Personal Information

Date_____

Name_____ Age_____

Address_____

City_____State_____Zip_____

Cell phone number_____

Email_____

Date of Birth_____/_____/_____ Marital Status_____

Number of children_____

Occupation_____

Family Physician_____

Person to notify in an emergency_____

Phone number_____

Referred to this office by_____

Confidential Patient History

Reason for seeking care today_____

_____

Please list ALL prescription medications, herbs, or over-the-counter pills you are taking:

Medication	Dosage	For what condition?	For how long?

Please list surgeries, accidents and major illnesses you have had, including dates:_____

_____

Please indicate if anyone in your family has had any of the following:

Cancer_____ Stroke_____ Diabetes_____ High Blood Pressure_____ Seizures_____

Heart Disease_____ Arthritis_____ Asthma_____ Allergies_____ Ulcers_____

Describe your average daily diet:

Breakfast Lunch Dinner

_____ _____ _____

_____ _____ _____

Describe your daily usage of the following:

Coffee, tea_____ Sodas, diet or regular_____

Alcohol_____ Tobacco_____

Recreational drugs_____

Describe your exercise regimen_____

Symptom Review

Put one check by symptoms you sometimes experience, and two checks for those which often occur.

HEAD AND FACE
- ■ Headaches
- ■ Dizziness
- ■ Memory loss
- ■ Other

EYES
- ■ Blurred vision
- ■ Eyelid problems
- ■ Pain
- ■ Red, itchy eyes
- ■ Other

EARS
- ■ Poor hearing
- ■ Earaches
- ■ Discharges
- ■ Ringing
- ■ Other

NOSE
- ■ Frequent colds
- ■ Allergies
- ■ Sinus trouble
- ■ Bleeding
- ■ Other

MOUTH
- ■ Gum problems
- ■ Teeth problems
- ■ Tongue problems
- ■ Lip problems
- ■ Jaw problems
- ■ Sweet tastes
- ■ Bitter tastes
- ■ Bad breath
- ■ Other

THROAT
- ■ Sore throat
- ■ Hoarseness
- ■ Difficulty swallowing
- ■ Frequent strep throat
- ■ Other

RESPIRATION
- ■ Difficulty breathing
- ■ Wheezing/asthma
- ■ Pain
- ■ Cough
- ■ Phlegm
- ■ Other

HEART AND THORAX
- ■ Palpitations
- ■ High blood pressure
- ■ Chest tightness/pain
- ■ Low blood pressure
- ■ Difficulty lying flat
- ■ Other

CIRCULATION
- ■ Bruise easily
- ■ Bleed easily
- ■ Cold limbs
- ■ Other

GASTROINTESTINAL
- ■ Excess thirst
- ■ Never thirsty
- ■ Excess appetite
- ■ Abdominal pain
- ■ Nausea
- ■ Diarrhea
- ■ Constipation
- ■ Hemorrhoids
- ■ Bloating after eating
- ■ Loose stools
- ■ Food allergies
- ■ Other

URINATION
- ■ Frequent
- ■ Difficulty
- ■ Painful
- ■ Nocturnal urination
- ■ Bleeding
- ■ Frequent UTI's
- ■ Other

SKIN
- ■ Rashes
- ■ Dryness
- ■ Moles or lumps that change
- ■ Excess sweat
- ■ Night sweats
- ■ Rarely sweat
- ■ Other

NEUROLOGICAL
- ■ Nervousness
- ■ Tremors
- ■ Convulsions
- ■ Numbness or tingling
- ■ Poor coordination
- ■ Nerve pain or neuralgia
- ■ Other

SLEEP
- ■ Insomnia
- ■ Drowsiness
- ■ Excess dreams
- ■ Other

ENERGY LEVELS
- ■ Low
- ■ High
- ■ Other

DISCLOSURE FORM

Scott Blunk, L.Ac. LLC
2601 S. Lemay Ave #25
Fort Collins, CO 80525
(970) 223-4422

My usual and customary fees are:

Initial Examination	$65
Acupuncture Treatment	$85
Total for new patient initial visit	$150

Education, Experience, Degrees, Certificates and Credentials

Colorado State University BS in Psychology	1976-1980
Pacific College of Oriental Medicine, San Diego, CA Masters of Traditional Oriental Medicine (MTOM)	1996-1999
USCC for TCM Special Study at Shandong University of Traditional Chinese Medicine, Jinan, China	1999

Licenses, Certificates, and Registrations in Acupuncture and Herbology

Council of Colleges of Acupuncture and Oriental Medicine Clean Needle Technique Course	January, 1999
National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Diplomate in Acupuncture (Dipl Ac)	June, 1999
National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Diplomate in Chinese Herbology (Dipl CH)	July, 1999
Certificate of Completion of Study in Acupuncture, Tui Na, and Herbology at Shandong University of Traditional Chinese Medicine, Jinan, China	June, 1999
Registered Acupuncturist in the State of Colorado	July, 1999 to present

Additionally, I have received formal training and had clinical experience at Pacific College of Oriental Medicine in San Diego, CA and in Jinan, China in the following adjunctive therapies:
moxibustion, auricular acupuncture, herbal therapies, cupping, gwa sha, Chinese therapeutic massage (Tui Na), Qi Gong and nutritional counseling.

This office complies with all rules and regulations promulgated by the Colorado Department of Health related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices. This office uses only single-use disposable needles, and disposes of them in a manner consistent with OSHA and Colorado State regulations.

The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies.
Bruce M. Douglas, Director of the Division of Registrations
1560 Broadway, Suite 1545
Denver, CO 80202
(303) 894-2464

Each patient who visits this office is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

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

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

Please read and sign the following:

I UNDERSTAND THAT "NO-SHOWS" OR CANCELING APPOINTMENTS, WITH LESS THAN 24 HOURS NOTICE, MAY KEEP OTHER PATIENTS FROM BEING ABLE TO RECEIVE TREATMENT. A MISSED APPOINTMENT FEE OF $25.00 WILL BE CHARGED, THIS FEE IS THE PATIENT'S RESPONSIBILITY.

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient:

_____ _____
Patient's Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

1. CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.

2. OBTAIN PAYMENT FROM THIRD PARTY PAYERS.

3. CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIANS CERTIFICATIONS.

I HAVE RECEIVED, READ AND UNDERSTAND YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT THIS HEALTH CARE OFFICE HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICE FROM TIME TO TIME AND THAT I MAY CONTACT THIS HEALTH CARE OFFICE AT ANY TIME AT THE ADDRESS ABOVE TO OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVATE PRACTICES.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

PATIENTS NAME _____

RELATIONSHIP TO PATIENT_____

SIGNATURE_____

DATE_____

OFFICE USE: REASON UNABLE TO OBTAIN SIGNATURE_____

_____

INITIALS_____ DATE_____

INSURANCE

If you are here for treatment covered by auto insurance, Workers Compensation or your health insurance, please read and sign below:

I hereby authorize payment of medical benefits directly to Scott Blunk, LAc. LLC for professional services rendered.

_____ _____

Insured patient Date