Left Hand Community Acupuncture **Health History Questionnaire**

This is a confidential questionnaire to help us determine the best individualized treatment plan for you.

Name:	**Home Phone:**
Address:	**Cell Phone:**
City, State, Zip Code	**Other:**
Email Address	**Gender:** Female / Male / _____
May we use your email address for the following?: 1) regarding your course of treatment Yes No 2) for automated appointment reminders Yes No 3) for our monthly email newsletter Yes No (your email address will not be used for any other purposes)	**Age:** _____ **Date of Birth:** _____/_____/_____
What is the best way to reach you to retain your healthcare privacy?	**Guardian (if under 18 years of age):**
How did you hear about us?	**Relationship Status:**
Family Physician:	**Phone:**
In case of emergency, please contact: (Name and Phone #)	**Date of last checkup?**
Are you afraid of needles? Yes No	(Please share your concerns with us)

Primary reasons for this visit:

#1	**Circle a range for your symptoms** mild <— —> severe 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	What makes it better?
	How is it impacting your daily life?	What makes it worse?
#2	**Circle a range for your symptoms** mild <— —> severe 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	What makes it better?
	How is it impacting your daily life?	What makes it worse?
#3	**Circle a range for your symptoms** mild <— —> severe 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	What makes it better?
	How is it impacting your daily life?	What makes it worse?

Current medications: (attach your sheet own if necessary) Include prescriptions AND over-the-counter meds.

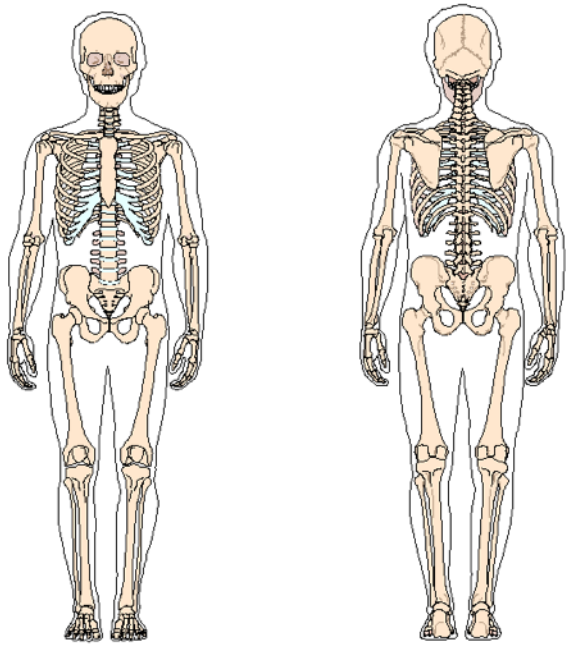
Medication	Dosage	Reason	How Long?	Prescribed By

Supplements: _____
_____

Significant Illnesses:

___High blood pressure	___Hepatitis A	___HIV
___Low blood pressure	___Hepatitis B	___AIDS
___Cancer	___Hepatitis C	___Hyperthyroid Disease
___Ulcers	___Herpes Simplex Type 1	___Hypothyroid Disease
___Chronic Fatigue	___Herpes Simplex Type 2	___Kidney Disease
___Asthma	___IBS	___Alcoholism
___Diabetes	___Gastritis	___Heart Disease
___Seizures	___Pancreatitis	___Other: _____
___Anemia	___Liver/Gallbladder Disease	_____

Musculoskeletal



Circle areas of pain and inflammation in your body

Have you ever been hospitalized? Y N
If yes, for what? _____
_____
_____
_____
_____

Have you ever had surgery? Y N If yes, for what?
_____
_____
_____
_____
_____

Do you have a history of: ___ Depression ___ Anxiety ___ Manic Depression ___ Panic Attacks
___ PTSD (Post Traumatic Stress Disorder) ___ Other _____

Allergies (food, drug, seasonal, environmental, nickel, silicone, other?) _____
_____

Foods	I eat these items	**0= none at all**	**1= a little**	**2=some**	**3= a lot**

