Anne Van Druten, Licensed Acupuncturist

Health History Questionnaire

Name ____ Date _______

Sex M / F (circle one) Date of Birth _____________ Age ______

Address ____

City ____________________________________ State ______________ Zip Code __________

Phone (cell)_____________________ (home) _____________________ (work) _____________________

Email Address ____

Height ________________ Weight ______________

Occupation ______________________________________ Employer ___________________________________

Emergency Contact/relationship to you ____

Emergency Contact telephone ____

Relationship Status (Circle One):

Single / Married / Separated / Divorced / Widowed / Living with partner / Other

Physician ______________________________ Physician's Phone # __________________________________

Emergency Contact Name ______________________ Emergency Contact Phone __________________________

Referred By ____

Have you been treated by Acupuncture or Oriental Medicine Before? No / Yes, Date ___ /___ /___

What is your main complaint today? ____

____

When did this problem begin? (Please be specific) ____

____

What treatments have you tried already? What were the results?____

____

Have you been given a diagnosis for this problem? If so, what? ____

To what extent does this problem interfere with your daily activities? (work, sleep, eating...) __________________

____

How severe is your problem right now? (Please mark the scale below)

I____I____I

No problem Moderate Worst Imaginable

What's the most severe level you have endured within the last week? (Please mark the scale below)

I____I____I

No problem Moderate Worst Imaginable

Past Medical History

Cancer___	Hepatitis___	Thyroid Disease___
High Blood Pressure___	Stroke___	Allergies___
Diabetes___	Seizures___	Pace Maker___
Heart Disease___	Rheumatic Fever ___	Other___

Surgeries (type and date)____

Significant Trauma (auto accidents, falls, etc.)____

____

Significant Dental Work (type and date) ____

Your Birth (prolonged labor, forceps delivery, caesarian section, other)____________________________________

____

Allergies (drugs, chemicals, foods, animals)____

Anne Van Druten, Licensed Acupuncturist

Family Medical History

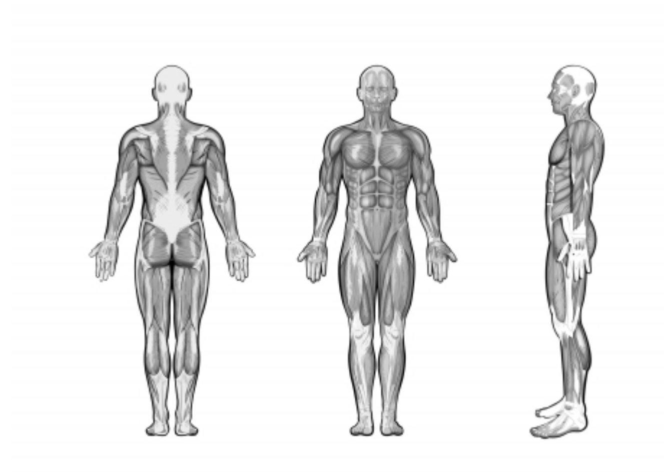
High Blood Pressure___
Heart Disease___
Arteriosclerosis___
Stroke___
Alcoholism___
Cancer___
Seizures___
Asthma___
Diabetes___

Occupational Stress (chemical, physical, psychological, etc.)____

Do you exercise regularly? Y or N Please describe____

Comments (please list any other problems you would like to discuss)____

Indicate Painful or Distressed Areas Below



Anne Van Druten, Licensed Acupuncturist

Please check any boxes of symptoms you have had in the past month

General
Chills___
Fevers___
Sweat easily___
Night sweats___
Localized weakness___
Bleed or bruise easily___
Peculiar tastes or smells___
Strong thirst (cold/hot)___
Thirst, no desire to drink___
Fatigue___
Sudden energy drop
*Time of day?*____________
Edema___
*Where?*________________
Poor sleeping___
Tremors___
Poor balance___
Cravings___
Change in appetite___
Poor appetite___
Weight change___
*Gain / Loss?*____

Skin & Hair
Rashes___
Itching___
Change in hair or skin__
Ulcerations___
Eczema___
Oozing skin lesion___
Hives___
Pimples___
Recent moles___
Loss of hair___
Dandruff___
Other hair or skin problems?________________

Head, Eyes, Ears, Nose & Throat
Dizziness___
Migraines___
Headaches___
*When?*__________________
*Where?*_________________
Facial Pain___
Poor Vision___
Color blindness___
Spots in front of eyes___
Eye pain___
Eye strain___
Cataracts___
Eye Dryness___
Excessive tearing___
Discharge from eyes___
Poor hearing___
Ringing in ears___
Earaches___
Discharge from ear___
Nose bleeds___
Sinus congestion___
Nasal drainage___
Grinding teeth___
Teeth problems___
Jaw clicks___
Concussions___
Recurrent sore throats___
Hoarseness___
Sores on lips/tongue___

