Danielle Hennes, Licensed Acupuncturist
117 County Rd 250 | Durango, CO 81301
enlivenacupuncture@gmail.com
Ph: 970-403-5898

NEW PATIENT INTAKE FORM

GENERAL PATIENT INFORMATION

Name: _____ **Date**: _____

Address: _____ **City/State/Zip:** _____

Date of Birth: ____/____/_____ **Age:** _____ **Email:** _____

Home #: _____ **Mobile #:** _____ **Work #:** _____

Gender: [M] / [F] **Height:** ____ ft ____ in **Weight:** _____ **Occupation:** _____

Emergency Contact: Name _____ Contact #: _____ Relation: _____

Guardian, if under 18: Name _____ Contact #: _____ Relation: _____

How did you hear about me?: _____

Have you had acupuncture before: [Y] / [N]

If yes: Please list reason / last treatment date / practitioner / location: _____

_____

_____

PRIMARY REASONS FOR SEEKING CARE

Please list the primary reasons for your visit today and how they are impacting your day-to-day activities:

Reason #1: _____

❑ Work	❑ Standing	❑ Sexually	❑ Other
❑ Sleep	❑ Emotional	❑ Recreation	_____
❑ Walking	❑ Relationships	❑ Bending	_____
❑ Sitting	❑ Sitting	❑ Stretching	_____

Reason #2: _____

❑ Work	❑ Standing	❑ Sexually	❑ Other
❑ Sleep	❑ Emotional	❑ Recreation	_____
❑ Walking	❑ Relationships	❑ Bending	_____
❑ Sitting	❑ Sitting	❑ Stretching	_____

Reason #3: _____

❑ Work	❑ Standing	❑ Sexually	❑ Other
❑ Sleep	❑ Emotional	❑ Recreation	_____
❑ Walking	❑ Relationships	❑ Bending	_____
❑ Sitting	❑ Sitting	❑ Stretching	_____

MEDICAL HISTORY

IMPORTANT: Complete this document as thoroughly as possible. Some questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. **All information is strictly confidential**.

How was your childhood health? _____

List any past or future surgeries: _____

_____

List any significant trauma. When did it occur? (auto accident, falls, emotional, sexual, etc): _____

_____

List exercise and sport activities you have been or are currently involved in: _____

_____

Please circle whether you, siblings, parents or children have history with the following:

Diabetes	Self / Siblings / Parents / Child	Allergies	Self / Siblings / Parents / Child
Heart Disease	Self / Siblings / Parents / Child	CVA (stroke)	Self / Siblings / Parents / Child
Asthma	Self / Siblings / Parents / Child	Pneumonia	Self / Siblings / Parents / Child
Jaundice	Self / Siblings / Parents / Child	Gonorrhea	Self / Siblings / Parents / Child
Syphilis	Self / Siblings / Parents / Child	Measles	Self / Siblings / Parents / Child
Meningitis	Self / Siblings / Parents / Child	HIV	Self / Siblings / Parents / Child
Epilepsy	Self / Siblings / Parents / Child	High Fever	Self / Siblings / Parents / Child
Paralysis	Self / Siblings / Parents / Child	Cancer	Self / Siblings / Parents / Child
Glaucoma	Self / Siblings / Parents / Child	Rheumatic Fever	Self / Siblings / Parents / Child
Vein Condition	Self / Siblings / Parents / Child	Thyroid Disorder	Self / Siblings / Parents / Child
Tuberculosis	Self / Siblings / Parents / Child	Emphysema	Self / Siblings / Parents / Child
Mumps	Self / Siblings / Parents / Child	Bleeding Tendency	Self / Siblings / Parents / Child
Chicken Pox	Self / Siblings / Parents / Child	Nervous Disorder	Self / Siblings / Parents / Child
Polio	Self / Siblings / Parents / Child	Mononucleosis	Self / Siblings / Parents / Child
Hepatitis	Self / Siblings / Parents / Child	Multiple Sclerosis	Self / Siblings / Parents / Child
Migraines	Self / Siblings / Parents / Child	High Blood Pressure	Self / Siblings / Parents / Child

