

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. If I sincerely believe your condition will not respond satisfactorily, I will not accept your case. If you have any questions, please ask. If you have anything you wish to bring to my attention which is not asked on this form, please note it in the *Comments* section. Thank You.

Name: _____ Date of Birth: _____ Age: _____
 Address: _____ Height: _____ Weight: _____ Sex: _____
 _____ Employer: _____
 _____ Occupation: _____
 Phone: _____ Hm/Wk/Cell _____ Had Acupuncture previously? YES NO
 Email: _____ Like to receive monthly newsletter? YES NO
 Spouse's Name: _____ Marital Status: _____
 Physician: _____ Referred to this office by: _____
 In Emergency, Notify: _____ Relationship: _____ Phone: _____

Main problem you would like help with: _____

When did the problem begin (be specific): _____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)? _____

Have you been given a diagnosis for the problem? If so, what? _____

What kind of treatments have you tried or are using? _____

Past Medical History – please note dates:

Cancer: _____	Chemo/Radiation: (dates) _____	
HIV/AIDS: _____	Lyme/Parasites: _____	Autoimmune Dx: _____
Venereal Disease: _____	High Blood Pressure: _____	Rheumatic Fever: _____
Hepatitis: _____	Heart Disease: _____	Diabetes: Type I / Type II _____
Mono/EBV/CFS: _____	Kidney/GallStones: _____	Chx Pox/Shingles: _____

Surgeries (types & dates): _____

Significant Traumas: _____

Significant Dental Work: _____

Scars & Locations: _____

Allergies (drugs, chemicals, foods, etc.) _____

Occupational Stress (chemical, physical, psychological) _____

Birth History (prolonged labor, forceps, premature, etc.) _____

FAMILY Medical History

☐ Cancer _____ ☐ Heart Disease _____ ☐ Asthma _____
☐ Diabetes _____ ☐ Stroke _____ ☐ Allergies _____
☐ High Blood Pressure _____ ☐ Seizures _____ ☐ Depression/Anxiety _____
Other: _____

Medications/Supplements

What medications and/or supplements are you currently taking? _____

Have you had any courses of antibiotics recently? ☐ Many ☐ A few ☐ 1 or 2 ☐ None Why? _____

Habits

Do you have a regular exercise program? Please describe: _____

Are you or have you been on a restricted diet? What kind and why? _____

Please indicate usage per day or per week:

Cigarettes	_____ per Day/Week/Month	Tea	_____ per Day/Week/Month
Alcohol	_____ per Day/Week/Month	Soft Drinks	_____ per Day/Week/Month
Drugs	_____ per Day/Week/Month	Sugar	_____ per Day/Week/Month
Coffee	_____ per Day/Week/Month	Water	_____ per Day/Week/Month

Please describe your average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Do you suffer from any of the following?

Check all that apply, and for each note if it is current or past.

General

☐ Recurrent Infections
☐ Night Sweats
☐ Sweat easily
☐ Bleed or bruise easily
☐ Strong thirst (prefer hot or cold?)
☐ Thirst with no desire to drink
☐ Fatigue
☐ Sudden energy drops
Time of day _____
☐ Poor Sleep
☐ Tremors
☐ Poor Balance
☐ Edema
☐ Underweight
☐ Overweight

Skin

☐ Rashes
☐ Itching
☐ Eczema

☐ Oozing
☐ Pimples
☐ Dry skin / scalp
☐ Recent moles
☐ Changes in hair/skin
☐ Other _____

Head/Eyes/Ears/Nose/Throat

☐ Headaches
Where _____
When _____
☐ Migraines
☐ Dizziness
☐ Discharge from ear
☐ Poor hearing
☐ Ringing in ears
☐ Blurry vision
☐ Night blindness
☐ Color blindness
☐ Spots in front of eyes

