

Acupuncture Client Intake

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight _____ Home Phone: _____

Address: _____
Street Address City State Zip

Home Ph: _____ Cell Ph: _____ Work Ph: _____

Circle one: Single Partnered Married Separated Widowed Divorced Sex: M F

Email Address: _____ Referred by: _____

Primary Care Doctor: _____ Hobbies: _____

Occupation: _____ Name of Spouse/Partner or Parent (if child) _____

Which of the following procedures have you experienced before? Circle one:

Acupuncture Herbal Medicine Chiropractic Massage Dietary Consultation

General and Informed Consent: I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me by the licensed acupuncturist listed. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping and gua sha, electrical stimulation, breathing techniques, exercise therapy, Chinese and western herbal medicine, nutritional counseling and neuromuscular therapy. I have been informed that acupuncture is a safe method of treatment, but may have side effects including general aches, nerve pain, bruising, numbness or tingling near the needle sites that may last for a few days, dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained or removed. Bruising is a common side effect from deep neuromuscular work, cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture. Infection is another possible risk, although the acupuncturist uses sterile disposable needles and maintains a clean and safe environment. Burns or scarring are potential risks of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements that may have been recommended are traditionally considered safe although some may be harmful in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, rashes and tingling of the tongue. I understand that it is my responsibility to inform the acupuncturist if I should become pregnant, and all pregnancies carry an innate amount of risk. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgement during the course of treatment. I understand that I may seek a second opinion from another health care professional and I may terminate treatment at any time. I understand that results are not guaranteed. I understand that 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. I understand that the acupuncturist is licensed by the State of Colorado, is nationally certified in Oriental Medicine and complies with any rules and regulations promulgated by the department of public health and environment. I understand that the practice of acupuncture is regulated by the department of regulatory agencies and can be contacted at: DORA 1560 Broadway, Ste 1550, Denver, CO 80202, 303-894-7855.

By voluntarily signing below I show that I have read this consent and have been told about the risks and benefits of acupuncture and other procedures and that I have had an opportunity to ask questions. I will not hold the acupuncturist or Life Chiropractic (Dr. John Wendt) liable for any injuries, accidents, conflicts or physical ailments that may occur after treatment.

Patient's (or guardian) Signature: _____ Date: _____



Financial Awareness and Consent: I understand that I will be financially responsible for all charges incurred by me, regardless of case type. I understand that the initial treatment and consult fee is \$120.00 and any follow up treatments are \$60.00. I understand that full payment of treatment, herbs or Chinese Medicine is due at the time of service. We accept cash, credit cards and checks. I understand that the fees for herbs, supplements are dependent on the specific herb or supplement.

I understand that there is a 24 hour cancellation policy and I may be charged \$25 for a missed appointment fee for failure to cancel or reschedule my appointment within the 24 hours of my scheduled appointment. I understand that a \$20 fee will be assessed for any returned checks.

We do not bill for acupuncture services. Be aware that Chinese herbs or supplements are not a covered benefit in most insurance policies. We will be happy to provide a superbill that you can file with your insurance company for any possible reimbursement.

Patient's (or guardian) Signature: _____ Date: _____

Kimberly LeBrun, Mac, LAc, Dipl OM

EDUCATION

2004-2007 Master's Degree in Acupuncture: Southwest Acupuncture College, Boulder, CO
1998-2001 Bachelor's in Science, Public Health and Health Promotion: University of Montana, Missoula, MT
1995-1997 Southern Oregon State College, Ashland, OR

CERTIFICATIONS

2007-Present Certification: Oriental Medicine by the National Certification Commission of Acupuncture and Oriental Medicine (NCCAOM) which includes Acupuncture, Chinese Herbology, Asian Bodywork, Biomedicine and Foundations of Oriental Medicine.
2004-Present Cardiopulmonary resuscitation (CPR), Red Cross, Boulder, CO
2004-Present Clean Needle Technique (CNT), Council of Colleges of Acupuncture and Oriental Medicine, Boulder, CO

CONTINUING EDUCATION HIGHLIGHTS

2011 Gluten Sensitivity with Neuro-endocrinology and Immunology with Apex, 2hrs.
2011 Mastering the Thyroid with Datis Kharrazian DC, 20hrs.
2009-2010 Apex Energetics Neurotransmitters and Brain Seminar with Datis Kharrazian DC, 30hrs.
Functional Blood Chemistry with Datis Kharrazian DC, 15hrs.
Functional Endocrinology with Datis Kharrazian DC, 15hrs.
2008 Infertility Seminar with Bob Flaws LAc, 13hrs.
2007-2008 David Euler Seminars, Kiiko Matsumoto Japanese Acupuncture, 30hrs.

LICENSES

2010-Present Licensure: Acupuncture in Colorado
2007-Present Licensure: Acupuncture in North Carolina



PRIMARY COMPLAINTS:

MEDICAL HISTORY

MEDICATIONS: Please list all prescribed (allopathic) drugs, non-prescribed medications, vitamins, herbs, etc. you are taking, stating what they are used for.