Other: _____

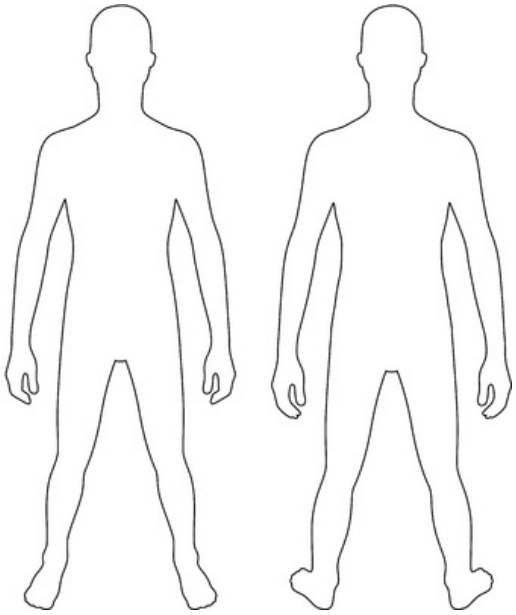
_____

_____

_____

MEDICAL HISTORY (continued)

Please clearly mark any areas of pain or any scars (please indicate which of the areas are scars):



Is the pain:

- ❑ Sharp
- ❑ Cramping
- ❑ Fixed
- ❑ Moving
- ❑ Burning
- ❑ Dull
- ❑ Aching

Do the following improve the pain?

- ❑ Pressure
- ❑ Cold
- ❑ Heat
- ❑ Exercise
- ❑ Other: _____

Do the following worsen the pain?

- ❑ Pressure
- ❑ Cold
- ❑ Heat
- ❑ Exercise
- ❑ Other: _____

CHINESE MEDICINE DIAGNOSIS

The following sections will be used in your Chinese Medicine diagnosis. Please check all that apply.

OVERALL TEMPERATURE (kidney function):

- ❑ Sweaty feet
- ❑ Hot body temp. (sensation)
- ❑ Cold body temp. (sensation)
- ❑ Afternoon flushes
- ❑ Night sweats
- ❑ Heat in hands, feet, or chest
- ❑ Hot flashes any time of day
- ❑ Thirsty
- ❑ Perspire easily
- ❑ Lack of perspiration
- ❑ Take water to bed

OVERALL ENERGY (lung/kidney function):

- ❑ Shortness of breath
- ❑ Low energy
- ❑ Difficulty keeping eyes open during day
- ❑ Feel worse after exercise
- ❑ General weakness
- ❑ Easily catch colds

OVERALL BLOOD:

- ❑ Dizziness
- ❑ See floating black spots

HEART FUNCTION:

- ❑ Palpitations
- ❑ Anxiety
- ❑ Sores on tip of the tongue
- ❑ Restlessness
- ❑ Mental confusion
- ❑ Chest pain traveling to shoulder
- ❑ Frequent dreams
- ❑ Wake unrefreshed

CHINESE MEDICINE DIAGNOSIS (continued)

LUNG FUNCTION:

- ❑ Coughs
- ❑ Nose bleeds
- ❑ Sinus congestion
- ❑ Dry mouth
- ❑ Sadness
- ❑ Dry throat
- ❑ Dry nose
- ❑ Dry skin
- ❑ Sore throat
- ❑ Difficulty breathing
- ❑ Sneezing
- ❑ Achy feeling
- ❑ Stiff neck
- ❑ Stiff shoulders
- ❑ Melancholy
- ❑ Alternative Fever/Chills
- ❑ Nasal Discharge / Color: _____
- ❑ Allergies / To what?:_____
- ❑ Headache / Location:_____
- ❑ Smoke cigarettes / # per day:_____

SPLEEN FUNCTION:

- ❑ Low appetite
- ❑ Abrupt weight gain
- ❑ Abrupt weight loss
- ❑ Abdominal bloating
- ❑ Gurgling noise in stomach
- ❑ Abdominal gas
- ❑ Prolapsed organ
- ❑ Fatigue after eating
- ❑ Easily bruised
- ❑ Hemorrhoids
- ❑ Pensive
- ❑ Worry
- ❑ Over-thinking

STOOL:

- ❑ Loose
- ❑ Constipated
- ❑ Incomplete
- ❑ Diarrhea
- ❑ Blood in stools
- ❑ Mucous in stools
- ❑ Undigested food in stools

DAMPNESS TRAPPED IN BODY:

- ❑ Mental heaviness
- ❑ Mental sluggishness
- ❑ Mental fogginess
- ❑ Generation sensation of heaviness in body
- ❑ Swollen hands
- ❑ Swollen feet
- ❑ Swollen joints
- ❑ Chest congestion
- ❑ Nausea
- ❑ Snoring

STOMACH FUNCTION:

- ❑ Large appetite
- ❑ Bad breath
- ❑ Mouth (canker) sores
- ❑ Burning sensation after eating
- ❑ Heartburn
- ❑ Acid regurgitation
- ❑ Ulcer (diagnosed)
- ❑ Bleeding, swelling, or painful gums
- ❑ Belching
- ❑ Hiccups
- ❑ Stomach pain
- ❑ Vomiting

