BOULDERBODYWORKS

Acupuncture Health History Questionnaire

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held in absolute confidentiality. If you have questions, please ask.

First Name:		Last Name:		Email:	
Cell:( )		Home:( )		Work: ( )	
Street:		City:		State:	Zip:
Weight:	Height:	Gender:	Pronouns:	Age:	Date of Birth:
Occupation:				Marital Status:	
Family Physician:		Check here, if you do not want to receive texts from us:			
In Emergency Notify:		Tel. No.: ( )			
Referred By:					
Have you been treated by acupuncture before?					
Main concern(s) with which you would like help:					
Condition or Disease:					
How long ago did this condition begin (be specific)?					
To what extent does this condition interfere with your daily activities (work, sleep, sex, etc.)?					
Have you been given a diagnosis for this condition?					
What kind of treatment have you tried?					
Past Medical History (please include dates):					
Significant Illnesses: Cancer, Diabetes, Hepatitis, High Blood Pressure, Heart Disease, Rheumatic Fever, Thyroid Disease, Seizures, Venereal Disease					

Surgeries:
Significant Trauma (auto accidents, falls, etc.)
Birth History (prolonged labor, forceps delivery, etc.):
Allergies (drugs, chemicals, foods):

Family Medical History
☐ Diabetes ☐ Cancer ☐ High Blood Pressure ☐ Seizures ☐ Asthma ☐ Allergies ☐ Stroke ☐ Heart Disease
Occupation:
Occupational Stress (chemical, physical, physiological): Do you have a regular exercise program? Please describe:
Current Medications (Please include vitamins, over-the-counter drugs, supplements and herbs):

Are you now or have you ever been on a restricted diet? _____ What kind? _____

Please describe your average daily diet:

Morning: Afternoon: Evening:

How many packs of cigarettes a day do you smoke? _____

How much coffee, tea or cola do you drink per week? _____

How much alcohol do you drink per week? _____

Please describe any use of drugs for non-medical purposes:

Menstruating Person:

How often do you menstruate?

For how many days do you bleed?

Is your flow light, moderate or heavy?

Do you have menstrual cramps?
If so, are they mild, moderate or severe?

Post-menopausal Person:
At what age did you stop menstruating?

Please list any issues you might have had associated with menopause.

General

- ☐ Poor Appetite
- ☐ Fever
- ☐ Sweat Easily
- ☐ Localized Weakness
- ☐ Bleed or Bruise Easily
- ☐ Peculiar Tastes or Smells
- ☐ Sudden Energy Drop (What time of day?) _____
- ☐ Poor Sleeping
- ☐ Chills
- ☐ Tremors
- ☐ Poor Balance
- ☐ Weight Loss
- ☐ Strong Thirst (cold or hot drinks)
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight Gain

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in Hair or Skin Texture
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of Hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent Moles

Any Other hair or skin problems?_____

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor Vision
- ☐ Cataracts
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Grinding Teeth
- ☐ Teeth Problems
- ☐ Concussions
- ☐ Eye Strain
- ☐ Night Blindness
- ☐ Blurry Vision
- ☐ Poor Hearing
- ☐ Nose Bleeds
- ☐ Facial Pain
- ☐ Jaw Clicks
- ☐ Migraines
- ☐ Eye Pain
- ☐ Color Blindness
- ☐ Earaches
- ☐ Spots in Front of Eyes
- ☐ Recurrent Sore Throats
- ☐ Sores
- ☐ Headaches (Where and When?)_____

Any other head or neck problems?_____

Cardiovascular

- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Cold Hands or Feet
- ☐ Blood Clots
- ☐ Low Blood Pressure
- ☐ Dizziness
- ☐ Swelling of the Hands
- ☐ Phlebitis
- ☐ Chest Pain
- ☐ Fainting
- ☐ Swelling of the Feet
- ☐ Difficulty in Breathing

Any other heart or blood vessel problems?_____

Respiratory

☐ Cough ☐ Coughing Blood ☐ Chest Pain
☐ Bronchitis ☐ Pneumonia ☐ Pain with a Deep Breath
☐ Difficulty in Breathing when Lying Down
☐ Production of Phlegm (What color?)