Cardiovascular
High blood pressure___
Low blood pressure___
Chest discomfort/pain___
Heart palpitations___
Cold hands or feet___
Swelling of hands___
Swelling of feet___
Blood clots___
Fainting___
Difficulty in breathing___
Other heart/blood vessel problems: ________________

Respiratory
Cough___
Asthma/wheezing___
Difficulty in breathing when lying down___
Phlegm___
*Color?*__________________
Coughing blood___
Pneumonia___
Bronchitis___
Other respiratory problems_________________

Gastrointestinal
Bad breath___
Nausea___
Vomiting___
Heartburn___
Belching___
Indigestion___
Diarrhea___
Constipation___
Chronic laxative use___
Blood in stools___
Black stools___
Abdominal pain/cramps___
Gas___
Rectal pain___
Hemorrhoids___
Other stomach or intestinal problems?________________
____

Genito-Urinary
Pain on urination___
Urgency to urinate___
Frequent urination___
Blood in urine___
Decrease in flow___
Dribbling___
Kidney stones___
Impotency___
Change of sexual drive___
Sores on genitals___
Do you wake to urinate?
Y / N
*How often?*______________
What color is your urine?___________________
Other genital or urinary system problems?__________

Pregnancy and Gynecology
\# of pregnancies___
\# of births___
\# premature births___
\# of miscarriages___
\# of abortions___
Age at first menses___
Length of full cycle___
Length of menses___
Last menses start date:
______/______/______
Last Pap smear:
______/______/______
Clots___
Heavy periods___
Light periods___
Painful periods___
Irregular periods___
Changes in body/psyche prior to menstruation___
Menopause___
Age:
Year:
Post-coital bleeding___
Vaginal sores___
Breast lumps___
Nipple discharge___
Do you practice birth control?
Y / N
*What type and for how long?*_____________
____

Musculoskeletal
Neck pain___
Shoulder pain___
Back pain___
Elbow pain___
Hand/wrist pain___
Hip pain___
Knee pain___
Foot/ankle/heel pain___
Muscle pain___
Muscle weakness___
Other pain?_______________
____
____

Neuropsychological
Seizures___
Areas of numbness___
Weakness___
Sleep disorder___
Concussion___
Violence potential___
Vertigo___
Lack of coordination___
Bad temper___
Depression___
Easily stressed___
Loss of balance___
Poor memory___
Anxiety___
Substance abuse___
Have you ever been treated for emotional problems?
Y / N

Diet

Please give a general description of the food you eat during a "typical" day.

Morning: ____

Afternoon: ____

Evening: ____

Before bed: ____

Between meals: ____

Medicine

Please list all medications you are taking, and for what condition. Please include prescriptions, vitamins, over-the-counter, etc):

Medicine	**For what condition**
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, essential oils and nutritional counseling.

I understand that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risk may occur.

I do not expect the clinical staff to be able to anticipate and explain al possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all y records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature____ Date___________________

CANCELLATION POLICY

I ask for 24 hours notice in advance of an appointment, if it is necessary to cancel or reschedule that appointment. You can do this by calling, texting or emailing me. All appointments that are rescheduled or cancelled with less than 24 hour advance notice and appointments missed without notice will be charged a $30 fee. Thank you for understanding. By signing below, you agree to this policy.

Signature____ Date___________________

Anne Van Druten, Licensed Acupuncturist

MANDATORY DISCLOSURE FORM

Colorado Community Acupuncture
Anne Van Druten, Dipl. Acup., MS, L.Ac.
1101 Village Rd, Ste UL-4D, Carbondale, CO 81623
970-510-0357

Education, Certification and Experience:

Anne Marie Van Druten earned her Bachelor of Professional Studies and Master of Science in Acupuncture degrees from the Swedish Institute in NYC in 2008. This three-year program consists of hundreds of acupuncture treatments at the school clinic. She was certified as a Diplomate in Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in 2009. This includes certification in Clean Needle Technique. In August of 2007, she traveled to Beijing, China where she observed Chinese Doctors of Acupunctaure and their administration and treatment of patients. She also trekked the 11,000 feet pilgrimage of the Emei Mountain in Sichuan Province, China. In 2009 she furthered her studies with a 1-year long course in Chinese Dietary therapy with Jeffrey Yuen. She is a licensed acupuncturist in the state of Ohio and Colorado and a member of the American Acupuncture Council.

Anne is trained and experienced in the recommendation and application of adjunctive therapies such as moxibustion, cupping and auriculotherapy. She received her BS in Fashion Merchandising from The Ohio State University in 2003. None of these licenses, certificates or registrations has ever been suspended or revoked.

