Groundswell Acupuncture

Welcome to Groundswell Acupuncture. We are thoroughly committed to working with you to enhance your health and wellness. We value your time and realize that office visits may be an interruption to an otherwise very busy schedule for you, and we commit to ensure that your time at our clinic is as focused and efficient as possible.

Enclosed you will find an extensive Patient Health History Questionnaire. This is our first introduction to you and your history. Effective medical healthcare is only possible when the practitioner completely understands the patient's physical, mental and emotional condition.

Chinese medicine is based largely on pattern recognition. Even the smallest details can relate to your overall constitutional picture so no detail is too small. With that in mind, your thoughtful and honest responses will help to determine an appropriate course of treatment specific to you and allow us to use time in the clinic most effectively. All responses are of course bound to the strict rules of doctor-patient confidentiality.

For your first visit please bring:

- An updated list of all medications & supplements you are taking. (space provided on intake form)
- Any lab results or relevant imaging received within the last year.

In general, if you are receiving acupuncture, to receive the most benefit, and to avoid side effects, please adhere to the following:

- Wear loose clothing.
- Have a light meal or snack before the visit, as heavy meals can cause nausea and an empty stomach can be the cause of dizziness or lightheadedness after the treatment.
- Do not drink coffee several hours prior to your appointment and make sure to drink enough water on the day of treatment.
- After your visit, it is preferable that you make the rest of your day as easy as possible. Please avoid heavy exertion. Moderate exercise is okay.
- Do not drink alcohol or use other intoxicating drugs, eat greasy or spicy food, or exercise excessively before or after your appointment.

We look forward to working with you!

801 Florida Rd. • Suite 11 • Durango, Colorado • 81301
970-335-8554
groundswellacu@gmail.com
www.groundswellacupuncture.com

Patient Information

Name _____

Address _____

_____

Home Phone (____) ____ – _____ Cell Phone (____) ____ – _____

Preferred contact number Home ☐ or Cell ☐

Email_____

Would you like to receive news and updates from Groundswell? ☐Email ☐US Post ☐Both

Occupation_____

Date of Birth_____Age_____

Preferred Name (Nickname, chosen, etc.)_____

Gender Identity _____

Emergency contact _____

Emergency contact relationship_____ Emergency contact phone #_____

How did you hear about us? _____

Basic Medical History

What are your most important health concerns? What brings you in today?

1. _____ Onset? _____
2. _____ Onset? _____
3. _____ Onset? _____
4. _____ Onset? _____

When did you last visit a doctor's office, clinic, or hospital? Please explain the circumstances:

_____

Do you currently have a primary care doctor? Y / N

Name: _____ Location:_____ Phone: _____

Are you currently under the care of any other physician/healthcare providers? Please list Name, Location, Phone, & Specialty for Each.

1. _____
2. _____

Are you aware of any allergies to food, drugs, or other environmental allergens (cats, mold, dust)? If yes, please list and explain: _____

What hospitalizations or surgeries have you had? Please include dates and outcome.

_____

_____

What diagnostic imaging studies have you had?

☐ Bone densities scan ☐ Mammogram ☐ Electrocardiogram ☐ Electroencephalogram
☐ X-rays ☐ CT scan ☐ MRI

Do you take any of the following more than once a week?

☐ Pain relievers (aspirin, ibuprofen)
☐ Diet pills, appetite suppressants
☐ Cortisone (cream or pills)
☐ Thyroid medication
☐ Antacids
☐ Laxatives
☐ Tranquilizers
☐ Antibiotics
☐ Sleeping pills
☐ Other: _____

Please list any prescription medications, over-the-counter medications, vitamins, or other supplements you are regularly taking, including dosage and frequency, if possible: _____

_____

_____

When during the day is your energy best? _____ Worst? _____

Your Healing Process

1. What three **expectations** do you have from today's visit to our clinic?

2. What three long-term **goals** do you have from working with our clinic?

3. At this present time, how committed are you to addressing the underlying causes of your signs and symptoms that may relate to your lifestyle? (0= not committed and 10= completely committed). Please circle:

   0 1 2 3 4 5 6 7 8 9 10

4. What types of daily or weekly lifestyle habits do you feel support or strengthen your health?

5. What types of daily or weekly lifestyle habits do you feel do not fully support your health?

6. What do you love doing; what brings you joy?

Basic family medical history

Do you have a family history of any of the following?