Any other lung problems?_____

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Diarrhea
☐ Constipation ☐ Gas ☐ Belching
☐ Black Stools ☐ Blood in Stools ☐ Indigestion
☐ Bad Breath ☐ Rectal Pain ☐ Hemorrhoids
☐ Abdominal Pain or Cramps
☐ Chronic Laxative Use

Any other problems with your stomach or intestines?_____
_____

Genito-Urinary

☐ Pain on Urination ☐ Frequent Urination ☐ Blood in Urine
☐ Urgency to Urinate ☐ Unable to Hold Urine ☐ Kidney Stones
☐ Decrease in Flow ☐ Impotence ☐ Sores on Genitals

Do you wake up to urinate?_____ If so, how many times?_____
Any particular color to your urine? _____
Any other problems with your genital or urinary system?_____
_____

Pregnancy and Gynecology

____ Number of pregnancies ____ Number of Births ____ Premature Births
____ Miscarriages ____ Abortions ____ Age at first Menses
____ Period between menses ____ Duration _____First date of last menses

☐ Unusual Character (Heavy or Light)
☐ Painful Periods ☐ Clots ☐ Last PAP
☐ Vaginal Discharge ☐ Vaginal Sores ☐ Breast Lumps
☐ Changes in body / psyche prior to menstruation

Do you practice birth control?_____. What type and for how long?_____
Are you currently trying to conceive? _____

Musculoskeletal

☐ Neck Pain ☐ Muscle Pains ☐ Knee Pain
☐ Back Pain ☐ Muscle Weakness ☐ Foot / Ankle Pains
☐ Hand / Wrist Pains ☐ Shoulder Pain ☐ Hip Pain

Are you currently training for an athletic event? _____
_____

Are you or have you been a competitive athlete?_____
_____

Neuropsychological

☐ Seizures ☐ Dizziness ☐ Loss of Balance
☐ Areas of Numbness ☐ Lack of Coordination ☐ Poor Memory
☐ Concussion ☐ Depression ☐ Anxiety
☐ Bad Temper ☐ Easily Susceptible to Stress

Have you ever been treated for depression or anxiety?_____
_____

Have you ever considered or attempted suicide?_____

Comments (please tell me any other concerns that you would like to discuss):

Cancellation Policy

For **Monday** appointments, we require that you notify us by **12PM** on the **previous Friday** to make any changes or cancellations. Changes made later than **12pm** on the **previous Friday** for a Monday appointment will be subject to the full fee of the service you were booked for.
_____Initial
For **Tuesday-Saturday** appointments, we require a full **48 hours' notice** for any cancellations or schedule changes. You will be charged the full fee if you miss, cancel or change your scheduled appointment with less than **48 hours' notice for Tuesday-Saturday appointments**.
_____Initial
We are closed on the following **Holidays**: New Years, Memorial Day, July 4, Labor Day, Thanksgiving, and Christmas. If you are scheduled to come in the day after one of these holidays, we require that you notify us by **12PM** the **previous business day** to cancel or make any schedule changes. Changes made later than **12PM the previous business day** for an appointment scheduled after a Holiday will be subject to the full fee of service you were booked for. _____Initial

By signing this cancellation policy:
I _____ (print your name) agree to pay all charges that are a direct result of my missing or canceling an appointment without appropriate notice. I understand that the credit card on file will be charged for the full amount no earlier than 48-hours after my missed or late cancelled appointment. If I would like to use a different method of payment, I understand that it is my responsibility to contact BoulderBodyworks prior to the 48-hour time frame to provide my preferred method of payment.

Signature: _____ Date: _____

Waitlist Policy

The waitlist policy applies to all classes and appointments except for Comprehensive Manual Therapy with David Schwartz and Orthopedic Manual Therapy with Elizabeth McClain.

If an appointment or space in class becomes available with greater than 24 hours' notice in accordance with your waitlist request, the appointment or class will automatically be booked and you will receive a confirmation of the booking. The cancellation policy will apply to that booking.
If an appointment becomes available with less than 24 hours' notice or after 12pm on a Friday for a Monday, *BBW* will contact all clients on the waitlist with the opening. The first to confirm will be scheduled.
Should you no longer be available for an appointment or class that you requested, it is your responsibility to cancel the reservation in accordance with the cancellation policy.