Frozen meals	0	1	2	3	**Organic**					**Conventional**				
Fast food	0	1	2	3	Fresh fruits, veggies	0	1	2	3	Fresh fruits, veggies	0	1	2	3
Raw foods	0	1	2	3	Meats	0	1	2	3	Meats	0	1	2	3
Homecooked meals	0	1	2	3	Eggs, Dairy	0	1	2	3	Eggs, Dairy	0	1	2	3
Sugary foods	0	1	2	3	Bread/Grains	0	1	2	3	Bread/Grains	0	1	2	3

Diets followed ___ Paleo ___ Mediterranean Diet ___ Vegetarian ___ Vegan ___ Zone Diet ___ Atkins ___ Other? _____

Beverages	How much?	How often?
Water	_____	_____
Soda	_____	_____
Coffee/Caffeinated Tea	_____	_____

Etc…	How much?	How often?
Alcohol	_____	_____
Tobacco	_____	_____
Recreational drugs	_____	_____
Medical Marijuana	_____	_____

Sleep: Number of hours a night _____
Time to bed _____Time to wake _____
Trouble falling asleep? _____
Trouble staying asleep? _____

Feel rested on waking?_____
Vivid dreams? _____
Worrying / Racing mind? _____
Heart palpitations? _____

Exercise: What type(s)?_____ How often? _____

Please rate your **MOOD:** 5 = Great 4 = Good 3 = Fair 2 = Poor 1 = Bad
Please rate your **STRESS level:** 5 = Great 4 = Good 3 = Fair 2 = Poor 1 = Bad
Please rate your **ENERGY level:** 5 = Great 4 = Good 3 = Fair 2 = Poor 1 = Bad

Symptoms Please check if any of these symptoms are significant concern for you:

General: ___Chills ___ Excess heat ___ Bleed / bruise easy ___ Muscle weakness/fatigue ___ Night sweats ___ Palpitations ___ Fatigue ___ Sweat easily ___ Tremor ___ Cold hands / feet ___ Edema ___ Trouble with weather changes ___ Tightness in chest

Gastrointestinal ___ Poor Appetite ___ Excessive Appetite ___ Cravings ___ Weight Loss ___ Weight Gain ___ Strong thirst ___ No thirst ___ Nausea ___ Vomiting ___ Gas/Belching ___ Bloating ___ Gallstones/Trouble with fatty foods ___ Indigestion ___ Heartburn / Reflux ___ Constipation ___ Loose Stool / Diarrhea ___ Black/Pale stools ___ Hemorrhoids ___ Hernia ___ Abdominal pain/cramps **Urinary** ___ Painful / Burning urination ___ Incontinence ___ Frequent / Excessive urination __ Urination at night __ Kidney stones ___ Urinary tract infection ___ Urgency ___ Bloody urination

Head / Ears / Eyes / Nose ___ Headaches / Migraines ___ Dizziness ___ Tinnitus ___ Hearing loss ___ Earaches ___ Eye pain ___ Poor vision ___ Cataracts ___ Floaters ___Sinus problems ___ Nose Bleed ___ Allergies / Hayfever ___ Runny nose / post-nasal drip ___ Grinding teeth ___ TMJ ___ Dental / gum problems ___Cold Sores ___ Poor balance ___ Poor memory

Respiratory ___ Difficulty swallowing ___ Persistent sore throat ___ Swollen glands ___ Cough/wheeze ___ Frequent colds ___ Pneumonia ___ Asthma ___ Tuberculosis ___ Emphysema ___ Bronchitis ___ Shortness of Breath

Skin/Hair ___ Rashes/Itching ___ Eczema ___Psoriasis ___Dermatitis ___ Ulcerations ___ Acne ___ Changes in skin ___ Hair loss/changes **Other** Any other health concerns or conditions you'd like us to know about?
_____
_____

Reproductive Health: please find the sections that make the most sense for you!