☐ Anemia	☐ Diabetes	☐ Hayfever/hives	☐ Liver disease
☐ Arthritis	☐ Epilepsy	☐ Heart disease	☐ Mental illness
☐ Asthma	☐ Gall bladder disease	☐ Heart murmur	☐ Stroke
☐ Cancer	☐ Glaucoma	☐ High blood pressure	☐ Tuberculosis
☐ Cataracts	☐ Goiter	☐ Kidney disease	

Is your father still living? Yes; his age_____ No; his age at time of death _____
Cause of death _____

Is your mother still living? Yes; her age_____ No: her age at time of death_____
Cause of death _____

Traumas

1. Have you ever experienced emotional trauma? ☐ Yes ☐ No ☐Unsure
   ☐ neglected ☐ abandoned ☐ physically abused
   ☐ emotionally abused ☐ sexually abused ☐ separated from your family
   ☐ other (please describe) _____

   Age(s)? _____

2. Have you ever experienced physical trauma? ☐ Yes ☐ No ☐Unsure
   ☐ broken any bones ☐ been injured in an accident ☐ suffered a concussion
   ☐ other (please describe) _____

   Age(s)?_____

Review of Systems

Please circle: Y = Yes, present condition P= Problem of the past

Head

Headaches	Y P N	Migraine headaches	Y P N
Head injury	Y P N	Jaw/TMJ problems	Y P N

Ears

Ringing	Y P N	Dizziness	Y P N
Earaches	Y P N	Impaired hearing	Y P N

Neck

	Lumps	Y P N	Swollen glands	Y P N				
	Goiter	Y P N	Pain or stiffness	Y P N				
Skin								
	Rashes	Y P N	Psoriasis	Y P N	Eczema, hives	Y P N		
	Lumps	Y P N	Acne, boils	Y P N	Color changes	Y P N		
	Itching	Y P N	Loss of hair	Y P N	Night sweats	Y P N		
Musculoskeletal								
	Joint pain	Y P N	Muscle spasms	Y P N	Weakness	Y P N		
	Arthritis	Y P N	Broken bones	Y P N	Sciatica	Y P N		
Eyes								
	Blurred vision	Y P N	Cataracts	Y P N	Glasses/contacts	Y P N		
	Eye pain/strain	Y P N	Glaucoma	Y P N	Tearing/dryness	Y P N		
	Spots in eyes	Y P N	Color blind	Y P N	Double vision	Y P N		
Nose/Sinuses								
	Stuffiness	Y P N	Loss of smell	Y P N	Sinus problems	Y P N		
	Hay fever	Y P N	Nose bleeds	Y P N	Frequent colds	Y P N		
Mouth/Throat								
	Hoarseness	Y P N	Gum problems	Y P N	Freq. sore throat	Y P N		
	Jaw clicks	Y P N	Dental cavities	Y P N	Sore lips/tongue	Y P N		
Respiratory								
	Asthma	Y P N	Wheezing	Y P N	Spitting up blood	Y P N		
	Cough	Y P N	Bronchitis	Y P N	Difficulty breathing	Y P N		
	Sputum	Y P N	Pneumonia	Y P N	Pain with breathing	Y P N		
	Pleurisy	Y P N	Emphysema	Y P N	Shortness of breath	Y P N		
	Tuberculosis	Y P N						
Cardiovascular								
	Angina	Y P N	Chest pain	Y P N	Blood clots	Y P N		
	Murmur	Y P N	Heart disease	Y P N	Rheumatic fever	Y P N		
	Fainting	Y P N	Ankle swelling	Y P N	Low blood pressure	Y P N		
	High Blood Pressure	Y P N						
Gastrointestinal								
	Diarrhea	Y P N	Constipation	Y P N	Changes in thirst	Y P N		
	Ulcers	Y P N	Black stool	Y P N	Coughing up blood	Y P N		
	Jaundice	Y P N	Hemorrhoids	Y P N	Gall bladder disease	Y P N		
	Heartburn	Y P N	Abdominal pain	Y P N	Blood in stool	Y P N		
	Liver disease	Y P N	How many bowel movements per day? _____					
Urinary								
	Incontinence	Y P N	Frequent infections	Y P N	Painful urination	Y P N		
	Kidney stones	Y P N	Frequency at night	Y P N				
Blood/Peripheral Vascular								
	Anemia	Y P N	Cold hands/feet	Y P N	Varicose veins	Y P N		
	Leg pain	Y P N	Easy bruising	Y P N				
Neurological								
	Fainting	Y P N	Paralysis	Y P N	Numbness/tingling	Y P N		
	Seizures	Y P N	Loss of memory	Y P N	Muscle weakness	Y P N		
Emotional								
	Mood swings	Y P N	Nervousness	Y P N	Tension/stressed	Y P N		
	Anxiety	Y P N	Depression	Y P N				
Endocrine								
	Hypothyroid	Y P N	Excessive thirst	Y P N	Cold intolerance	Y P N		
	Hyperthyroid	Y P N	Excessive hunger	Y P N	Heat intolerance	Y P N		

Male Reproductive

Hernias	Y P N	Testicular masses	Y P N	Discharge or sores	Y P N
Prostate issues	Y P N	Sexual difficulty	Y P N	Testicular pain	Y P N
Venereal disease	Y P N	Premature ejaculation	Y P N	Impotence	Y P N