EYES (liver function):

- ❑ Itchy
- ❑ Bloodshot
- ❑ Hot
- ❑ Dry
- ❑ Watery
- ❑ Gritty
- ❑ Blurry vision
- ❑ Decreased night vision
- ❑ Near-sighted
- ❑ Far-sighted

CHINESE MEDICINE DIAGNOSIS (continued)

LIVER, GALL BLADDER FUNCTION:

- ❑ Frustration
- ❑ Depression
- ❑ Irritability
- ❑ Skin rashes
- ❑ Chest pain
- ❑ Anger easily
- ❑ Alternating diarrhea/ constipation
- ❑ Headache at top of head
- ❑ Tight sensation in chest
- ❑ Bitter taste in mouth
- ❑ Tingling sensation
- ❑ Numbness
- ❑ Muscle spasms
- ❑ Muscle twitching
- ❑ Muscle cramping
- ❑ Seizures
- ❑ High-pitched ringing in ears
- ❑ Gall stones (history or current)
- ❑ Convulsions
- ❑ Lump in throat
- ❑ Neck tension
- ❑ Drink alcohol
- ❑ Shoulder tension
- ❑ Limited range-of-motion, neck
- ❑ Limited range-of-motion, shoulder
- ❑ Recreational drugs

KIDNEY, URINARY BLADDER FUNCTION:

- ❑ Frequent cavities
- ❑ Easily broken bones
- ❑ Sore knees
- ❑ Weak knees
- ❑ Cold sensation in the knees
- ❑ Low back pain
- ❑ Memory problems
- ❑ Excessive hair loss
- ❑ Low-pitched ringing in ears
- ❑ Kidney stone
- ❑ Bladder infections
- ❑ Wake during night to urinate
- ❑ Lack of bladder control
- ❑ Fear
- ❑ Easily startles

URINATION:

- ❑ Normal color
- ❑ Dark yellow
- ❑ Clear
- ❑ Reddish
- ❑ Cloudy
- ❑ Scanty
- ❑ Profuse
- ❑ Strong color
- ❑ Burning
- ❑ Painful
- ❑ Painful
- ❑ Discharge
- ❑ Difficult
- ❑ Urgent
- ❑ Frequent

LIBIDO:

- ❑ Normal
- ❑ High
- ❑ Low

MEN ONLY:

- ❑ Swollen testes
- ❑ Testicular pain
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Feeling of cold/numbness in genitalia
- ❑ Other _____

CHINESE MEDICINE DIAGNOSIS (continued)

WOMEN ONLY:

Regular menstrual cycle?: [Y] or [N] Age of 1st menstruation:_____ Number of Children:_____

Average number days of flow:_____ Vaginal discharge: [Y] or [N] Pregnant?: [Y] or [N]

Number of Pregnancies:_____ Age of menopause (if applicable): _____

Average number days in entire cycle:_____ Bleeding in between periods?: [Y] or [N]

Do you experience any of the following pre-menstrual symptoms:

- ❑ Nausea
- ❑ Food cravings
- ❑ Depression
- ❑ Vomiting
- ❑ Headaches/Migraines
- ❑ Irritability
- ❑ Water retention
- ❑ Anxiety
- ❑ Breast swelling
- ❑ Breast tenderness
- ❑ Other emotion, _____
- ❑ Dull pain, where? _____
- ❑ Sharp pain, where? _____

Please fill out the following menstrual chart	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/Cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

MEDICATIONS, VITAMINS, & SUPPLEMENTS

Please list all medications, vitamins and supplements taken in he chart below:

Date Started	Name	Reason for Taking	Dosage	Quantity	Freq.

LIFESTYLE & DIET

Avg # Hours of Sleep per Night: _____ Avg # Times Awakened at Night: _____

	Meals Eaten at Home	**Meals Eaten Out**
Meal:	**Avg # Meals per Week / Typical Meal**	**Avg # Meals per Week / Typical Meal**
Breakfast	_____	_____
Lunch	_____	_____
Dinner	_____	_____
Snacks	_____	_____

Beverage:	**Avg # per Day**	**Beverage:**	**Avg # per Day**
Water	_____	Juice	_____
Coffee	_____	Mile	_____
Tea	_____	Alcohol	_____
Soda	_____	Vegetables (#servings)	_____

Are there foods you avoid because they don' t make you feel good?

