

Tui Na Bodywork Intake Form for Meeting Point Community Acupuncture

Full Name	Sex <input type="checkbox"/> F <input type="checkbox"/> M	Date
Date of birth	Age	Occupation
Main phone #	Other phone #	
Email address	May we contact you by email? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address: Street	City	State Zip
Emergency contact: Name	Phone	
How did you learn about us? (if referred please leave name and relationship)		

Main Problem (s): _____

What diagnosis, if any, have you received for this problem? _____
 When did this problem begin? _____ What are the causes of this problem? _____
 To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?

What kind of treatment have you tried? _____
 What makes this problem worse? _____ What makes this problem better? _____
 Is there anybody in your family with the same/similar problems? _____

Medical History

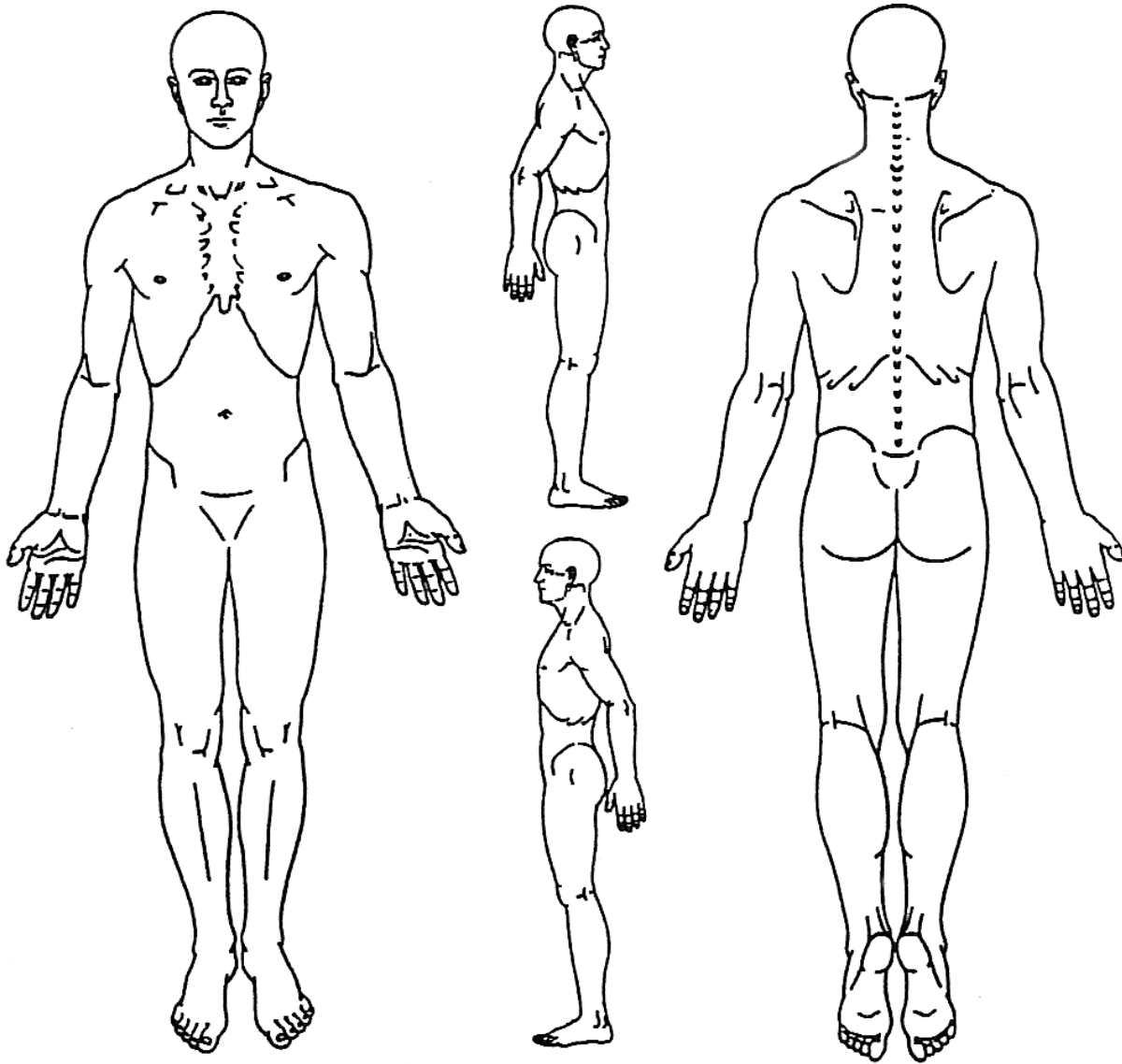
Surgeries: _____
 Significant Trauma: (auto, sports, etc) _____

