THRIVE COMM*UNITY* ACUPUNCTURE

149 W. HARVARD ST., SUITE 401, FORT COLLINS, CO 80525

PATIENT INFORMATION AND HISTORY

NAME: _____ DATE: _____

ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

OCCUPATION: _____ EMAIL: _____

AGE: ____ DATE OF BIRTH: ____/____/____ SEX/GENDER: _____

PLEASE TELL US HOW YOU HEARD OF OUR CLINIC: _____

DO WE HAVE YOUR PERMISSION TO "THANK" THEM FOR THEIR REFERRAL? Yes ___ No ___

HAVE YOU RECEIVED ACUPUNCTURE BEFORE? _____

EMERGENCY CONTACT: NAME: _____ PHONE: _____

LIST ALL MEDICATIONS OR DIETARY SUPPLEMENTS YOU ARE CURRENTLY TAKING:

Medication_____Dosage_____Reason_____How Long

_____

_____

_____

PLEASE INDICATE THE USE AND FREQUENCY OF THE FOLLOWING:

	Yes	No	Amount		Yes	No	Amount
Coffee:	___	___	_____	Tobacco:	___	___	_____
Alcohol:	___	___	_____	Recreational Drugs:	___	___	_____
Diet Soda:	___	___	_____	Regular Soda:	___	___	_____

LIST THE TOP 3 THINGS YOU WOULD LIKE TO WORK ON:

1) _____

2) _____

3) _____

LIST ANY ALLERGIES, FOOD SENSITIVITIES OR CRAVINGS: _____

_____

LIST ANY ACCIDENTS, SURGERIES, OR HOSPITALIZATIONS (INCLUDE DATES): _____

_____

SYMPTOM SURVEY

The following is a list of symptoms that you may or may not experience. Please indicate as follows:

Blank mark = never experience
S = sometimes experience
O = often experience

__ lack of appetite
__ excessive appetite
__ loose stool/diarrhea
__ indigestion
__ bloating after eating
__ vomiting
__ belching/burping
__ heartburn/reflux
__ hemorrhoids
__ abdominal pain
__ constipation

_____
__ arthritis
__ insomnia
__ heart palpitations
__ cold hands and feet
__ chest pain
__ sleep too much
__ hand swelling
__ ankle swelling
__ low blood pressure
__ high blood pressure
__ bleed easily
__ numbness/tingling in extremities

__ cough
__ shortness of breath
__ sinus problems
__ asthma
__ difficulty inhaling
__ bronchitis
__ hay fever/rhinitis

_____

__ back pain
__ sciatic nerve
__ joint pain
__ mouth sores
__ muscle spasms
__ shingles
__ knee problems
__ kidney stones
__ headaches/migraines
__ dizziness
__ poor balance
__ poor memory
__ facial nerve pain

__ failing vision
__ cataracts
__ glaucoma
__ other eye problem
__ pimples/acne
__ eczema/psoriasis
__ moles/warts
__ bruise easily
__ varicose veins
__ skin cancer
__ hair loss
__ toenail fungus
__ brittle nails

__ frequent colds
__ hypo or hyperthyroid
__ lump in throat
__ grind teeth
__ fatigue
__ perspire easily
__ ear ringing
__ sudden weight loss
__ decreased sex drive
__ urinary infections
__ incontinence

Which emotions most closely describe you:

__ Happy __ Easily irritable/angry __ Difficulty making decisions __ Numb
__ Depressed __ Stressed/anxious __ Fearful __ Sad

HOW OFTEN DO YOU EXERCISE & WHAT TYPE: _____

_____

Women Only:

Are you pregnant? Y___ N___ Number of pregnancies? _____ Number of live births? _____
Do you frequently get yeast infections? _____
Do you have infertility issues? _____

Circle any of the following PMS symptoms that apply to you:

Irregular painful heavy flow scanty flow water retention breast lumps clots
emotional changes spotting between periods constipation/diarrhea migraines backache
Do you have abnormal vaginal discharge? _____ (please describe) _____

_____

FEE SCHEDULE

- New Patient: Intake Consultation & Treatment: $50.00, Seniors 60+: $40.00
- Follow up Treatment: $45.00, Seniors 60+: $30.00

