Beth Kearns Acupuncture

921 Main Street, Louisville, CO 80027
(303)324-4686

Patient Health History

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

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F Marital status: S M D W

Address_____City, State, Zip_____

Home Phone_____ Cell_____ Work_____

Email_____ Name of Spouse_____ Phone_____

Name of Emergency Contact _____ Phone_____

Relationship_____ Referred By_____

By giving your email address, our scheduling system will automatically send you confirmation emails and you will be added to our email list. You may unsubscribe at any time. Your information will not be shared with anyone. Please see Medical Information Privacy form for more information.

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. Thank you.

1. When and where did you last receive health care? _____

For what reason? _____

2. Please identify the health concerns that have brought you to seek acupuncture treatment (in order of importance):

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

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

_____

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

_____

_____

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

If so, how far along are you and has your pregnancy been normal so far? _____

_____

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

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

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

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

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

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

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

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

Others: _____

12. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

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

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

For the questions below: CURRENT=CIRCLE EXPERIENCED IN THE PAST=UNDERLINE

14. **Emotional**:

Mood Swings Nervousness Mental Tension Anxiety Depression

15. **Energy and Immunity**:

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

16. **Head, Eye, Ear, Nose, and Throat**:

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

17. **Respiratory**:

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema
Persistent Cough	Pleurisy	Asthma	Tuberculosis
Shortness of Breath	Other Respiratory Problems: _____		

18. **Cardiovascular**:

Heart Disease	Chest Pain	Swelling of Ankles	High Blood Pressure	
Palpitations/Fluttering	Stroke	Heart Murmurs	Rheumatic Fever	Varicose Veins

19. **Gastrointestinal** :

Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain	Passing Gas	Heartburn
Belching	Gall Bladder Disease	Liver Disease	Hepatitis B or C	Hemorrhoids	Abdominal Pain

20. **Genito-Urinary Tract**:

Kidney Disease	Painful Urination	Frequent UTI	Frequent Urination	Heavy Flow
Kidney Stones	Impaired Urination	Blood in Urine	Frequent Urination at Night	

21. **Female Reproductive/Breasts**:

Irregular Cycles	Breast Lumps/Tenderness	Nipple Discharge	Heavy Flow
Vaginal Discharge	Premenstrual Problems	Clotting	Bleeding Between Cycles
Menopausal Symptoms	Difficulty Conceiving	Painful Periods	

22. **Menstrual/Birthing History:**

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

23. **Male Reproductive**:

Sexual Difficulties	Prostate Problems	Testicular Pain/Swelling	Penile Discharge

24. **Musculoskeletal**:

Neck/Shoulder Pain	Muscle Spasms/Cramps	Arm Pain	Upper Back Pain	Mid Back Pain
Low Back Pain	Leg Pain	Joint Pain (if so, where?): _____		

25. **Neurologic**:

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

26. **Endocrine**:

Hypothyroid	Hypoglycemia	Hyperthyroid	Diabetes Mellitus	Night Sweats	Feeling Hot or Cold

27. **Other**:

Anemia	Cancer	Rashes	Eczema/Hives	Cold Hands/Feet

Is there anything else we should know? _____

_____

28. **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/Drug 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. Television habits: _____ Reading habits: _____

k. Interests and hobbies: _____

Signature: _____ Date: _____

Client, Guardian or Authorized Rep.

Print:_____

If other than Client

DISCLOSURE STATEMENT
CONSENT FORM
MEDICAL INFORMATION PRIVACY

Your practitioner is Elizabeth A. Kearns
921 Main Street, Louisville, CO 80027
(303) 324-4686

Education

Elizabeth has graduated from the Institute of Taoist Education and Acupuncture in Louisville, CO, after studying Classical Five Element Acupuncture for four years and two years of undergraduate studies at Metropolitan State College and Community College of Denver in Denver, CO, Naropa University in Boulder, CO, and Front Range Community College in Westminster, CO. Elizabeth is licensed by the State of Colorado to practice acupuncture. She is certified by the National Certification Commission for Acupuncture and Oriental Medicine. No license, certificate or registration has ever been revoked. She complies with all the rules and regulations set forth by the departments of health. She uses only sterile disposable needles and is trained in the use of direct moxibustion.

