

Sanctuary for Heart Magic
Acupuncture New Client Intake Form

Date: ____ / ____ / ____

Name: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Occupation: _____ Cell Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Marital Status: S M W D Number of Children: _____

Emergency contact: _____ Phone number of emergency contact: _____

Who referred you and/or how did you hear about our office and the services we offer?

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Primary concerns or reasons for seeking support

1. _____
2. _____
3. _____

2) In what ways have you already worked with the reasons that you are seeking support?

What concerns, if any, do you have around the reasons you are seeking support?

4) What areas of life, if any, feel like they are not in full expression? (circle)

Work Family Personal relationships Hobbies Life enjoyment Relaxation Other:_____

5) What triggers you out of presence of alignment? (circle)

Pain Movements Environmental factors Foods Emotions Repeating thoughts

Other:_____

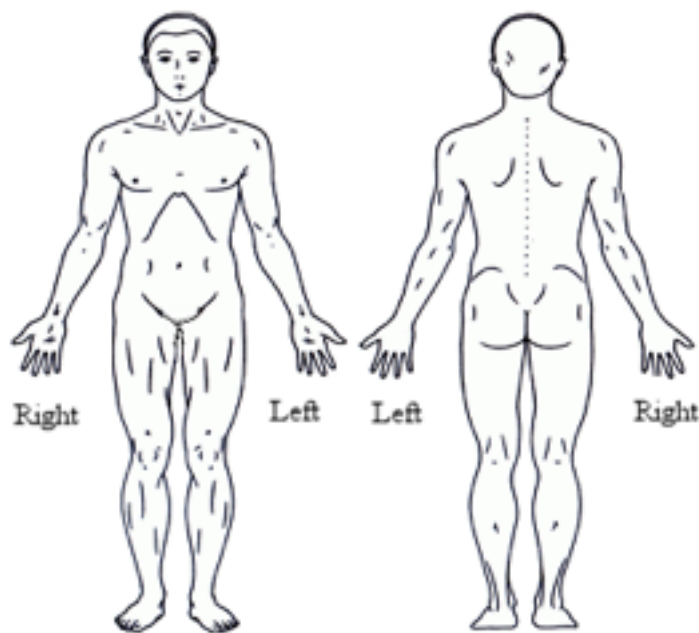
GENERAL INJURY HISTORY

GENERAL PHYSICAL TRAUMA:

List any physical injuries, along with dates of injury, that are of significant to why you are seeking support

Please mark on the diagram all the places in your body that you have ever been injured.

Please also mark any areas affected by disease. (Examples include heart disease, cancer, stroke, multiple sclerosis, etc.)



PAST MEDICAL HISTORY:

Please list any past medical history including surgeries, procedures, and medical diagnoses:

FAMILY MEDICAL HISTORY:

Please list any pertinent family history:

For each symptom below that you currently have, rate its severity from 1-5 (5 being worst). Leave blank if N/A.