Are you currently pregnant? _____	# of pregnancies _____
Planning to become pregnant? _____	# of live births _____
Are you using birth control? _____	# of miscarriages _____
What type?_____	# of abortions _____

How old were you when you had your first period? _____ When was the first day of your last period? _____

Average # of days in cycle _____ Average number of days of flow: _____

Average number of pads/tampons used per day: Day 1:____ Day 2: ____ Day 3: ____ Day 4: ____ Day 5: ____

Flow is: Light Normal Heavy

Color is: Pale Dark Bright Red Brown Purple

Blood clots? Yes No Size of clots_____

Do you experience any of the following before or during your menstrual period?

___ Water retention	___ Pain / cramping	___ Nausea
___ Breast tenderness / swelling	___ Migraines	___ Hot flashes
___ Depression	___ Insomnia	___ Night sweats
___ Irritability	___ Diarrhea / Constipation	___ Acne

Vaginal Discharge? Yes No If yes, is there a color or odor?_____

Is your libido: Low Normal High

Have you ever been diagnosed with any of the following:

___ Endometriosis	___ Cervical Dysplasia	___ Ovarian Cysts
___ Polycystic Ovary Syndrome	___ Uterine Fibroids	___ Fertility Issues
___ Pelvic Inflammatory disease		

Age of menopause onset? _____ Menopause Symptoms: _____

Hormone Replacement therapy? Yes No

Date of last **PAP smear:** _____ Results: _____

Date of last **Prostate check up**: _____ Results: _____

Have you ever experienced any of the following:

___ Groin pain	___ Nocturnal emissions	___ Prostate problems
___ Decreased libido	___ Swelling in testicles	___ Dribbling urination
___ Overactive libido	___ Premature ejaculation	___ Painful urination
___ Testicular pain	___ Fertility Issues	___ Difficult urination
	___ Impotence	___ Incontinence

Other reproductive health issues? _____

_____

Anything else? :-) _____

_____

Left Hand Community Acupuncture Financial Policy

Community Room Suggested Fee Guideline

It is the intention of Left Hand Community Acupuncture to provide acupuncture and other treatment modalities that everyone can afford. **The chart below is intended as *a guideline only***, and we understand that everyone's situation is unique. Please take into consideration your frequency and length of treatment when choosing your rate, and remember that you can change the amount as needed during the course of treatment.

Annual Income	Suggested Treatment Fee
$60,000 & Up	$55
$52,000 - $59,000	$50
$44,000 - $51,000	$45
$36,000 - $43,000	$40
$28,000 - $35,000	$35
$20,000 - $27,000	$30
Under $20,000	$25

Initial consultation and Treatment: A one-time fee of $15 is added to the initial appointment, plus cost of treatment.

Insurance: In order to keep our treatment fees low and affordable, we do not bill insurance. If you plan to seek reimbursement from your insurance company, please pay the full amount and we will provide you with a superbill for you to submit to your insurance company.

Cancellation Policy

Because treatments are by appointment only and your appointment time is reserved specifically for you, we request that you acknowledge and respect our cancellation policy. If you need to cancel or reschedule an appointment, please do so **at least 24 hours before your appointment time** by calling our office at 720-248-8626. If we are unable to answer, please leave a message. Patients who do not honor their appointment time will be charged a cancellation fee as follows:

Cancellation with more than 24-hours notice: no charge
Cancellation with less than 24-hours notice or failure to show: $10.00

We ask for a commitment from you to be here when you are scheduled. Being late for your appointment can disrupt the flow of that day's schedule and so we ask that you please arrive on time. If you arrive later than 15 minutes after your scheduled appointment, your treatment may be forfeited at the discretion of the practitioner and our cancellation policy and associated fees will apply.

Financial Policy

Payment is expected at time of service by cash, check or credit card. Our sliding scale applies to all payments made the day of service, if payments are made after the date of service we reserve the right to bill $120 per treatment.

The patient agrees to pay all banking fees associated with returned checks.

No refunds will be given for services already rendered. If you have paid for a treatment package in full and decide to discontinue treatment, you will be refunded for unused services less a 20% processing fee.

I have read, understand, and will abide by the above fee schedule, cancellation, and financial policies.

_____ _____

Signature Date