Sacred Elements

Five Element Acupuncture and Traditional Chinese Medicine

5921 S Middlefiled Rd, Suite 100 Littleton, CO 80123 303-507-8021

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Personal Information

Your personal information will be kept personal. We will use the following information to contact you only with your permission.

Name_____ Birth date _____Today's Date _____

Home Address_____

City_____ State_____ Zip_____

May I have your permission to send the following mailings to this address?
Holiday, Birthday and Thank you for your referral cards? Y N
Promotional coupons, discounted services, invitations to events in this office (maximum of 4 mailings per year)? Y N

Best Phone #_____ May I contact you at this #? Y N May I leave a message at this #? Y N

2nd Best Phone #_____ May I contact you at this #? Y N May I leave a message at this #? Y N

e-mail address _____
May I have your permission to send the following e-mails to this address?
Holiday, Birthday and Thank you for your referral cards? Y N
Promotional coupons, discounted services, invitations to events in this office? Y N

If the patient is a minor, please list legal guardian responsible for this account ___

Contact information for legal guardian: _____

Emergency Contact: Name_____ Phone:_____

How did you hear about me? Referred by:_____ ☐ Google ☐ Yahoo ☐ Yelp ☐ Other

Have you had acupuncture therapy before? Yes No With Whom? _____

Have you had a professional massage before? Yes No Approximately how many times? 1 2 3 4 5 6+

Please list any prescription or over-the-counter medications you are presently taking:

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If your medications do not fit on this page, check this box ☐ and continue on the back.

Chief Complaint

Please list 1 to 5 health concerns that you would like to address. Place them in the order of priority.

1 _____

2_____

3_____

4_____

5_____

Please answer the following questions regarding your #1 concern

How long have you had this condition? _____

What was happening or going on in your life when it began? _____

_____

What other forms of treatment have you sought? _____

_____

What helps your condition? _____

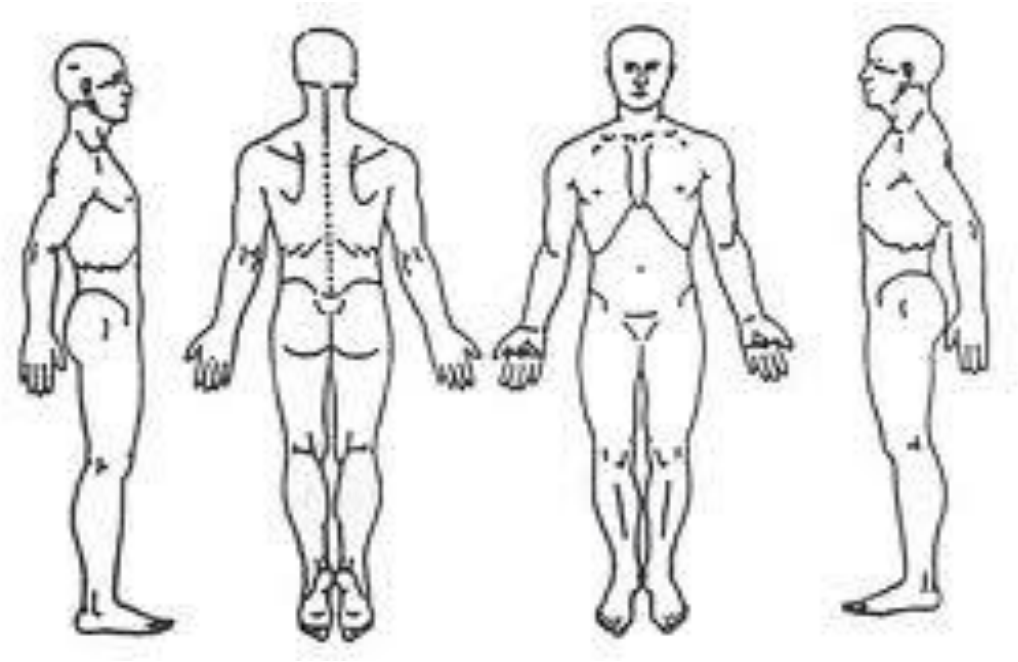
What aggravates your condition? _____

To what extent does the problem effect your daily activities (work, sleep, eating. etc.)? _____

_____

Please mark all of the areas in your body where you feel pain or discomfort regularly or presently:
mark the area with the following symbol to indicate the type of pain:

○ Dull/achy X sharp/stabbing △ burning □ tingling/ numbness/electrical



Confidential Health History

Patient Name: Date:

Family Medical History

Please check the box corresponding to the family member(s) that have had the following health conditions

Y=Yourself F=Father M=Mother S=Siblings O= Other (Grandparents, Aunts and Uncles)

Y	F	M	S	O	High Blood Pressure	Y	F	M	S	O	Breast Cancer	Y	F	M	S	O	HIV/AIDS
Y	F	M	S	O	Heart Disease	Y	F	M	S	O	Colon Cancer	Y	F	M	S	O	Depression
Y	F	M	S	O	Stroke	Y	F	M	S	O	Other Cancer	Y	F	M	S	O	Anxiety
Y	F	M	S	O	High Cholesterol	Y	F	M	S	O	Seizures	Y	F	M	S	O	Suicidal thoughts
Y	F	M	S	O	Pacemaker	Y	F	M	S	O	Hepatitis B	Y	F	M	S	O	other
Y	F	M	S	O	Diabetes	Y	F	M	S	O	Hepatitis C	Y	F	M	S	O	other
Y	F	M	S	O	Obesity	Y	F	M	S	O	Other Hepatitis	Y	F	M	S	O	other

Office Notes:

Medical History

List any hospitalizations with date and reason:

List any major or chronic health incidents, including accidents:

List any allergies:

Are you pregnant? Yes No Are you trying to become pregnant? Yes No

Office notes:

Missed Appointment Policy

A missed appointment is a loss to everyone. If you need to cancel an appointment please give me 48 hours notice so I can fill your spot. If you cancel or miss an appointment with less than 24 hours notice you may be charged the full price of the scheduled appointment. _____ (please initial)

Disclosures

Please read the PDF of all three disclosures (also on the website) and sign below on this sheet to acknowledge that you have read and understand the information provided in each document.

Informed Consent for acupuncture treatment and care

This document contains important information about the risks and benefits of acupuncture and related therapies. It outlines your right to be informed about any and all treatment you receive, as well as your right to refuse any treatment. Your responsibilities as a patient are also described. Please read the entire document and sign below to acknowledge that you have read and understand the Informed Consent document.

_____ _____

Please Print Patient's Name Print Guardian's Name (if applicable)

_____ _____

Patient or Guardian's Signature Date

HIPPA Regulations

The information provided in this document illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Please read the entire document and sign below to acknowledge that you have read and understand the HIPPA regulations.

_____ _____

Please Print Patient's Name Print Guardian's Name (if applicable)

_____ _____

Patient or Guardian's Signature Date

Department of Regulatory Agencies Disclosure

This Document includes information including fee schedule, patient rights, and licensing as well as information on how to lodge a formal complaint against a licensed acupuncturist. Please read the entire document and sign below to acknowledge that you have read and understand the Department of Regulatory Agencies Disclosure.

_____ _____

Please Print Patient's Name Print Guardian's Name (if applicable)

_____ _____

Patient or Guardian's Signature Date