LATE ARRIVAL AND MISSED APPOINTMENTS POLICIES

Our clinic exists for one purpose: ***To help you, your family and your neighbors have access to quality, affordable, convenient, and effective Traditional Chinese Medicine health care.***

In order to best serve you and your neighbors, we have important policies that we need you to understand:

- **Any appointment that is missed or cancelled with less than 24 hours notice will be charged the full service amount. We appreciate your understanding our need to consistently apply this policy, which helps us serve you and your neighbors with high quality, affordable acupuncture. We ask that this fee be paid the same day by phone.**

- **It is important that you check in for your appointment 10 minutes before your appointment time. We will do our very best to accommodate you if you arrive late for your appointment, however, if you arrive late and we are unable to accommodate you because our schedule is full, we will consider it a missed appointment and will need to charge you accordingly.**

- **We cannot guarantee you will be seeing a specific acupuncturist nor be able to reserve a table or chair at any time. We will try to accommodate these needs to the best of our ability!**

We thank you for understanding the need for these policies!

Your signature below confirms that you have read and agree to these policies.

Signature _____ Date _____/_____/_____

Printed Name _____

COLORADO MANDATORY DISCLOSURE AND INFORMED CONSENT FORM

Each patient has the following rights:

- **The patient is allowed to receive information about the methods of therapy, the techniques used, and the duration of therapy**
- **The patient is allowed to 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 Professions and Occupations immediately.**

The practice of acupuncture is regulated by the by the Department of Regulatory Agencies. The Director of the Division of Professions & Occupations may be contacted at:

Division of Professions & Occupations Acupuncturist Licensure

1560 Broadway, Suite 1350, Denver, Colorado 80202, (303)894-7800, dora_acupunctureboard@state.co.us

I confirm that I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that Thrive Community Acupuncture does not provide primary care, or Western (allopathic) medical care. I hereby release Thrive Community Acupuncture and its employees and subcontractors from any and all liability that may occur in connection with the acupuncture, body work, or herbal treatment I receive, except for failure to perform with appropriate medical care. I hereby give my consent to acupuncture, cupping, e-stim, and acupressure and any herbal/homeopathic treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient (or Parent/Guardian):_____

Our Practitioner's Education, Certification and Experience:

David Gorski, L.Ac., Dipl. Ac., is licensed in the state of Colorado having graduated Southwest Acupuncture College in Boulder, CO with his MS Ac.

Informed Consent:

I hereby request and consent to the performance of acupuncture procedures by my acupuncturist David Gorski, Jeff Brew, or Crystal Bowland such other duly licensed acupuncturist as your clinic has on staff.

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 may include nerve damage, organ puncture, infection, and spontaneous miscarriage. Other side effects 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(s) 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 anticipate and explain all possible risks and complications, and I permit the acupuncturist to determine and/or alter the course of treatment as they judge 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 understand that it is always possible that a needle may accidentally be left in place or fall on my clothing after my treatment, and I understand that I am responsible for double-checking that all needles have been removed. I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content, and 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.

I have furthermore been informed that Thrive CommUnity Acupuncture clinic's acupuncturists are not medical doctors and do not provide primary care medicine or diagnostic medical procedures. I understand, too, that if I think there is any possibility that I may be experiencing a serious health concern, or if I want someone knowledgeable to review my medical history with me, I need to see a primary care physician prior to acupuncture treatment. I understand that, as a complementary care provider, Thrive CommUnity Acupuncture is pleased to communicate with my physician at my request.

I understand, acknowledge, and voluntarily accept the risk associated with acupuncture services, use of your facilities, and I hereby release you (including our affiliates, agents, and employees) from liability for any injury or claim (including, without limitation, personal, bodily, or mental injury, property damage or economic loss), which may result from your acupuncture, cupping, or from taking herbs ordered by or recommended by the acupuncturist, my failure to disclose any pre-existing condition, limitation or sensitivity, or my failure to inform my therapist of discomfort during my session.

_____ _____

Signature of Patient or Person Authorized to Consent (state relationship) Date