



WELCOME LETTER

Welcome to East Winds Acupuncture; we look forward to working with you on your journey to health.

We are committed to helping you and will focus our efforts toward assuring you a pleasant experience as well as an excellent outcome. We feel that it is vital that you commit yourself to the “plan” that we recommend for you upon your first visit with us.

On that note we ask that you comply with the following cancellation policies.

- We reserve the right to charge you for appointments cancelled or broken without 24 hours advance notice, at full cost of treatment.
 - Appointment cancellations should be made 24 hours in advance of your scheduled appointment time. We understand emergencies do arise. We simply ask that you extend the courtesy to fellow patients, by letting us that you need to cancel. This will allow us to open your time slot for another patient as well as reschedule your appointment.
- Your care is important to us and we make every effort to accommodate your busy schedule. However, if you are more than 10 minutes late for an appointment, and it cannot be rescheduled the same day, you have the option of accepting a shortened acupuncture session, or paying for a missed appointment.

As of January 1st, 2015 we will require a credit card when scheduling all New Patient appointments. If you do not show for your appointment, your card will be charged 50% of the new patient fee which will be a total of \$67.50.

Our goal is to help you and many other patients experience the benefits of acupuncture and Oriental Medicine. We block off two hours for all new patients. If you no-show without giving 24 hours’ notice, that time is not available for another patient who may need an appointment. We know you understand.

Our goal is high quality, efficient care, and to accommodate all patients who would like to be seen by Dr. Diane.

Please sign this form and bring it with you completed health history forms. It is important that you fill ALL sections and pages of these forms so we don’t waste precious one on one time with Dr. Diane.

Thank you.

Sincerely;
Diane Cridennda L.Ac FABORM NCCAOM

Date: _____

Patient Name (print): _____ Patient Signature _____

Treatment(s) you have received for this Condition 1) _____

 2) _____ 3) _____

SYMPTOMS – NOTE: For each symptom you currently have, rate its severity from 1-10 (10 being the worst). Leave blank if Not Applicable. Circle choice if two choices are given.

LIVER / GALLBLADDER		
_____ Irritability / Anger	_____ Poor Memory	_____ Low Resistance to Colds or Flu
_____ Depression / Stress	_____ Loss of Hair	_____ Sneezing
_____ Headaches / Migraines	_____ Hearing Problems	_____ Mild Fever Comes & goes
_____ Visual Problems	_____ Cavities	_____ Smokes Cigarettes
_____ Red / Dry / Itchy Eyes	_____ Fear	_____ Emphysema
_____ Gall Stones	_____ Hot Flash/ Night Sweating	_____ Bronchitis
_____ Dizziness	_____ Do you crave: Salty	_____ Black / Blood in Stools
_____ Blurred Vision		_____ Constipation
_____ Feeling of Lump in Throat	HEART/SMALL INTESTING	
_____ Clenching of Teeth at Night	_____ Heart Palpitations	_____ IBS
_____ Muscle Cramping / Twitching	_____ Chest Pain	_____ Colitis/ Spastic Colon
_____ Tension	_____ Insomnia / Sleep Problems	_____ Diarrhea
_____ Joints/Neck/Shoulder Pain/Tight	_____ Easily Startled	_____ Do you Crave : Pungent
_____ Poor Circulation	_____ Restlessness / Agitation	
	_____ Vivid Dreams	SPLEEN / STOMACH
_____ Soft / Brittle Nails	_____ Lack of Joy in Life	_____ Heaviness Anywhere in the Body
_____ Emotional Eater	_____ Do you crave: Bitter	_____ Fatigue on a Scale of 1(low) –10 (high)
_____ Bad Taste		_____ Hard to get up in the Morning
		_____ Muscles Feel Tired Often
_____ Bad Breath	LUNG / LARGE INTESTINE	
_____ Do you Crave: Sour	_____ Bloody Cough	_____ Edema (swelling) <input type="checkbox"/> hands <input type="checkbox"/> feet
	_____ Dry Cough	_____ Easily Bruising & Bleeding
KIDNEY/ URINARY BLADDER	_____ Cough with Sputum	_____ Bad Breath
_____ Urinary Problems	_____ Nasal Discharge / Circle Color -	_____ Nausea/ Vomiting
_____ Bladder Infection	_____ White Yellow Green	_____ Difficulty Digesting Fatty Foods
_____ Dropped Bladder	_____ Post Nasal Drip / Circle Color:	_____ Nausea/ Vomiting
_____ Incontinence	_____ White Yellow Green	_____ Gas / Belching
_____ Lack of Bladder Control	_____ Sinus Infection/ Congestion	_____ Hemorrhoids
_____ Weakness/ Pain in Low Back	_____ Itchy, Red, or Painful Throat	_____ Constipation
_____ Decrease Bone Density	_____ Dry Mouth/ Throat/ Nose	_____ Diarrhea
_____ Feel Cold Easily	_____ Skin Rashes / Hives	_____ Abdominal Pain
_____ Cold Hands	_____ Snoring	_____ Indigestion / Heartburn
_____ Cold Feet	_____ Grief / Sadness	_____ Over - Thinking
_____ Low Sex Drive / Libido	_____ Shortness of Breath	_____ Tendency to Gain Weight
_____ Excess Sexual Desire	_____ Allergies / Asthma	_____ Brain Foggy
		_____ Do you Crave: Sweet