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type)			Breathing problems			High cholesterol		
Diabetes			Heart Disease			High blood pressure		
Hepatitis			Digestive disorders			Emotional disorders		
Thyroid disease			Venereal disease			Anemia		
Seizures			Alcoholism			Tuberculosis		
Arthritis			Depression or Anxiety			Other		

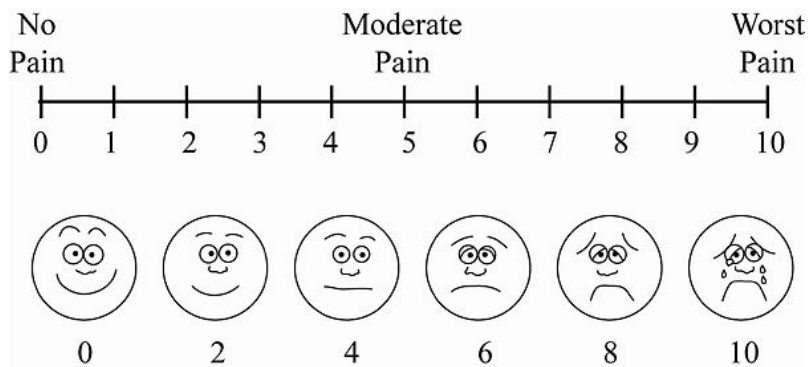
Medication taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

GENERAL PAIN AND DISABILITY INDEX IMAGING

KEY	Use the letters below to indicate the type and location of your sensations right now:				
A = Ache	P = Pins & Needles	B = Burning	S = Stabbing	N = Numbness	O = Other



Please Indicate Pain on Scale by Circling Corresponding Number or Facial Expression:



INFORMED CONSENT TO TREAT & MANDATORY DISCLOSURE FORM

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by James George-Holland (herby referred to as Jamie) who is a licensed acupuncturist, applied clinical nutritionist, & Asian bodywork therapist: acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpitation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual therapy such as Asian bodywork therapy (including: rocking, kneading, pushing, pulling, stretching, rhythmic striking, pressing, rolling, vibrating, grasping, etc...), cupping, moxibustion heat therapy, magnetic stimulation, the application of topical ointments, liniments and lotions; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with my practitioner, or with other personnel, the nature and purpose of acupuncture and Oriental medical procedures, the methods of therapy, the techniques used, and the duration of therapy. Although I am aware that acupuncture and other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied. I understand that I may seek a second opinion from another health care professional or may terminate therapy at any time. I also understand that in a professional relationship, sexual intimacy is never appropriate and should be immediately reported to the Director of the Division of Professions and Occupations in the Department of Regulatory Agencies.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bruising or pain or other strong sensation where the needle is inserted, or at location where bodywork, cupping (which will can leave marks on the skin for up to 1 week), or topical ointment/ lotion/ liniment is applied, or radiating from those locations; nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and genera aches. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgment during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I understand that acupuncture and Oriental medicine treatments may not have the desired therapeutic affect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is reasonable cause to believe that treatment is not appropriate for a patient who is under the influence of illegal drugs, alcohol, or appears to be overly medicated, then a treatment may not be performed at that time. In this case the patient will be informed that they may not be treated at that time and will be requested to reschedule their appointment.

We comply with all rules and regulations promulgated by the Colorado Department of Public Health and Environment, including those related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices. The Colorado Department of Regulatory Agencies, whose contact is as on the right, regulates the practice of acupuncture.

Director of Professions and Occupations
Acupuncturist Licensure
1560 Broadway, Suite 1350
Denver, CO 80202
(303) 894-7800

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask question about its content, and by signing below I agree to the above named procedures and conditions of treatment. 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 with James George-Holland.

Patient's Name (please print)

Patients Signature

Signature of Patient's Representative (if applicable)

Date Signed

Signature Acknowledging Receipt of HIPPA Policy