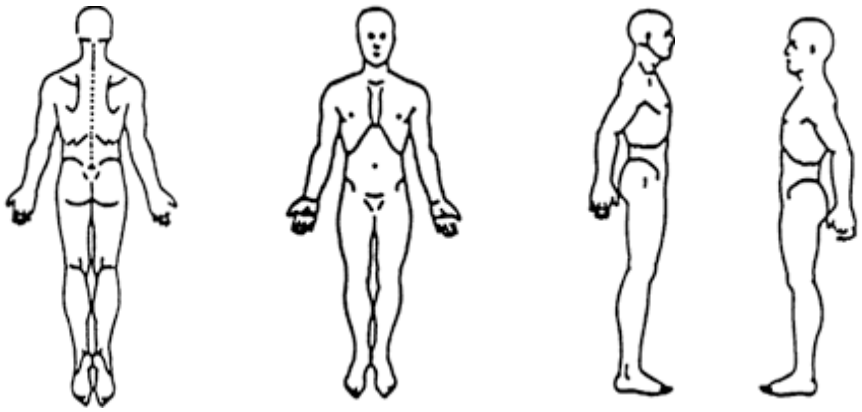
If so, how far along are you? _____

4. Do you have any infectious diseases? Y N If yes, please identify: _____

5. **Family History:**	Father	Mother	Brothers	Sisters	Spouse	Children
Check those applicable:						
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Addiction	_____	_____	_____	_____	_____	_____
Asthma/Hay Fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

6. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

Body Pain (circle / shade areas of pain, ache, burning, and/or numbness)



7. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

8. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

9. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

10. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

11. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

12. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension

13. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

14. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

15. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: _____

16. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

17. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

18. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

19. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

20. **Menstrual/Birthing History:**

1. Age of First Menses: _____
2. # of Days of Menses: _____
3. Length of Cycle: _____
4. Birth Control Type: _____
5. # of Pregnancies: _____
6. # of Miscarriages: _____
7. # of Abortions: _____
8. # of Live Births: _____

21. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

22. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

23. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

24. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

25. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

_____

_____

26. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

g. Nicotine/Alcohol/Caffeine Use: _____

h. Have you experienced any major traumas? Y N Explain: _____

_____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Interests and hobbies: _____

Acknowledgement of Receipt of the
NOTICE OF ACUPUNCTURE THERAPY CLINIC LLC PATIENT PRIVACY PRACTICES

I have received the NOTICE OF ACUPUNCTURE THERAPY CLINIC LLC PATIENT PRIVACY PRACTICES from Katie Thomas, LAc, which describes how ACUPUNCTURE THERAPY CLINIC LLC may use and disclose my protected health care information to carry out treatment, payment of services, health care operations, and other purposes that are allowed by law. This Notice also describes my patient rights and ACUPUNCTURE THERAPY CLINIC LLC requirements to protect my health information.

ACUPUNCTURE THERAPY CLINIC LLC reserves the right to change the privacy practices that are described in the NOTICE OF ACUPUNCTURE THERAPY CLINIC LLC PATIENT PRIVACY PRACTICES. All changes will be posted at ACUPUNCTURE THERAPY CLINIC LLC. I understand that I may request a copy of this notice at any time and discuss its contents with the Privacy Officer, Katie Thomas, LAc.

The most current copy of this notice will be posted in the clinic.

_____ _____

Signature of Patient or Personal Representative Date

Authorization to Release Information to Physician: I hereby authorize my physician and/or specialist to release to this office and this office to them any medical and/or other information acquired which concerns my condition or other disabilities. A copy and/or fax of this authorization shall be as valid as the original.

Name of Physician: _____
Patient's Signature: _____ Date: _____

Katie Thomas, LAc. and this practice recognizes the responsibility of filling out the practitioner's insurance statement and bill to give you for your insurance and accounting purposes. If you choose to assign benefits please fill in:

□ **Assignment of Insurance Benefits:** I hereby irrevocably assign the insurance benefit payments to which I am entitled, directly to Acupuncture Therapy Clinic. A copy and/or fax of this authorization shall be as valid as the original.
Patient's Signature: _____ Date: _____

I understand and agree that accident and health insurance policies are an arrangement between myself and an insurance carrier. I also understand that this acupuncturist's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount paid directly to this acupuncturist's office will be credited to my account or receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Furthermore, I understand that if I suspend or terminate my care and treatment, any remaining fees for professional services rendered me will be immediately due and payable.