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose sprays, and topical creams. NOTE: If need more space, use page 6 under 'Notes/Anything Else'

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better _____

Have you had acupuncture before? _____

If yes, who and where? _____

Any concerns or fears about the needles? _____ If yes, what? _____

What are your goals from your acupuncture visits? 1. _____
 2. _____
 3. _____

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "C" under the appropriate person's column. "P" should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the space below.

	You	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
Age							
AIDS / HIV							
Alcohol Abuse							
Anxiety							
Anorexia / Bulimia							
Arthritis							
Asthma / Hay Fever / Allergy							
Back Trouble							
Bursitis							
Cancer							
Constipation							
Depression							
Diabetes							
Digestive Trouble							
Headaches							
Heart Trouble							
Hepatitis							
High Blood Pressure							
Immune Disorder							
Insomnia							
Kidney Trouble							
Liver Trouble							
Migraine							
Neck Pain							
Thyroid Disorder							
Suicidal Tendencies/self/others							
Tobacco							
Weight Problem							
Other Emotional Problems: _____							
Other: _____							

If any of the above family members are deceased, please list their age at death and cause.

SURGERIES (Including the removal of wisdom teeth)

Date or Age	Type Of Surgery	Location of Scar

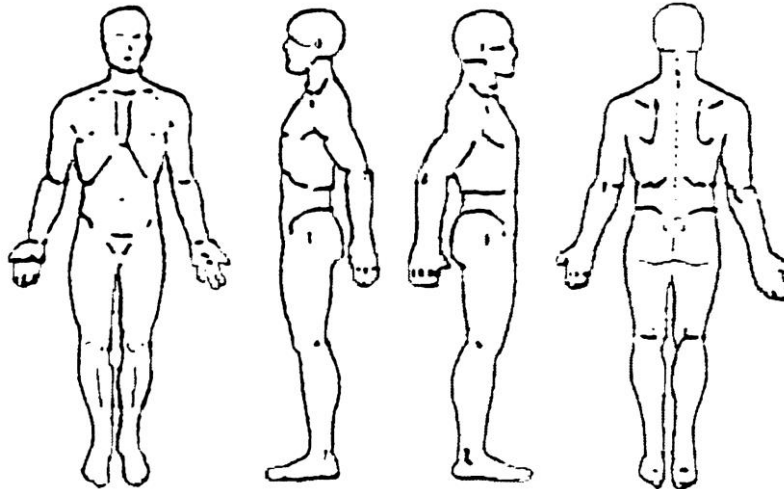
MUSCULOSKELETAL

- Muscle Cramps – Where?
- Joint Swelling – Where?
- What Makes this Better? :

- Muscle Pain / Rheumatism – Where?
- Tendonitis – Where?