HIPAA CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFO FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

BIRTHDATE _____ Driver's License # _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

_____

_____

_____

Patient:

X_____ _____ _____

Patient Signature or Legal Representative **Date** **Witness Signature**

Office Use Only:

☐ Accepted _____ _____

☐ Denied Signature Title Date

BOULDERBODYWORKS

Acupuncture Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Chinese Materia Medica by a licensed acupuncturist at *Boulder Bodyworks*. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Chinese Herbs: I understand that substances from the Chinese Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call BoulderBodyworks as soon as possible.*

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed medical physician. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date:_____

Printed Name: _____ **Date of Birth:** _____

BOULDERBODYWORKS

Colorado Mandatory Disclosure Form

Please read the following information. Once your questions have been answered to your satisfaction and you feel you understand this statement, please sign and date below.

Education and Experience

Nina has been practicing Chinese medicine for 30 years. She holds a Master's Degree in Oriental Medicine from Southwest Acupuncture College, where she taught for 12 years, reaching the level of Full Professor and supervising the college's Oncology clinic for many years. In 2008, she took a group of students to study in Harbin, China at a leading university hospital. Prior to that, Nina was part of an integrative Western and complementary medicine clinic, Wellspring For Women, for 8 years.
Nina's specialties include chronic digestive and respiratory illnesses, as well as women's healthcare and a range of acute and chronic internal medicine issues. Her expertise lies in combining acupuncture with Chinese herbal medicine to achieve the best results. Nina brings years of experience and knowledge, as well as deep compassion for her patients, to her practice of Chinese medicine.

BoulderBodyworks complies with the rules and regulations of Colorado's Department of Regulatory Agencies (DORA). Proper sanitation and sterilization of medical equipment and cleaning of the surrounding office are strictly adhered to. Only single-use, disposable, factory-sterilized needles are utilized.

Patient's Rights

The patient is entitled to receive information about the methods of therapy and techniques used, and the suggested duration of therapy, if known.

The patient may seek a second opinion from another health care professional or may terminate treatment at any time.

In a professional relationship, sexual intimacy is never appropriate and should be immediately reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies (DORA). If you have comments, questions, or complaints, contact the Director of the Division of Professions and Occupations - Acupuncturist Licensure, 1560 Broadway, Suite 1350, Denver, CO 80202; Call 303-894-7800 or E-mail dora_acupunctureboard@state.co.us.

I have read and understand this document.

Patient Name _____Date_____
Patient Signatare_____Date_____

Due to the 2019-2020 outbreak of the novel Coronavirus (COVID-19), BoulderBodyworks, LLC is taking extra precautions with the care of every client to include health history review and enhanced sanitation/disinfection procedures in accordance with Boulder, Colorado guidelines.

Symptoms of COVID-19 include:

- ☐ Fever
- ☐ Fatigue
- ☐ Dry Cough
- ☐ Difficulty Breathing

I agree to the following:

- I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced the symptoms listed above WITHIN THE LAST 14 DAYS.
- I affirm that I, as well as all household members, have not been diagnosed with COVID-19 WITHIN THE PAST 30 DAYS.
- I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 WITHIN THE PAST 30 DAYS.
- I affirm that I, as well as all household members, have not traveled outside of the country, or to any city considered to be a "hot spot" for COVID-19 infections WITHIN THE PAST 30 DAYS.

I understand that BoulderBodyworks, LLC cannot be held liable for any exposure to the COVID-19 virus caused by misinformation on this form or the health history provided by each client.

Mask Policy

Treatments with Elizabeth: A KN95 or equivalent mask is required.

Acupuncture, Massage Therapy, Manual Therapy & treatments with David: Mask is optional.

Mask Policy for Pilates: Mask is optional.

By signing below, I agree to each statement above as well as the other details of the waiver and release BoulderBodyworks, LLC from any and all liability for the unintentional exposure or harm due to COVID-19 or any injury occurred while in the studio. BoulderBodyworks, LLC and all instructors and staff members agree to abide by these standards and affirms the same.

(Signature of Client or Guardian): _____ Date: _____