Acupuncture Regulation

Director of Registrations
Acupuncturists Licensure
1560 Broadway, Suite 1350
Denver, CO 80202-5140
(303) 894-7800

The following disclosures are in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Statute Title 12 Article 29.5, and with HIPAA regulations. In addition, all rules and regulations set forth by the Department of health are strictly adhered to by Elizabeth including proper sterilization and cleaning of equipment and office. Clients are entitled to receive information about the methods of therapy, techniques used, and the duration of therapy, if known. Clients may seek a second opinion and may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate. The practice of acupuncture is regulated by the Department of Regulatory Agencies. Any complaints should be directed to its Director of the Division of Registration in Denver CO at the above address.

Elizabeth gathers and maintains information concerning clients which may include non-public personal information from medical histories, treatment notes, all test results and any letters, faxes, emails or telephone conversations between the client and this clinic. She maintains information clients share with the clinic from other healthcare practitioners, from insurance companies, from workman's comp, from employers and from other third party administrators (e.g. requests for medical records, claim payment information). She records financial transactions between clients and herself.

Safeguards for protection of personal information in place include:

- Policies and procedures for handling information confidentially, including using client codes rather than names.
- Limited access to locked facilities where all client information is stored.
- Requirements for third parties to contractually comply with privacy laws.

She may use and/or disclose your confidential information without your authorization for the following purposes:

- Providing treatment, payment, or health care operations.
- Billing and getting authorization for treatment from insurance companies and Workman's Compensation.
- Providing information about treatment alternatives, other health related benefits and services.

- As required by law (i.e. to a public health authority or to the FDA, or for work related illness or injuries, or to the sponsor of a group's health plan, health insurance issuer, or HMO).

Your authorization is required in order for the clinic to use (if you choose) to other health care providers or other individuals to receive information about you. You may revoke that authorization in writing at any time. You have the right to:

- Request an alternate address or method of contacting you.
- Inspect and copy your confidential information.
- Request restrictions on certain uses or disclosures; however, these restrictions are subject to agreement by clinic personnel.
- Receive an accounting of the disclosures the clinic makes involving your confidential information.
- Amend your confidential information (in limited situations).

In certain states, and under most conditions, a client is able to access and correct personal information Elizabeth has gathered (e.g. name, address, Social Security number, etc.).

Elizabeth will maintain the privacy of confidential information as required by law and by the notice currently in effect. I t is also required by law to provide this notice of its legal duties and privacy practices related to protected health information. She reserves the right to make changes or revisions to the terms of this notice, and will make available at the office a new notice if any material changes are made.

If a client believes his/her rights have been violated, he/she may contact the secretary of the Department of Health and Human Services. The client will not be penalized for filing a complaint.

Fee Schedule (due at time of service)

Initial Appointment (up to 2 hours)	$140	Treatment (up to 1 hour)	$ 85

I,_____ have read and understood this disclosure and information privacy statement, and voluntarily consent to be treated by acupuncture administered by Elizabeth A. Kearns, L.Ac.

I understand that:

- Acupuncture is performed by the insertion of special needles through the skin, or by applying heat via moxibustion or by any combination of the foregoing, at certain body points.
- Certain side effects by result. These could include some discomfort, weakness, fainting, nausea, pneumothorax and localized bruising.
- NO GUARANTEE is made concerning the outcome of these acupuncture treatments, and I may stop them at any time.

I certify that all questions I have asked concerning this consent have been answered before signing.

Signature of Client or Guardian_____Date_____.

If you would like a copy of this, please ask.

Cancellation Policy

Please read and initial each of the following:

_____ Please give at least 48 hours notice to cancel or change an appointment so that we may try to fill that time. Half of the treatment amount will be charged for cancellations with **less than 24 business hours** notice.

_____If the appointment you would like to change is on a Monday, appointment changes need to be received by 2:00pm Friday.

_____Appointment cancellations and appointment changes are **NOT excepted by email**. Please call or text.

Thank you.

Name of Client_____

Print_____
If other than client (Parent, Guardian or Authorized Rep)

Sign_____
Client, Parent, Guardian, or Authorized Rep

Date:_____

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