LV/GB Irritability / frustration Impatience Depression High Stress Emotional eating Visual problems / floaters Blurred vision Poor night vision Red / dry / itchy eyes Headaches / migraines Dizziness Feeling of lump in throat Muscle twitching / spasm Neck / shoulder tension Limited range of motion Brittle nails Prone to tendon injuries Sighing PMS Genital itching/rashes/pain Easy to anger Unclear on life direction Trouble moving forward Hard time making decisions Low self esteem Lack of courage Unfulfilled desires Feel tense in body & mind HT/SI Palpitations Chest pain / tightness Hypertension Insomnia / sleep problems Vivid dreams Forgetful / poor memory Aversion to heat Bitter taste in mouth Mouth ulcers/cankers Stuttering Dull complexion Hard to be present Lack of joy in life Restless / easily agitated Anxious	KD/UB Frequent urination Bladder infection Lack of bladder control Wake to urinate Ankle swelling Feel cold easily Cold hands / feet Night sweats / hot flushing Low sex drive Loss of head hair Hearing problems Tinnitus Fragile bones Scoliosis Hard to keep weight on Slow to heal Crave salty food Frequent thirst Poor long term memory Low willpower Significant energy depletion Delayed recovery Chronic Fear/Terror Envy/Jealousy Hold grudges LU/LI Dry cough Cough with phlegm Nasal discharge / drip Sinus infection / congestion Itchy / painful throat Dry mouth / throat / nose Skin rashes / hives Snoring Shortness of breath Allergies / asthma Weak immune system Alternate fever / chills Grief / sadness Difficulty letting go	SP/ST Heaviness in the head / body Fatigue after eating Difficult getting up in the AM Water retention Swollen glands Bruise easily Hemorrhoids Varicose veins Nose bleeds Bad breath Poor appetite Increased appetite Poor digestion Nausea / vomiting Bloating / gas Constipation Loose stool Alternate constipation / loose Abdominal pain Intestinal pain / cramping Heartburn Hard to loose weight Yeast infection Aversion to cold Cold nose Increased thirst Muscular tiredness/weak Hard to hold body upright Poor muscle tone Sweat easily w/out exertion Crave sweets Over-thinking Foggy mind Tends to worry Trouble focusing PC/SJ Pressure in the chest Anxiety in the chest Body temp dysregulation Irregular cycles: sleep, eating or hormonal Body systems not coordinated with each other Feel closed off from others Poor emotional boundaries Easily effected by emotions Feeling "out of sync" Scattered Trouble adapting to change
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CHEMICAL HISTORY

1) Please list any prescription or over-the-counter medications you are currently taking. Also list any toxic or environmental exposures.

1. _____ 2. _____
 3. _____ 4. _____
 5. _____ 6. _____

EMOTIONAL HISTORY

With each of the following potential stressful situations, please indicate the severity either past or current

Potential Spinal Stress/Tension Sources	PAST	CURRENT
Childhood Stress	☐ Mild ☐ Moderate ☐ Extreme	☐ Mild ☐ Moderate ☐ Extreme
School Stress	☐ Mild ☐ Moderate ☐ Extreme	☐ Mild ☐ Moderate ☐ Extreme
Family Stress	☐ Mild ☐ Moderate ☐ Extreme	☐ Mild ☐ Moderate ☐ Extreme
Personal Relationships	☐ Mild ☐ Moderate ☐ Extreme	☐ Mild ☐ Moderate ☐ Extreme
Stress of Being Sick	☐ Mild ☐ Moderate ☐ Extreme	☐ Mild ☐ Moderate ☐ Extreme
Work Stress	☐ Mild ☐ Moderate ☐ Extreme	☐ Mild ☐ Moderate ☐ Extreme
Loss of Loved One	☐ Mild ☐ Moderate ☐ Extreme	☐ Mild ☐ Moderate ☐ Extreme
Change in Lifestyle	☐ Mild ☐ Moderate ☐ Extreme	☐ Mild ☐ Moderate ☐ Extreme
Change in Vocation	☐ Mild ☐ Moderate ☐ Extreme	☐ Mild ☐ Moderate ☐ Extreme
Abuse (Verbal, Physical, Emotional, Sexual, etc)	☐ Mild ☐ Moderate ☐ Extreme	☐ Mild ☐ Moderate ☐ Extreme

OVERALL STRESS SURVEY

Please grade your Current Life Stresses using the following scale:

0 - No awareness of any stress 1 - Slightly stressful 2 - Moderately stressful 3 - Extremely stressful

0 1 2 3	Overall Physical Stress/Trauma: (includes: falls, accidents, injuries, repeated postural stress, impacts, difficult birth, physical abuse, loss of consciousness, broken/fractured bones, etc.)
0 1 2 3	Overall Emotional/Mental Stress: (includes: loss of loved ones, rapid change in life situations, abuse, move of /school, legal concerns, financial concerns, divorce, relationships, etc)
0 1 2 3	Overall Chemical Stress: (includes: prescription drugs, smoke, alcohol, caffeine, fumes, food additives, anesthesia from surgery, over-the-counter medications, etc.)

YOUR SPECIFIC NEEDS AND HOPES FOR HELP IN THIS OFFICE?