☐ Eye Pain
☐ Excessive Tearing
☐ Squint
☐ Glasses
☐ Sore eyes
☐ Facial Pain
☐ Nose bleeds
☐ Nasal discharge
☐ Blocked nose
☐ Snoring
☐ Grinding teeth
☐ Teeth problems
☐ Recurrent sore throat
☐ Hoarseness
☐ Tonsillitis
☐ Swollen glands
☐ Sores on lips/mouth
☐ Other _____

Cardiovascular

- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest discomfort/pain
- ☐ Heart Palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands or feet
- ☐ Blood Clots
- ☐ Spider veins
- ☐ Fainting
- ☐ Other _____

Respiratory

- ☐ Difficulty breathing
- ☐ Pain with breathing
- ☐ Shallow breathing
- ☐ Shortness of breath
- ☐ Production of phlegm
Color _____
- ☐ Recurrent cough
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Asthma/Wheezing
- ☐ Tonsils Removed
- ☐ Other _____

Digestion

- ☐ Bad breath
- ☐ Change in appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Indigestion
- ☐ Belching
- ☐ Abdominal pain or cramps
- ☐ Weight gain
- ☐ Weight loss
- ☐ Loose stools / Diarrhea
- ☐ Strong smelling stools
- ☐ Bloody stools
- ☐ Pale stools
- ☐ Green stools
- ☐ Black stools
- ☐ Constipation
- ☐ Alternating Constipation/Diarrhea
- ☐ Pain with passing stools
- ☐ Gas
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Anorexia nervosa
- ☐ Bulimia
- ☐ Other _____

Genito-urinary

- ☐ Pain on urination
- ☐ Urgency with urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in urinary flow
- ☐ Unable to hold urine
- ☐ Incontinence at night
- ☐ Dribbling urination
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Impotency
- ☐ Changes in sexual drive
- ☐ Rashes
- ☐ Do you wake at night to urinate?
How many times? _____
- ☐ Other _____

Gynecological

- # of pregnancies _____
- # births _____
- # premature births _____
- # abortions _____
- Age of 1st menses _____
- # days between menses _____
- Duration of menses _____
- 1st day of last menses _____
- Age of menopause _____
- ☐ Other _____
- Date of last PAP _____

PMS

- ☐ Irregular periods
- ☐ Painful periods
- ☐ Light periods
- ☐ Heavy periods
- ☐ Clots
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Infertility
- ☐ Vaginal discharge
- ☐ Vaginal sores
- ☐ Postcoital bleeding
- ☐ Breast lumps
- ☐ Nipple discharge
- ☐ Other _____

Do you practice birth control?

☐ yes ☐ no

What type and for how long?

Are you pregnant now?

- ☐ yes
- ☐ no
- ☐ don't know/maybe

Musculoskeletal

- ☐ Neck ache/pain
- ☐ Back ache/pain
- ☐ Knee ache/pain
- ☐ Shoulder pain
- ☐ Elbow/Forearm pain
- ☐ Hand/Wrist pain
- ☐ Foot/Ankle pain
- ☐ Joint/Bone problems
- ☐ Torn tissues
- ☐ Prostheses
- ☐ Muscle pain/weakness
- ☐ Hernia
- ☐ Other _____

Neurological

- ☐ Seizures
- ☐ Nerve damage
- ☐ Paralysis _____
- ☐ Stroke _____
- ☐ Sleep disorder
- ☐ Concussion _____
- ☐ Vertigo
- ☐ Lack of coordination
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Difficulty in concentrating

Behavioral

- ☐ Vacant
- ☐ Moody
- ☐ Easily susceptible to stress
- ☐ Aggressive/Bad temper
- ☐ Lose control of emotions
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Depression
- ☐ Fear
- ☐ Substance abuse
- ☐ Other _____

Have you ever been treated for emotional problems?

☐ yes ☐ no

Have you ever considered or attempted suicide?

