Left Hand Community Acupuncture **Health History Questionnaire**

This is a confidential questionnaire to help us determine the best individualized treatment plan for you.

Name:	**Home Phone:**
Address:	**Cell Phone:**
City, State, Zip Code	**Other:**
Email Address	**Preferred Pronouns:**
May we use your email address for the following?: 1) regarding your course of treatment Yes No 2) for our very occasional newsletter Yes No (your email address will not be used for any other purposes)	**Age:** _____ **Date of Birth:** _____/_____/_____
What is the best way to reach you to retain your healthcare privacy?	**Guardian (if under 18 years of age):**
Your Physician (MD, DO, ND):	**Phone:**
How did you hear about us?	**Date of last checkup?**
In case of emergency, please contact: (Name and Phone #)	**Have you had acupuncture before?** Yes No
Are you afraid of needles? Yes No	(Please share your concerns with us)

Primary reasons for this visit:

#1	**Circle a range for your symptoms** mild <— —> severe 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	What makes it better?
	How is it impacting your daily life?	What makes it worse?
#2	**Circle a range for your symptoms** mild <— —> severe 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	What makes it better?
	How is it impacting your daily life?	What makes it worse?
#3	**Circle a range for your symptoms** mild <— —> severe 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	What makes it better?
	How is it impacting your daily life?	What makes it worse?

Current medications: (attach your sheet own if necessary) Include prescriptions AND over-the-counter meds.

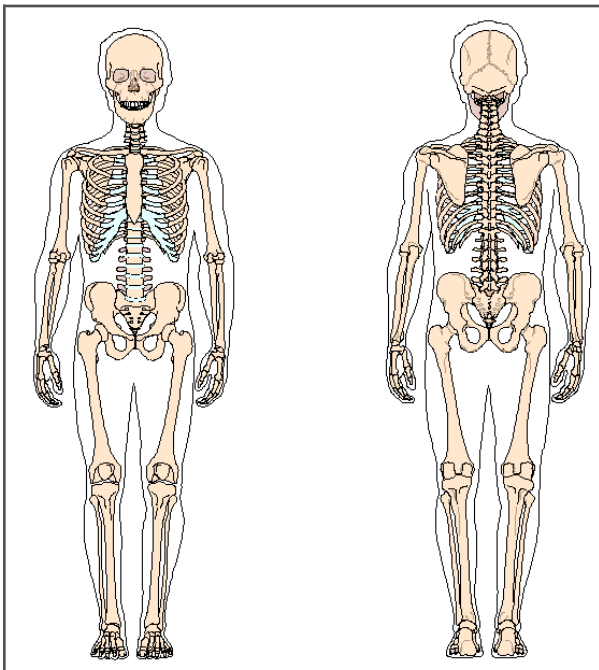
Medication	Dosage	Reason	How Long?	Prescribed By

Supplements: _____
_____

Significant Illnesses:

___High blood pressure	___Hepatitis A	___HIV
___Low blood pressure	___Hepatitis B	___AIDS
___Cancer	___Hepatitis C	___Hyperthyroid Disease
___Ulcers	___Herpes Simplex Type 1	___Hypothyroid Disease
___Chronic Fatigue	___Herpes Simplex Type 2	___Kidney Disease
___Asthma	___IBS	___Alcoholism
___Diabetes Type_____	___Gastritis	___Heart Disease
___Seizures	___Pancreatitis	___Other: _____
___Anemia	___Liver/Gallbladder Disease	_____

Musculoskeletal



Circle areas of pain and inflammation in your body

Have you ever been hospitalized? Y N
If yes, for what? _____
_____
_____
_____
_____

Have you ever had surgery? Y N If yes, for what?
_____
_____
_____
_____
_____

Do you have a history of: ___ Depression ___ Anxiety ___ Manic Depression ___ Panic Attacks
___ PTSD (Post Traumatic Stress Disorder) ___ Other _____

Allergies (food, drug, seasonal, environmental, nickel, silicone, other?) _____
_____

Foods	I eat these items	**0= none at all**	**1= a little**	**2=some**	**3= a lot**
Frozen meals	0 1 2 3	**Organic**			
Fast food	0 1 2 3	Fresh fruits, veggies	0 1 2 3	**Conventional**	
Raw foods	0 1 2 3	Meats	0 1 2 3	Fresh fruits, veggies	0 1 2 3
Homecooked meals	0 1 2 3	Eggs, Dairy	0 1 2 3	Meats	0 1 2 3
Sugary foods	0 1 2 3	Bread/Grains	0 1 2 3	Eggs, Dairy	0 1 2 3
				Bread/Grains	0 1 2 3

Diets followed ___ Paleo ___ Mediterranean Diet ___ Vegetarian ___ Vegan ___ Zone Diet ___ Atkins ___ Other? _____

Beverages	How much?	How often?	**Etc…**	How much?	How often?
Water	_____	_____	Alcohol	_____	_____
Soda	_____	_____	Tobacco	_____	_____
Coffee/Caffeinated Tea	_____	_____	Recreational drugs	_____	_____
			Medical Marijuana	_____	_____

My Sleep Is: Good / OK / Sometimes OK / Poor
Number of hours a night _____
Time to bed _____Time to wake _____
Trouble falling/staying asleep? _____