What is your commitment level to improving your overall well-being? _____%

What are your goals with us?

1. _____

2. _____

3. _____

Is there anything else you may wish to share which may help us to better understand you and your reasons for seeking support?

Disclosure Statement

This disclosure statement is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Statute Title 12 Article 29.5. All rules and regulations set forth by the Department of Health are strictly adhered to, including proper cleaning, sterilization, and sanitation of equipment and office. The practice of acupuncture is regulated by the Department of Regulatory Agencies. Inquiries should be made to: Director of Registrations, Acupuncturists Licensure, 1560 Broadway, Suite 1350, Denver, CO 80202, (303)894-7800. Patients are entitled to receive information about the methods of therapy, techniques used, and the duration of therapy, if known. Patients may seek a second opinion and may terminate therapy at any time. 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.

Clinic Fee Schedule (due at time of service)

Acupuncture new client visit: \$185

Acupuncture return client visit: \$140-\$150

We ask for 24 hours notice in advance of an appointment if it is necessary to cancel or reschedule. All appointments that are canceled or rescheduled with less than 24 hours notice, as well as appointments missed without notice, will be charged the full visit for that appointment.

Initial _____

Insurance: We do not bill insurance. Upon request, we will provide you with a receipt for your insurance company.

Practitioner Education, Certification, and Experience

Dr. Amanda Love, DC, L.Ac, NCCAOM Dipl. Ac. issued in 2011. Master of Science, Finger Lakes School of Acupuncture in Seneca Falls, NY, 2011. CO Licensed Acupuncturist #2062.

Amanda is a licensed, board certified acupuncturist in the state of Colorado. She completed her National Board Certification with NCCAOM, as well as over 2,200 hours of education and clinical skill performance at the Finger Lakes School of Acupuncture to receive her Master of Science in Acupuncture. She also received certification in Clean Needle Technique and training in adjunctive therapies such as moxibustion, tuina, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations. Amanda also holds a Doctorate in Chiropractic from New York Chiropractic College 2010 and a Bachelor's of Science in Occupational Therapy 2004. She is licensed in the state of Colorado as both a Chiropractor and Occupational Therapist in addition to her Acupuncturist license. Chiropractic CO#7235. Occupational Therapist CO#4189. None of her licenses, certificates, or registrations have ever been suspended or revoked.

Informed Consent

When a patient seeks acupuncture care and we accept a patient for such care, it is essential for both the patient and the practitioner to be working for the same objective. It is important that both understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo acupuncture care after being advised of the known benefits, risks and alternatives.

Acupuncture is a system that influences the energetic system within the body. According to Chinese medicine there are meridians that carry "qi" inside and around our bodies. Imbalances or blockages within this system can influence how we interact with ourselves, the world around us and can cause disharmonies to occur within these energetic systems. When any of these things occur they can influence our state of health and wellness. In this office acupuncture is utilized to integrate, balance or remove blockages within this system so the body can self-regulate and heal. When this is successfully accomplished improvements in health and well-being often follow.

Energetic imbalances are manipulated by acupuncture needle insertion, acupressure, moxibustion, cupping and bodywork. Acupuncture is a safe method of treatment and it may have side effects including discomfort, pain, dizziness, bruising, or numbness at site of procedure. Unusual and rare risks of acupuncture include nerve damage, organ puncture including lung puncture, infection, and spontaneous miscarriage. Other side effects and risks may occur. If I suspect that I am pregnant, I will immediately inform the acupuncturist.

If during the course of care we encounter non-acupuncture or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

Our practice 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.

All questions regarding the practitioner's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of acupuncture care have been explained to me to my satisfaction. I understand that there are no guarantees regarding cure or improvement of my condition. I understand that 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 me outside of these facilities.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications and I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist judges to be in my best interests based upon the facts then known. I understand that I have the choice to accept or reject treatment at any time.

I have read and fully understand the above statements and accept acupuncture care on this basis. By signing below I agree 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.

Print Name

Signature

Date

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant. If I become pregnant I will inform the practitioner immediately.

Signature

Date

Consent to evaluate and treat a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive acupuncture care.