Please list any hospitalizations, accidents and past illnesses. Include dates and ages.

Please check: Do you use or do any of the following on a regular basis?

- Alcohol
- Tobacco
- Drugs
- Coffee or Tea
- Exercise
- Soft Drinks
- Salt
- Sugar
- Vegetarian Diet
- Consumption of soy products

Please List any serious diseases in your family history such as Cancer, Diabetes, Hypertension, Heart Disease, etc.

Mother:

Father:

Grandparents:

Siblings:



Please circle current complaints and check past complaints

Musculoskeletal

Neck pain	Muscle pain	Knee pain
Back pain	Muscle weakness	Foot/Ankle pain
Hand/wrist pain	Muscle spasms	Hip pain
Elbow pain	Shoulder pain	Hernia pain
Brittle Bones	Deformities of Bones	Areas of Numbness & Tingling
Joint swelling	Arm pain	Rib pain
Leg cramps	Muscle Atrophy	Other:

Neurophysiological/Emotional

Seizures	Dizziness	Loss of balance
Regions of numbness	Lack of coordination	Poor memory/concentration
Head injury	Loss of Memory	Anxiety
Bad temper	Low stress tolerance	Sadness
Worry, Over-thinking	Fearful	Weepy
Mood swings	Suicidal	Depression
Confusion	Tremors	Paralysis
Convulsions	Tics	Mental Illness

General

Night sweats	Insomnia	Fatigue
Fevers	Chills	Nightmares
Spontaneous sweating	Hot or Cold Intolerance	Cravings
Weakness	Bleed or Bruise easily	Weight gain/loss
Psoriasis	Rashes	Eczema
Sudden energy drop: time?	Hair loss	Itchy or dry skin
Sleep too much	Swollen glands	Acne
Fungal infections	Dandruff	Ulcerations
Dental Amalgams	All symptoms worsen when tired?	Symptoms worsen with stress?

Cardiovascular

High Blood Pressure	Low Blood Pressure	Chest pain
Irregular heartbeat	Blood Clots	Fainting
Swelling of feet/hands	Varicose Veins	Rapid heartbeat/palpitations

Respiratory

Cough	Coughing blood	Asthma
Bronchitis	Pneumonia	Sinus Congestion
Difficulty breathing	Nasal congestion	Nose bleeds
Catch colds frequently/easily	Production of phlegm: color?	Allergies

Gastrointestinal

Increased appetite	Decreased appetite	Nausea
Vomiting	Diarrhea	Constipation
Gas	Belching	Loose stools
Black stools	Rectal pain	Indigestion



Light stools	Hemorrhoids	Bad breath
Parasites	Heartburn/indigestion	Foods sit in stomach
Itchy anus	Anal fissures/fistula	Hiccup
Blood in stool	Problems swallowing	Hepatitis
Excessive Thirst	Gallstones	Food allergies
Mouth sores	Peculiar tastes/smells	Desire for hot/cold foods
Current weight _____ lbs.	Reflux	Hiatal Hernia

Genito-Urinary

Pain on Urination/urinary tract infection	Frequent urination	Blood in urine
Urgency to urinate	Unable to hold urine	Kidney stones
Decrease in flow	Genital sores	Night time urination
Dark urine	Cloudy urine	Urine smells strongly
Bedwetting	Difficulty urinating	Edema: where? _____

Head, Eyes, Ears and Throat

Fainting	Grinding teeth	Migraines
Headaches	Spots in front of Eyes/Floaters	Blurry vision
Poor night vision	Light sensitivity	Red/itchy eyes
Eye pain	Pressure behind eyes	Sores on lips/tongue
Earaches	Increased ear wax	ringing in ears
Poor hearing	Ear pressure	Dizziness

Women

Endometriosis	Polycystic Ovarian Disease	Days between periods: _____ days
Days of bleeding: _____ days	Menstrual blood color: _____	Clots
Heavy or light periods	Irregular or no periods	Menstrual pain
PMS	Number of pregnancies: _____	Number of Abortions: _____
Number of children: _____	Method of birth control?	Are you pregnant? yes no
Difficult birth/Caesareans	Increased/Decreased libido	Hot flashes
Vaginal dryness	Night sweats	Age menses began: _____
Breast problems	Vaginal discharge/sores	Age at Menopause: _____
Date of last PAP?	Sexually transmitted disease	HPV positive? yes no
Female Infertility Issues	Infertility	Number of miscarriages _____
Anovulation	Immune issues like high ANA	Pelvic inflammatory disease
Used birth control pills or Depo-Provera	Tested for Chlamydia? yes no	# of IUI or IVF cycles? _____
FSH levels if known	Fibroids Adhesions Cysts	Low progesterone

Males

Prostrate problems	Painful/swollen testicles	Discharge
Ejaculation problems	Impotence	Sexually Transmitted Disease
Increased/decreased libido	Other:	
Male Fertility Issues	Infertility	Varicocele
Undescended testicles	Sperm analysis normal? yes no	Immune issues like Antisperm Antibodies

Anything else you would like us to know: _____