Patient/Guardian's Signature: _____ Date: _____

Acupuncture Therapy Clinic LLC
Katie Thomas, LAc
Consent Form

Primary Care & Medical Records: I do hereby voluntarily consent to be treated with acupuncture and/or substances from Katie Thomas, LAc, a licensed acupuncturist. I understand that acupuncturists in the state of Colorado are not primary care providers. Katie Thomas, LAc, recommends that all patients have a regular primary care physician. All patients must provide medical records from a primary care provider upon request.

Group Treatment: Treatment may be administered in a group setting in a large room. It is possible that other individuals in the room may hear or see case and treatment information.

Acupuncture/Facial Rejuvenation Acupuncture: Acupuncture is performed by the insertion of needles through the skin of the body to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. There may occasionally be adverse side effects such as: local bruising, minor bleeding, fainting, pain or discomfort, the possible aggravation of symptoms existing prior to acupuncture treatment and very rarely lung puncture (pneumothorax).

Moxibustion/Direct Moxibustion: Preformed by the application of heat to the skin at points on or near the surface of the body. With this therapy, there is a risk of burning or scarring.

Electro-Acupuncture: Electro-acupuncture may be administered with the acupuncture. There may be certain adverse side effects such as: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment.

Chinese Herbs: Chinese herbs and substances may be recommended to treat bodily dysfunction or diseases or to modify or prevent pain perception and to normalize the body's physiological functions. Patients must follow the directions for administration and dosage. There may occasionally be adverse side effects such as: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. With any problems associated with these substances, patients should suspend taking them and call Katie Thomas, LAc, as soon as possible.

Acupressure-Massage: Acupressure-massage is used to modify or prevent pain perception and to normalize the body's physiological functions. There may be certain adverse side effects such as: muscle soreness or achiness and the possible aggravation of symptoms existing prior to the treatment.

All of the above information has been explained to me by Katie Thomas, LAc. I have had my questions answered.

- I consent to treatment with acupuncture and Oriental Medicine from Katie Thomas, LAc.
- I understand that there are no guarantees concerning treatment.
- I understand that there may be other treatment alternatives, including treatment that might be offered by a licensed physician.
- I understand that I am free to refuse or stop treatment at any time.

Patient Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Colorado Mandatory Disclosure
Katie Thomas, LAc

Fee Schedule

Initial Evaluation	$90
Follow-Up Treatment	$70
Bounced Check	$30

Discounts or lower fees may apply to patients who belong to certain eligible affinity plans or who pay at time of visit

Cancellation Policy

Appointment cancelation requires at least a 24 HOURS notice. Patients who are more than 15 minutes late may have their appointment canceled. Appointments cancelled without 24-hour notice will be charged the full cost of the treatment.

Patient's Rights

- This office complies with all rules and regulations promulgated by the Colorado Department of Public Health and Environment, including those related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices.
- The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, CO 80202. Telephone (303)894-2440.
- The patient is entitled to receive information about the methods of therapy, techniques used, and 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.

Certifications

- Licensed Acupuncturist – CO State
- Diplomate in Oriental Medicine and Chinese Herbology – National Creditation Commission for Acupuncture and Oriental Medicine
- Clean Needle Technique
- National Acudetox Specialist

No License has ever been suspended or revoked

Education

- Oregon College of Oriental Medicine, Portland, OR
  - Master's of Acupuncture and Oriental Medicine (MAcOM) – August, 2008
  - 3,272 hours of training
  - 960 hours of clinical practice
  - Additional training in adjunctive therapies such as moxibustion, cupping/gua sha, dietary/lifestyle recommendations, and tuina
- The Evergreen State College, Olympia, WA
  - B.A. emphasis in Environmental Studies – June, 2000

I have read and understand this document.
Name: _____
Guardian: _____
Date: _____