

Date \_\_\_\_\_

### Personal Information

Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Best daytime phone number \_\_\_\_\_

Cell or home 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 \_\_\_\_\_    Recreational drugs \_\_\_\_\_

Alcohol \_\_\_\_\_    Tobacco \_\_\_\_\_

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	\$55
Follow-up Exam	\$35
Acupuncture Treatment	\$65
Infrared Heat	\$15
Therapeutic Massage	\$35

### Education, Experience, Degrees, Certificates and Credentials

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

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

**Scott Blunk, LAc LLC**  
2601 S. Lemay Ave., Ste. 25  
Ft. Collins, CO 80525  
(970) 223-4422

## PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ⑩ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ⑩ Obtain payment from third-party payers.
- ⑩ Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such **Notice of Privacy Practices** prior to signing this consent. I understand that this organization has the right to change its **Notice of Privacy Practices** at any time and that I may contact this organization at the address above to obtain a current copy.

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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient (circle one):      I am the patient      Representative for the patient

## **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.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date