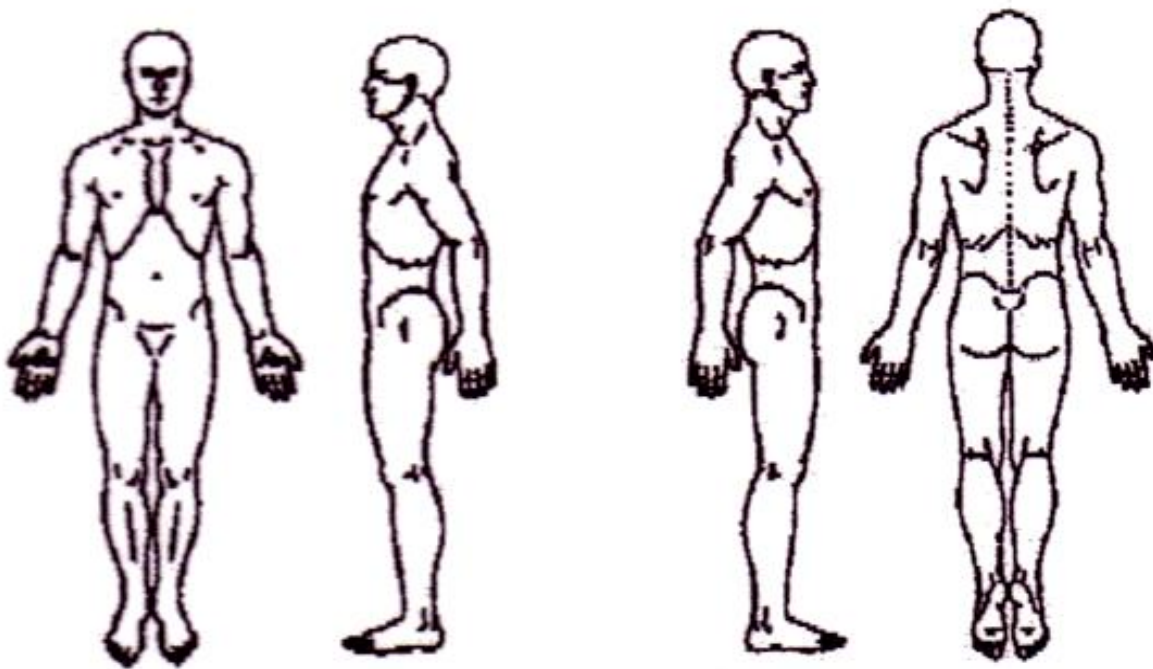
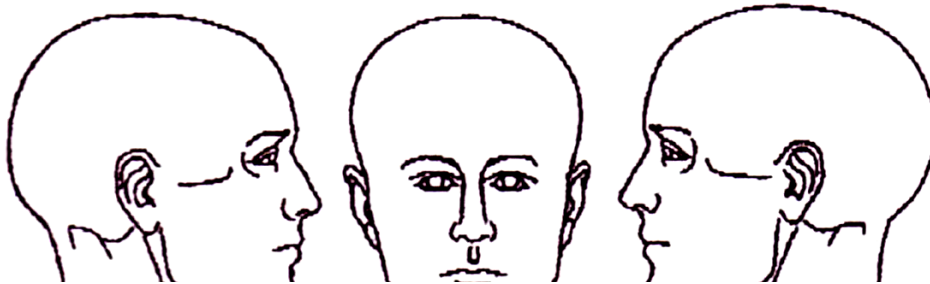
☐ yes ☐ no

Please note the severity of your pain or concern right now:

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____
No Problem Worst Imaginable

Please note the greatest degree of severity of this problem within the last week:

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____
No Problem Worst Imaginable



Additional
Comments: _____

Email: At times, Kellie Krasovec Acupuncture (KKA) uses email to correspond with patients as a convenience. However, these emails are not encrypted and could theoretically be read by an outside party with the technical skills to intercept such correspondences. By initialing this, you consent to allow KKA and its associates to correspond with you via email despite these potential risks. **Initial:** ____

Informed Consent for Acupuncture & Chinese Medicine Treatment

I, the undersigned, hereby request and consent to the performance of acupuncture procedures including, but not limited to, moxibustion, cupping (dry and/or wet), plum blossom, gua sha, electroacupuncture, Tuina (Chinese massage), and Chinese herbal supplements, on me or the patient for whom I am legally responsible, by my acupuncture practitioner. I recognize the potential risk and benefit of this procedure as described below:

Potential Risk:

Discomfort, pain, infection, weakness, fainting, nausea, temporary discoloration at site of procedure, occasional aggravation of symptoms existing prior to the treatment.