Clinic Fee Schedule (payment is due at time of service):

Service	Fee
New Patient Evaluation & Treatments (90 minutes)	Sliding scale $40 - $60
Established Patient Treatment (75 minutes)	Sliding scale $30 - $50
Aroma Touch® Essential Oil Application (40 minutes)	$50
Cupping Only (30 minutes)	$40

Patient's Rights:

- Patients are entitled to receive information about the methods of therapy, techniques used, and the duration of therapy, if known.
- Patients may seek a second opinion from another health care professional and may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported immediately to the Director of the Division of Registrations in the Department of Regulatory Agencies.

This clinic complies with all rules and regulations promulgated by the Colorado Department of Public Health, including the proper cleaning and sterilization of needles and the sanitation of the acupuncture office. The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies. Any complaints should be directed to:

Director of Professions and Occupations
Acupuncturist Licensure
1560 Broadway, Suite 1350 Denver, CO, 80202
Telephone: 303.894.7800

______________________________________ ____________________

SIGNATURE OF PATIENT DATE

Anne Van Druten, Licensed Acupuncturist

Colorado Community Acupuncture
1101 Village Rd., Ste. UL-4D. Carbondale, CO 81623
www.CoCommunityAcupuncture.com

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

This notice describes how your health information may be used and disclosed. Please Review it carefully.

Your Rights

You have certain rights with respect to your health information, subject to legal limitations, including:

- Obtaining an electronic or paper copy of your record. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Asking us to correct incorrect or incomplete information. We may say "no," but if we do, we'll tell you why in writing within 60 days.
- Requesting confidential communications or asking us to contact you in a specific way (e.g., home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- Asking us to limit what we use or share for treatment, payment, or our operation. We are not required to agree to your request, and we may say "no." If, however, you pay for a service or item out-of-pocket in full, you can request that we not share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Obtaining a list (accounting) of those with whom we've shared your information for six years prior to the date you ask, who we shared it with, and why. The list will not include disclosures for treatment, payment, and health care operations, and certain other disclosures (e.g. made at your request). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for additional accountings.
- Obtaining a paper copy of this notice at any time, even if you agreed to receive the notice electronically.
- Designating someone to act for you. If you have a medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act on your behalf before we take any action.
- Filing a complaint if you feel we have violated your rights by contacting: Privacy Officer, 725 Lincoln Ave., Carbondale, CO 81623, 917-583-7710, or annev.wellness@gmail.com; or U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Ave, S.W.,Washington, D.C. 20201, 1-877-696-6775, www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against anyone for filing a complaint.

Your Choices

- You have the right and choice to have us share information with family, friends, or others involved in your care; share information in a disaster relief situation; or include your information in a hospital directory.
- We will not sell your information or share it for marketing unless you give us written permission. We may, however, contact you for fundraising efforts, but you can tell us not to contact you again.
- We will not share psychotherapy notes unless you give us written permission.

If you are not able to tell us your choice, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

We can use your health information and share it with others for treatment, payment, and health care operations. This includes sharing information with others who are treating you, to bill and get paid, and to run our practice and improve care.

We are also allowed or required to share your information in other ways, such as:

- Providing you with information related to your health;
- Contacting you regarding appointments, treatment alternatives, or other health related services;
- Incidental uses or disclosures (e.g., listing your name on a sign-in sheet, etc.);
- Compliance with all laws (including reports of adverse reactions, suspected abuse, neglect or violence);
- Providing information to law enforcement or correctional institutions;
- Providing information to a coroner, medical examiner, funeral director, or for organ procurement;

- Public health activities when requested by a public health authority or the FDA.
- Responding to health oversight agencies;
- Responding to court or administrative orders, subpoenas, discovery requests or lawful process;
- Research activities;
- When necessary to avert a serious threat to health or safety;
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities;
- Providing information regarding your location, general condition or death to disaster relief agencies;
- Providing information for workers' compensation claims; or
- Informing a family member, other relative, or close personal friend when:
    - Information is relevant to the individual's involvement with your care;
    - Notification of your location, general condition or death;
    - To assist in your heath care (pick-up prescriptions or documents, follow-up care instructions etc.).

Our practice will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing.

Our Responsibilities
We are required to maintain the privacy and security of your protected health information and to let you know promptly if a breach occurs that may compromise the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us in writing that we can. If you tell us we can, you may change your mind at any time, but please let us know in writing if you change your mind.

Changes to the Terms of this Notice
We reserve the right to change the terms of this notice. The newly effective notice will be posted in our office, on our website, and will be available upon request. This Notice is effective September 23, 2013.

For more information see: *www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.*

Patient Acknowledgement
I acknowledge receiving a copy of this notice regarding the use and disclosure of my health information.

____ _______________________________
***Signature* of Patient/Legal Guardian** **Date**

____ ____
Print Patient name (required) **Print Legal Guardian name (if necessary)**

INTERNAL PRACTICE USE ONLY: ____ refused to sign.

____ ________________________________
***Signature* of Practice Representative** **Date**