Ridge Line Chiropractic Acupuncture Intake

Name: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Cell Provider: _____

Occupation: _____ Work Phone: _____

Emergency Contact: _____ Contact Number: _____

Who may I thank for referring you to this office? _____

DOB: _____ Age: _____ Weight: _____ Height: _____ Gender: _____

Marital Status: _____ Number of Children: _____

Have you received acupuncture before: _____ With whom? _____

Please list any medications, OTC medications, supplements, vitamins, or herbs you are currently taking:

Medication	Dosage	Reason	How Long

Please indicate any major illnesses/conditions or a blood relative (parent, sibling, grandparent) have had:

Illness/Condition	Who	Date (approximate)
Cancer:		
Hepatitis:		
High Blood Pressure:		
Rheumatic Fever:		
Infectious Disease:		
Diabetes:		
Heart Disease:		
Seizures:		
Emotional Disorders:		
Turberculosis:		
Gonorrhea:		
Syphilis:		
HIV:		
AIDS:		
HPV:		
Chlamydia:		
Herpes:		

Do you drink alcohol? _____ If yes, how frequent? _____

Do you smoke? _____ If yes, how frequent? _____

Do you drink coffee? _____ If yes, how many cups daily? _____

Do you take recreational drugs? _____ If yes, which and frequency? _____

Do you drink soda/pop? _____ If yes, how often _____

How often do you eat out? _____

How many 8 oz glasses of water do you drink per day? _____

Do you prefer water hot, cold, or room temperature? _____

What is your reason for seeking treatment? _____

What other treatment therapies have you sought for this? _____

Do you have latex allergies? _____

Do you have any allergies to medications? _____

Do you have any food allergies or sensitivities? _____

Please list any major illnesses, surgeries, accidents with dates. _____

DIET

How many times a day do you eat? _____

Are there any foods you exclude from your diet? _____

What foods are in a typical breakfast, lunch, dinner, snack(s)? _____

Please circle the appropriate answer for each of the following area:

Health:	Great	Good	Average	Poor	Bad
Diet:	Great	Good	Average	Poor	Bad
Exercise:	Great	Good	Average	Poor	Bad
Career:	Great	Good	Average	Poor	Bad
Family:	Great	Good	Average	Poor	Bad
Relationship:	Great	Good	Average	Poor	Bad

Sex:	Great	Good	Average	Poor	Bad
Self:	Great	Good	Average	Poor	Bad
Spirituality:	Great	Good	Average	Poor	Bad
Sleep:	Great	Good	Average	Poor	Bad

SLEEP

What time do you go to bed? _____ What time do you wake? _____

Average number of hours of sleep? _____ Do you feel rested when you wake? _____

Do you have problems falling asleep? _____ If yes, please explain _____

Do you wake during the night? _____ How many times? _____

What causes you to wake? _____

WOMEN ONLY

Are you pregnant? _____ If yes, how many weeks? _____ If no, are you trying to get pregnant? _____

# of pregnancies? _____ # of live births? _____ # of miscarriages? _____ # of abortions _____

Have you been diagnosed with:

Ovarian cyst? _____ Fibroids? _____ Fibrocystic Breast? _____ PID? _____ Endometriosis? _____

Other: _____

# of days between periods: _____ # of days of flow: _____

Color of flow: _____

Are there clots? _____ If yes, what size?(dime, nickel, etc) _____

Do you experience PMS symptoms? _____ If yes, please describe: _____

Average # of tampons/pads used per day:

1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____ 6th _____ 7th _____

SYMPTOMS SURVEY

Please Mark the following symptoms with:

(X) if you experience them occasionally *(+) if you experience them frequently* *( ) leave blank if you don't experience*

