Patient Intake Form

Name: Phone: home work

Street cell email

City age ht wt birthdate sex

State Zip occupation referred by

Main problem physician

Other concurrent therapies

Past Medical History (include dates):

Significant illnesses: ___Cancer ___Diabetes ___ High Blood Pressure ___ Heart Disease ___Hepatitis

___ Thyroid Disease___ Seizures ___ Other

Surgeries:

Significant Trauma (auto accidents, falls, etc) _____

Birth History: (Complications or Difficult Labor) _____

Medicines taken in the last 2 months (include vitamins, over the counter, prescribed meds) _____

_____

Exercise: _____

Average Daily Diet:

Morning: Afternoon Evening

Habits: ___ Cigarettes ___Coffee ___Tea ___Cola ___ Alcohol___ Drugs ___ Sugar ___ Salt___ Other

Family Medical History: __Diabetes ___ Cancer ___High Blood Pressure ___Heart Disease

___ Stroke ___Asthma ___ Allergies ___Alcoholism ___ Other_____

Notes:

_____

_____

GENERAL:

___ Poor Appetite ___Heavy Appetite ___Poor Sleep ___Heavy Sleep

___ Insomnia ___Fatigue ___Tremors ___Vertigo

___ Cold Hands ___ Cold feet ___ Fevers ___ Cravings

___ Chills ___ Night Sweats ___ Sweat easily ___ Poor coordination

___ Weakness ___ Strong thirst ___ bleed or bruise easily

SKIN AND HAIR:

___ Rashes ___ Hives ___Itching ___Eczema

___ Pimples ___ Dandruff ___ Loss of hair ___ Change in hair/skin

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HEAD, EYES, EARS, NOSE AND THOAT:

___ Dizziness ___ Concussions ___ Migraines ___ Glasses

___Eye pain/strain ___ Poor vision ___ Color Blindness ___ Night Blindness

___ Ringing in Ears ___ Poor hearing ___ Nose Bleeds ___ Sinus Problems

___ Mucus/Phlegm ___ Gum Problems ___ Spots in Eyes ___ Dry Mouth/Eyes/Mouth

___ Teeth Problems ___ Headaches ___ Herpes ___ Recurrent Sore Throats

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CARDIOVASCULAR:

___ Chest Pain ___ Irreg Heartbeat ___Dizziness ___ High/Low Blood Pressure

___ Blood Clots ___Fainting ___ Phlebitis ___ Difficulty Breathing

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RESPIRATORY:

___ Cough ___Asthma ___Bronchitis ___ Coughing Blood

___ Pneumonia ___ Tight Chest ___ Phlegm ___ Difficulty Breathing

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GASTROINTESTIONAL:

___ Nausea ___ Vomiting ___ Diarrhea ___ Constipation

___ Gas ___ Belching ___ Hemorrhoids ___ Bloody Stools

___ Laxative Use ___ Sensitive Abdomen ___ Smelly Stools ___ Stomach Pain/Cramping

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GENITO-URINARY:

___ Frequent urination ___ Blood in Urine ___Urgency to Urinate ___ Pain with Urination

___ Unable to Hold Urine ___ Kidney Stones ___ Impotency ___ Wake up to Urinate

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PREGNANCY AND GYNECOLOGY:

___ Number of Pregnancies ___ Number of Births ___Premature Births ___Miscarriages

___ Age at First Menses ___ Vaginal Discharge ___ Last PAP ___ Irregular Periods

___ Painful Periods ___ Heavy Periods ___ PMS ___ Menopause

MUSCULOSKETAL:

___ Neck Pain ___ Back Pain ___ Joint pain ___ Shoulder Pain

NEUROPSYCHOLOGICAL:

___ Seizures ___ Poor Memory ___ Numbness ___ Tremors

___ Depression ___ Anxiety ___ Bad temper ___ Considered Suicide

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CLASSICAL:

PREFERENCE	MOST LIKED	LEAST LIKED
SEASON	_____	_____
TASTE	_____	_____
CLIMATE	_____	_____
TIME OF DAY	_____	_____

DO NOT FILL OUT BELOW THIS LINE

CHINA CONNCETION HEALTH CARE CENTER

Bonnie Kenny L.Ac., Dipl., CH

1460 Pierce St

Lakewood CO, 80214

303-238-8160

Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatment by the above named acupuncturist and/or other licensed acupuncturist who now or in the future treat me while employed by, or serving as back-up for the treating acupuncturist named above, including those working at this office/clinic or any other office/clinic.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, massage, Oriental or Western herbal medicine, and nutritional counseling.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising, soreness, and/or tingling near the needling sites that may last a few days. There have been extremely rare instances of fainting, infections, and scaring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy, therefore I will notify that acupuncturist of any suspected pregnancy. If I experience any gastrointestinal upset or allergic reactions I will inform the acupuncturist.

I understand although he acupuncturist will do all that can be done based on education, knowledge, and experience the responsibility of my health care remains up to me.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential.

I have read or have read to me the above consent. I have also had an opportunity to ask questions about its content by the acupuncturist and/or staff, by signing below I agree to above named procedures. 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.

Name_____Date_____

MANDATORY DISCLOSURE OF INFORMATION TO PATIENTS
REGARDING ACUPUNCTURE

China Connection Health Care Center
6531 Valley Cir
Morrison, CO 80465
Bonnie Kenny L.AC., Dipl. C.H.
303-697-0302

FEE SCHEDULE

Brief initial evaluation including acupuncture	105.00
Brief re-examination including acupuncture	85.00
Herbal Consultation	60.00
Acupuncture (per 15 min)	85.00
Electro-acupuncture (per 15 min)	95.00
Stop smoking	95.00

If you have insurance that covers acupuncture these prices may not apply as each insurance company has a pre-set amount that we are required to bill for. If there is a co-pay this may also vary. Please check with your insurance company if you have further questions.

The patient is entitled to receive information about the methods of therapy, the techniques used and the duration of therapy if known. The patient may seek a second opinion from another health professional or may terminate therapy at any time. In a professional relationship sexual intimacy is never appropriate and should be reported to the department of regulatory agencies.
Bonnie Kenny is certified by the National Commission for the Certification of Oriental Medicine in both acupuncture and Chinese herbology. Eligibility to sit for these exams is based on three years of apprenticeship, plus two years of supervised clinical practice, totaling 6,000 hours of clinical experience. Certification is based on successfully completing the clean needle technique test and passing the written and practical examinations.
This office complies with the rules and regulations promulgated by the Department of Health, including the proper cleaning and sterilizing of needles (we use only disposable needles), and the sanitation of acupuncture offices. The practice of acupuncture is regulated by the Department of Regulatory Agencies. Complaints can be reported to:
1525 Sherman St Room 132
Denver, CO 80203
303-894-7758

My signature is in acknowledgement that I have read and understand the information contained on this page.

Name_____ Date_____

China Connection Health Care Center
1460 Pierce St
Lakewood, CO 80214
Bonnie Kenny L.Ac., Dipl. C.H.
303-238-8160

Document of Acknowledgement that patient has access to receive provider's Notice of Privacy Practices.

Name of Practice: China Connection Health Care Center
Provider: Bonnie Kenny L.Ac., Dipl. CH

Name of Patient _____ Date of Birth _____

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have access to receive China Connection Health Care Center's Notice of Privacy Practices.

Signature of Patient _____ Date _____