Feel rested on waking?_____
Vivid dreams? _____
Worrying / Racing mind? _____
Heart palpitations? _____

Exercise: What type(s)?_____ How often? _____

Please rate your **MOOD:** 5 = Great 4 = Good 3 = Fair 2 = Poor 1 = Bad
Please rate your **STRESS level:** 5 = Great 4 = Good 3 = Fair 2 = Poor 1 = Bad
Please rate your **ENERGY level:** 5 = Great 4 = Good 3 = Fair 2 = Poor 1 = Bad

Symptoms Please check if any of these symptoms are significant concern for you:

General: ___Chills ___ Excess heat ___ Bleed / bruise easy ___ Muscle weakness/fatigue ___ Night sweats ___ Palpitations ___ Fatigue ___ Sweat easily ___ Tremor ___ Cold hands / feet ___ Edema ___ Trouble with weather changes ___ Tightness in chest

Gastrointestinal ___ Poor Appetite ___ Excessive Appetite ___ Cravings ___ Weight Loss ___ Weight Gain ___ Strong thirst ___ No thirst ___ Nausea ___ Vomiting ___ Gas/Belching ___ Bloating ___ Gallstones/Trouble with fatty foods ___ Indigestion ___ Heartburn / Reflux ___ Constipation ___ Loose Stool / Diarrhea ___ Black/Pale stools ___ Hemorrhoids ___ Hernia ___ Abdominal pain/cramps **Urinary** ___ Painful / Burning urination ___ Incontinence ___ Frequent / Excessive urination __ Urination at night __ Kidney stones ___ Urinary tract infection ___ Urgency ___ Bloody urination

Head / Ears / Eyes / Nose ___ Headaches / Migraines ___ Dizziness ___ Tinnitus ___ Hearing loss ___ Earaches ___ Eye pain ___ Poor vision ___ Cataracts ___ Floaters ___Sinus problems ___ Nose Bleed ___ Allergies / Hayfever ___ Runny nose / post-nasal drip ___ Grinding teeth ___ TMJ ___ Dental / gum problems ___Cold Sores ___ Poor balance ___ Poor memory

Respiratory ___ Difficulty swallowing ___ Persistent sore throat ___ Swollen glands ___ Cough/wheeze ___ Frequent colds ___ Pneumonia ___ Asthma ___ Tuberculosis ___ Emphysema ___ Bronchitis ___ Shortness of Breath

Skin/Hair ___ Rashes/Itching ___ Eczema ___Psoriasis ___Dermatitis ___ Ulcerations ___ Acne ___ Changes in skin ___ Hair loss/changes **Any other health concerns or conditions you'd like us to know about?** _____
_____

****HORMONE / REPRODUCTIVE /SEXUAL HEALTH CONCERNS? ASK FOR AN ADDITIONAL PAGE!*****

Left Hand Community Acupuncture Financial Policy

Suggested Fee Guideline
It is the intention of Left Hand Community Acupuncture to provide acupuncture and other treatment modalities that most can afford. The chart below is intended as *a guideline only*, and we understand that everyone's situation is unique.

Annual Income	**Single Service**	**Double Service**
$100,000 and up	$85.00 - $100.00	$110.00 - $120.00
$90,000 - 99,000	$75.00 - $85.00	$100.00 - $110.00
$80,000 - 89,000	$65.00 - $70.00	$95.00 - $100.00
$65,000 - 79,000	$60.00 - $65.00	$92.00 - $95.00
$50,000 - 64,000	$55.00 - 60.00	$90.00 - $92.00
$40,000 - 49,000	$50.00 - $55.00	$87.00 - $90.00
$30,000 - 39,000	$45.00 - $50.00	$85.00 - $87.00

~A one-time, initial intake fee of $15 is added to the first appointment**~**

Insurance: In order to keep our treatment fees low and affordable, we do not bill insurance. If you plan to seek reimbursement from your insurance company, please pay the full amount and we will provide you with a superbill for you to submit to your insurance company.

Cancellation Policy
Because treatments are by appointment only and your appointment time is reserved specifically for you, we request that you acknowledge and respect our cancellation policy. If you need to cancel or reschedule an appointment, please do so **at least 12 hours before your appointment time** by emailing or calling our office at 720-378-6090. If we are unable to answer, please leave a message. Patients who do not honor their appointment time will be charged a cancellation fee as follows:

Cancellation with more than 12-hours notice:	no charge
Cancellation with less than 12-hours notice or failure to show:	$15.00 for single appointment $25.00 for double

We ask for a commitment from you to be here when you are scheduled. Being late for your appointment can disrupt the flow of that day's schedule. If you arrive later than 15 minutes after your scheduled appointment, your treatment may be forfeited at the discretion of the practitioner and our missed appointment fees will apply.

Financial Policy
Payment is expected at time of service by cash, check or credit card. Our sliding scale applies to all payments made the day of service, if payments are made after the date of service we reserve the right to bill $120 per treatment. I understand any money held as credit at Left Hand Community Acupuncture needs to be used within 24 months of its payment date or be forfeited.

The patient agrees to pay all banking fees associated with returned checks.

No refunds will be given for services already rendered. If you have paid for a treatment package in full and decide to discontinue treatment, you will be refunded for unused services less a 20% processing fee.

I have read, understand, and will abide by the above fee schedule, cancellation, and financial policies.

_____ _____

Signature Date