( ) high cholesterol
( ) high blood pressure
( ) intolerance to weather
( ) numbness/tingling
( ) cold hands/feet
( ) recent use of antibiotics
( ) nightmares
( ) vivid dreams
( ) heart palpitations
( ) irregular heart beat
( ) ear ringing/tinnitus
( ) lack of appetite
( ) excessive appetite
( ) soft/brittle nails
( ) sudden weight loss/gain
( ) diarrhea/loose stools
( ) constipation
( ) hemorrhoids
( ) acid reflux/heart burn
( ) burping/belching
( ) vaginal discharge
( ) abdominal pain
( ) indigestion/digestive problems
( ) difficulty digesting
( ) easily angered/agitated
( ) laughing for no reason
( ) difficulty making decisions

( ) cough
( ) shortness of breath
( ) low back pain/weakness
( ) decreased sense of smell
( ) nasal problems
( ) acne
( ) rashes
( ) bronchitis
( ) frequent colds/flu
( ) colitis/diverticulitis
( ) Carpal Tunnel Syndrome
( ) decreased vision
( ) floaters in vision
( ) dry/itchy/red eyes
( ) spasms/twitching of muscles
( ) knee pain/weakness
( ) decreased hearing
( ) urinary problems
( ) kidney stones
( ) gallstones
( ) blood in stool
( ) black tarry stool
( ) bruise easily
( ) light colored stools
( ) sciatic pain
( ) mental restlessness
( ) difficulty digesting oily/greasy food

( ) asthma
( ) allergies
( ) hay fever
( ) fainting
( ) headache
( ) migraine
( ) dizziness
( ) insomnia
( ) vomiting
( ) nausea
( ) chest pain
( ) angina
( ) edema
( ) fatigue
( ) hair loss
( ) gas
( ) TMJ
( ) IBS
( ) concussion(s)
( ) seizures
( ) depression
( ) dental issues
( ) difficulty breathing when lying down

Informed Consent

I hereby request and consent to the performance of acupuncture and Traditional Chinese Medicine procedures by a licensed practitioner at Ridge Line Chiropractic. I have been informed that acupuncture is a safe method of treatment but that it may have side effects including pain, bruising, and numbness at site of needle, discomfort, and dizziness. Extremely rare risks include nerve damage, organ puncture, possibility of miscarriage, burns from moxibustion or heating lamps, and infection. Other side effects and risk may occur. If I suspect I am pregnant I will immediately inform my treating practitioner. I understand that there are no guarantees regarding the improvement of my condition. I understand there may be limitations to the care provided and that, in my best interest, I may be referred to another acupuncture practitioner or other healthcare provider who may be more qualified to treat my condition. I do not expect explanation of/or anticipate all risks or complications. I permit my treating practitioner to determine and/or alter the course of treatment which is based upon the known facts. I understand that I have the right to accept or reject treatment at any time.
I have read and understand the above consent. Also, I have had the opportunity to ask questions regarding this consent. By signing below, I am agreeing to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition (s) for which I seek treatment.

Patient's Rights

- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registration in the Department of Regulatory Agencies (DORA).
- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of the therapy (if known).
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
  The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-2440.

Education and Experience

Alyssa Damron earned her Master of Acupuncture degree from the Phoenix Institute of Herbal Medicine and Acupuncture in November 2012. This four-year program consists of 3,500 hours of education including 1,000 hours of clinical practice. Alyssa was certified as a Diplomate in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in November 2012. This includes certification in Clean Needle Technique. Alyssa has not had any license, registration, or certification revoked or suspended. Alyssa's training includes adjunctive therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations.

Alyssa is a registered acupuncturist in Colorado and also holds a personal training certification from the American Council on Exercise. None of these licenses, certificates, or registrations has ever been suspended or revoked.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized and they are disposed of in a manner consistent with OSHA and Colorado State regulations.

Cash at Time of Service Fee Schedule

Intake Consultation and Treatment: $85*
Follow-up Treatment(tx): $85/per or $520 for 8 tx

*Coupons or other special discounts may apply.
**Herbs are purchased separately.

I have read and understand this document. I understand my rights and responsibilities as a patient.

Patient's Name (Please print): _____

_____ _____
Patient or Guardian's Signature Date