



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: <input type="checkbox"/>		
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:

Please tell me your current **creative outlets**:

General

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

Skin and Hair

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Recent Moles |
| <input type="checkbox"/> Change in Hair or Skin Texture | | |

Any Other hair or skin problems? _____

Head, Eyes, Ears, Nose and Throat

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

Any other head or neck problems? _____

Cardiovascular

- | | | |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Swelling of the Hands | <input type="checkbox"/> Swelling of the Feet |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty in Breathing |

Any other heart or blood vessel problems? _____

Respiratory

- | | | |
|--|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with a Deep Breath |
| <input type="checkbox"/> Difficulty in Breathing when Lying Down | | |
| <input type="checkbox"/> Production of Phlegm (What color?) | | |

Any other lung problems? _____

Gastrointestinal

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Black Stools | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal Pain or Cramps | | |
| <input type="checkbox"/> Chronic Laxative Use | | |

Any other problems with your stomach or intestines? _____

Genito-Urinary

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Urgency to Urinate | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Decrease in Flow | <input type="checkbox"/> Impotence | <input type="checkbox"/> 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

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Unusual Character (Heavy or Light) | <input type="checkbox"/> Clots | <input type="checkbox"/> Last PAP |
| <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Vaginal Sores | <input type="checkbox"/> Breast Lumps |
| <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> 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

- | | | |
|---|--|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Muscle Pains | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Foot / Ankle Pains |
| <input type="checkbox"/> Hand / Wrist Pains | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Hip Pain |

Are you currently training for an athletic event? _____

Are you or have you been a competitive athlete? _____

Neuropsychological

- | | | |
|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bad Temper | <input type="checkbox"/> 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

Cancellation notice: Mon by Fri 10 AM | Tue–Sat 48 hrs | Post-holiday by 10 AM prior business day.

Monday appointments & class reservations:

For Monday appointments or class reservations, please notify us by 10:00 AM on the previous Friday to cancel or make changes. Changes made after 10:00 AM Friday will be charged the full fee of the service/class booked. _____ Initial

Tuesday–Saturday appointments & class reservations:

For Tuesday–Saturday appointments and class reservations, we require 48 hours’ notice for any cancellations or schedule changes. Missed appointments/classes—or changes made with less than 48 hours’ notice—will be charged the full fee of the service/class booked. _____ Initial

Holiday closures & appointments after a holiday:

Our business office is closed on: New Year’s Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day, and Christmas Day. If you are scheduled the day after a holiday, changes or cancellations must be made by 10:00 AM on the previous business day. Changes made after that time will be charged the full fee of the service booked. _____ Initial

Payment Policy (All Sales Final)

All sales are final. We charge the card on file at the start of your session. If you would like to use a different form of payment, you must tell us prior to the start of the session. If we have already run the card on file and you ask us to void the transaction, a 3.75% credit-card processing fee will apply. _____ Initial

Agreement:

By signing below, I, _____ (print name), agree to the terms above. The card on file may be charged the full amount.

Signature: _____ Date: _____



**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



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 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:** _____



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

Andrew J Pollak received his Master of Science in Oriental Medicine from Southwest Acupuncture College in Boulder, CO in August 2017 and his Doctorate of Acupuncture and Chinese Medicine from the American College of Traditional Chinese Medicine in August 2019. The five-year Chinese medical training curriculum included over 3200 hours of didactic and clinical education and over 900 hours of clinical practice. He is certified as a Diplomate of Oriental Medicine with the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), which includes certification in Acupuncture, Chinese Herbology, and Clean Needle Technique. Andrew's training includes adjunct therapies such as moxibustion, East Asian bodywork techniques (Shiatsu), gua sha, electrical stimulation (e-stim), auriculotherapy, and dietary and lifestyle recommendations. Andrew is a licensed acupuncturist in the States of Colorado and Texas and is in good standing with DORA, TMB and NCCAOM. None of these licenses, certificates, or registrations have ever been suspended or revoked.

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 Signature _____ Date _____