Potential Benefits:

Drugless relief of presenting symptoms and improved balance of the body's circulations, which may lead to prevention or elimination of the presenting problems and strengthen the constitution.

I agree to inform acupuncturist if I become pregnant or if I am potentially pregnant.

I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my presenting condition and for any future conditions for which I seek treatment.

I hereby release Kellie Krasovec from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation.

Signature of Patient or Patient's Representative

Date

Print Name of Patient or Patient's Representative

Date

Signature of Witness

Date

COLORADO MANDATORY DISCLOSURE STATEMENT

Kellie Krasovec, Dipl.Ac., L.Ac.
137 Main Street, O-201
Riverwalk Diamond Bldg.
Edwards, CO 81632
970.926.6588

INITIAL INTAKE AND TREATMENT:	\$180 - \$220
FOLLOW-UP TREATMENT:	\$125 - \$170
COSMETIC ACUPUNCTURE:	\$180 initial visit: \$165 per Tx
CELLUMA LIGHT THERAPY:	\$30 per 30 minute treatment
HERBAL FORMULAS:	varies

Kellie Krasovec is certified as a Diplomate in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine. She earned her Master of Science in Oriental Medicine in 2005 from Southwest Acupuncture College located in Santa Fe, New Mexico. This four-year program includes 1873 actual classroom hours and 1030 clinical hours. The degree includes training in acupuncture, auriculotherapy, moxibustion, cupping, tuina, Chinese herbology, electrical stimulation and nutritional therapy.

Kellie Krasovec earned three advanced certificates during additional studies in Beijing, China, in 2004 and 2005. Two of these were awarded by the Beijing International Acupuncture Training Centre for programs in Acupuncture and Moxibustion as well as Chinese Herbal Medicine. A third was awarded by Guang An Men Hospital for in-hospital training in Traditional Chinese Medicine. She is also certified as a Facial Rejuvenation practitioner.

Kellie Krasovec is a member of the American Acupuncture Council and is licensed acupuncturist by the state of Colorado.

This practitioner complies with all the rules and regulations promulgated by the Colorado Department of Public Health and Environment, including those related to the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. *Only single-use, disposable, factory-sterilized needles are used.*

As a patient you are entitled to receive information about the methods of therapy, techniques used and duration of such therapy, if known.

As a patient you are entitled to seek a second opinion from another health care professional and may terminate therapy at any time.

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

The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies at the following address:

Director, Division of Registrations
Acupuncturists Licensure
1560 Broadway, Suite 1350
Denver, CO 80202
303.894.7800

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

Patient or Guardian's signature

Date

Financial Policy

- Payment is due at time of service, unless otherwise arranged prior to treatment.
- Failure to give 24-hour notice for cancellation of any appointment will result in \$25 cancellation fee.
- Failure to notify office and failure to meet appointment without any notice will result in a \$125 missed appointment fee.

Any patient wishing to have insurance cover all or a portion of their treatment should contact their insurance provider to learn the coverage boundaries of their policies with respect to Traditional Chinese Medicine including Acupuncture.

- I am able to provide my patients with a Superbill upon request.
- A Superbill is an invoice for your visit that uses standardized codes for all of the treatments performed. This process requires the patient to pay the full cost of the treatment out-of-pocket at the time of the visit. The Superbill can thereafter be submitted to your insurance carrier for full or partial reimbursement depending on your policy. Patients wishing to make use of this service should check with their insurance carriers to be sure that Superbills are accepted.

Payment Agreement *(please check and sign)*

- ☐ I understand the above terms and agree to keep my account current by paying with cash, check or a credit card at each visit.

Signature

Date

Print Name