_____

_____

_____

_____

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COLORADO MANDATORY DISCLOSURE STATEMENT

Education:

Master's Degree in Traditional Chinese Medicine, *Five Branches University* - 2009

- Four year program
- More than 3200 hrs of education
- Over 1000 clinical hrs
- 200 hr Tuina Massage Certificate from Five Branches University
- 240 hr Five Element Acupuncture Certificate from Five Branches

Bachelor's of Science in Nutrition, *Indiana University* - 2004

Licensed Acupuncturist in the state of:

- Colorado
- California

None of these memberships or licenses has ever been suspended or revoked.

Certifications:

- Certified as a Diplomate in Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) -2010
- Certified by the Council of Colleges of Acupuncture and Oriental Medicine in Clean Needle Technique -2007

Professional Memberships:

- California State Oriental Medicine Association (CSOMA)
- American Association of Acupuncture and Oriental Medicine (AAAOM)
- National Acupuncture Detox Association (NADA)

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health and Environment, including the proper cleaning and sterilization of needles used in the practice of acupuncture and sanitation of the acupuncture office. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule:

- Intake Consultation and Treatment ..... $120 + cost of herbs
- Follow-up Treatment ..... $85 + cost of herbs
- Herbal Consultation only $70
- Acupuncture Consultation and Treatment $90
- Follow-up Acupuncture Treatment $70

Cancellation Policy:

The clinic has a 24 hour cancellation policy. If a cancellation is made within 24 hours a charge of $70 will be collected before the following appointment can be made. Discretion on the part of the practitioner will be used.

Patient's Rights:

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the 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 the Director of the Division of Registrations.
- I am trained and experienced in the recommendation and application of adjunctive therapies and herbs as defined by traditional oriental medical concepts.

The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies. If you have questions, comments, or concerns contact:

Director, Division of Registrations Acupuncturist Licensure
1560 Broadway, Suite 1350
Denver, CO 80202
Phone: (303)894-7800

Your signature below is acknowledgment that you have reviewed a copy of our Colorado Mandatory Disclosure Statement.

_____ _____
Patient or Guardian's Signature Date

_____
Printed Name

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Enliven Acupuncture LLC respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, and treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations.

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services including:
    - medical quality review by your health plan;
    - accounting, legal, risk management, and insurance services;
    - audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights:

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you.

You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant this request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy
- Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing.
- Ask us to change your health information. You may give us this request in writing.
- You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records;
- When you request, we will give you a list of disclosures of your health information.
- The list will not include disclosure to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months;
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing;
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact us at (970) 403-5898

Our Responsibilities; we are required to:

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of the Notice by calling and asking for it or to pick one up.

To ask for Help, have any questions or comments:

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact us at (970) 403-5898.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to our practice/health care facility. You may also file a complaint with the U.S. Secretary of Health and Human Services.

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

Enliven Acupuncture LLC

Your signature below is acknowledgment that you have reviewed a copy of our Notice of Privacy Practices.

_____ _____

Patient or Guardian's Signature Date

_____

Printed Name

_____ _____

Witness/Staff Member Date

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ACUPUNTURE INFORMATION & INFORMED CONSENT

Acupuncture is performed by the insertion of **PRE-STERILIZED, DISPOSABLE** acupuncture needles through the skin and/or the application of heat or electrical stimulation to the skin, or both, at certain points on the body. The benefits and risks of receiving acupuncture and Chinese Medical treatment have been explained to me. Although rare, certain side effects may result from Acupuncture.

I understand that each procedure or treatment has specific risks and benefits. I acknowledge that no guarantees have been made to me as to the results of treatment or examination by Enliven Acupuncture LLC.

I have been informed of the risk and benefits of the procedures and products listed below that apply to my treatment. Acupuncture needles to stimulate points and meridians, including the specific risks of needling certain points. The use of mechanical, magnetic or electrical stimulation of acupuncture points, moxibustion, herbs, acupressure, massage, and nutrition and food therapies.

I have been informed of the risks and benefits of the procedures and products listed below:

1) Minor bruising
2) Needle sickness
3) Broken needles
4) Some pain at the site of needle-insertion
5) Infection
6) Risks from needling in the vicinity of an infection
7) Burns from moxibustion or heat lamp
8) "Sha" red or purple discoloration of the skin (similar to a bruise) which may remain for 1 to 7 days.
9) Potential side effects of nutritional supplements and herbs.

Your signature below is acknowledgment that you have reviewed a copy of our Informed Consent.

_____ _____

Patient or Guardian's Signature Date

_____

Printed Name