Female Reproductive

Age of first menses_____ Age of last menses (if menopausal) _____

Length of cycle_____ Duration of menses _____

Date of last annual exam _____

Painful menses	Y P N	Endometriosis	Y P N	Ovarian cysts	Y P N
Heavy flow	Y P N	Fertility issues	Y P N	Cervical dysplasia	Y P N
Breasts tender	Y P N	Venereal disease	Y P N	Bleeding between cycles	Y P N
Sexually active	Y P N	Cycles regular	Y P N	Menopausal symptoms	Y P N
Sexual difficulty	Y P N	Abnormal pap	Y P N	PMS	Y P N
Breast lump(s)	Y P N	Nipple discharge	Y P N	Do self breast exams	Y P N
Birth control	Y P N	If yes, what type?_____			

Number of pregnancies_____ Number of live births _____

Number of miscarriages _____ Number of abortions _____

Is there anything else you would like us know in order to serve you better?

_____

_____

I feel that I have answered the above questions to the best of my ability and understand that if I choose to omit any health information I do so at my own risk and that in no way will the healthcare provider be responsible for any omitted information.

X_____ _____

Patient Signature Date

(Or Patient Representative – indicate relationship if signing for patient)

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital administration.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to: quality assessment activities, employee review activities, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Use Required by Law: We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; or for Inmates. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500

Other permitted and Required Uses and Disclosures will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

X_____ _____

Patient *Signature* Date

(Or Patient Representative – indicate relationship if signing for patient)

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (as listed below), or 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 & gua sha, breathing techniques, exercise therapy, Tui-Na (Chinese massage), Chinese or western herbal medicine, essential oils and nutritional counseling**. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including **bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is a possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment.** I understand that I should not make significant movements while the needles are being inserted, retained, or removed. One side effect of cupping and gua sha may **be bruising or temporary skin discoloration**. **Burns and/or scarring** are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I will immediately notify the acupuncturist of any effects associated with the consumption of the herbs.

I will notify the acupuncturist who is caring for me if I am or become pregnant, or I have a bleeding disorder. I will notify the acupuncturist of any significant changes in my health, or new diagnoses by my primary medical physician. I understand that my acupuncturist encourages me to see a primary medical physician in conjunction with acupuncture, and herbal treatments. I do not expect the acupuncturist to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this 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.

_____

Print Name

X_____ _____

Patient Signature (or Representative) Date

_____

(Print Representative)

COLORADO MANDATORY DISCLOSURE STATEMENT

Groundswell Acupuncture LLC.

Education:

- National College of Natural Medicine, Portland, Oregon. 4 years
  Masters Degree of Science in Oriental Medicine
- Pitzer College, Claremont, California, 4 years
  Bachelor of Arts in Anthropology and Art

Certification, Licenses, and Registrations*:

- National College of Natural Medicine
  Shiatsu Certificate, 2014
- Council of Acupuncture and Oriental Medicine
  Clean Needle Technique Certificate, 2013
- National Commission for the Certification of Acupuncture and Oriental Medicine
  Diplomat in Acupuncture, 2014
  *No certification, license or registration ever revoked or suspended

Training and Experience:

- Acupuncture
- Chinese Herbal Medicine
- Moxibustion
- Cupping
- Electric Stimulation
- Acupressure
- Shiatsu
- Essential Oils
- Dietary Therapy
- Qi Gong
- Lifestyle recommendations

Disclosure Statement:

This disclosure is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Title 12 Article 29.5. All rules and regulations set forth by the Department of Public Health and Environment are strictly adhered to by including proper cleaning and sterilization of equipment and office.
The practice of acupuncture is regulated by the Department of Regulatory Agencies. Any complaints should be directed to: Director of Professions and Occupations in the department of Regulatory Agencies,1560 Broadway, Suite 1350, Denver, Colorado 80202, phone (303) 894-7800.

Patients are entitled to receive information about the methods, therapies, techniques used, and duration of therapy, if known. Patients may seek a second opinion and may terminate therapy at any time. In a Professional relationship, sexual intimacy is never appropriate and should be reported to the Director of Registration in the Department of Regulator Agencies.

My training and experience may include the recommendation and application of adjunctive therapies and herbs, as defined by the concepts of traditional oriental medicine.

Fee Schedule (subject to review each January and July):

Initial visit with exam……$110.00
Follow-up visit……$65.00
Missed appointments (less than 24 hour notice)……$25.00

Payment is expected at time of treatment; cash, personal check, or credit card accepted. There is a $5 weekly charge on unpaid balances. All returned checks are subject to a $35 service fee. Herbal prescriptions, patents, or other herbal products are priced separately. I ask you make every effort to notify me as far in advance as possible if you are unable to keep an appointment. I require 24-hour notice for cancellation or above fee is implemented.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Groundswell Acupuncture to release information necessary to secure payment to insurance billers, insurance companies and other related entities.

Signature: X_____ Date:_____