Date___________________________________

Personal Information

Name____ Age_________

Address____

City_________________________________State______________________Zip____________

Best 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 prescription medications, herbs, or over-the-counter pills you are taking:

Medication	Dosage	For what condition?	How long?

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

____

____

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

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

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	$95
Total initial visit	$160

<u>Education, Experience, Degrees, Certificates and Credentials</u>

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

<u>Licenses, Certificates, and Registrations in Acupuncture and Herbology</u>

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
Graduate McKay Method® Energy Healing System	December 2019

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