- Arthritis – Where?
- Bursitis – Where?

Please mark problem areas on diagram:



<p>Location of Pain</p> <p>Is the Pain</p> <p><input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Tingling <input type="checkbox"/> Other: _____</p> <p>On a Scale of 1 (Low) – 10 (unbearable):</p> <p>Is the Pain Better With:</p> <p><input type="checkbox"/> Rest <input type="checkbox"/> Activity <input type="checkbox"/> Ice</p> <p><input type="checkbox"/> Heat <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Massage <input type="checkbox"/> Chiropractic</p>	<p>Location of Pain</p> <p>Is the Pain</p> <p><input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Tingling <input type="checkbox"/> Other: _____</p> <p>On a Scale of 1 (Low) – 10 (unbearable):</p> <p>Is the Pain Better With:</p> <p><input type="checkbox"/> Rest <input type="checkbox"/> Activity <input type="checkbox"/> Ice</p> <p><input type="checkbox"/> Heat <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Massage <input type="checkbox"/> Chiropractic</p>
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Female Fertility Form

Date ____/____/____	Age	Body Type	Height:	Weight:	Complexion:	Occupation:
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Are you being treated by: _____

LMP: _____ Cycle Duration _____
 RE & I Clinic / Fertility Specialist: RMFC / CCRM / FCC / Conceptions / CU
 Other OBGYN doctor _____ Start Date: _____ Month/Year

Western Diagnosis _____

1. How many times per week do you have intercourse? _____ x per week
2. Do you use lube for vaginal dryness? _____

3. Fertility treatments (including cancelled cycles):

Date	Natural, IUI IVF, Other	Medication Used	# of Mature Eggs / Follicles	Pregnancy Yes/No	If Miscarried, Indicate at which Week	Other Comments and Locations

4. Your Diagnostics / Date

Elevated FSH	Uterine Fibroids / Polyps	Endometriosis / Adhesions	PCOS	POF	Low Progesterone Level	PID	STD's	Herpes

Others: _____

5. If you have PCOS, are you taking:

Glucophage	Fortamet	How long?	Are you taking extra B-Complex Vitamins?

6. Female Health:

PID	Chlamydia	STD's	Herpes	Antisperm Antibodies	Others

7. Procedures performed / Dates

Laparoscopy	HSG-Hysterosalpingogram	Others:

8. Lab Results/ Dates

FSH Level Day 3	HCG	Prolactin	TSH	T3:	T4:	Free T4:	OAR	Others

9. Lab Results on File Y / N

9. Supplements and/or Vitamins?

Date	Prenatal	Fish Oil	Greens Plus	Antioxidants	Royal Jelly/ Propolis	Additional Folic Acid	Others

10. Planned ART / Date:

IUI w/ Injectables	IUI w/ Oral Meds	Clomid	IVF	PGD/CCS	Femara letrozole	other

11. Fertility History / Dates

Pregnancies	Children	Miscarriages	Abortions	Ectopics	D&C	Abnormal Pap Smear	Others

12. Other:

<p>Age at which menses began? _____</p> <p>Oral Contraceptive Pill? _____ How long? _____</p> <p>List name of birth control _____</p> <p>How long have you tried to conceive? _____</p> <p>Clomid challenge test? _____</p> <p>Date: _____</p> <p>Day 3 _____ at Day 10 _____ at _____ (month/year)</p> <p>Recurrent yeast infections? _____ How often? _____</p>	<p>Natural Ovulation Y / N</p> <p>Which day of your cycle are you on today _____ to _____</p> <p>Typically, how many days are there from one period to the next _____ to _____ days?</p> <p>Today is which day of your cycle? _____</p> <p>Current month treatment plan _____ (Natural, IUI, IVF, Any Tests, etc.)</p>
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13. PMS

	10 Days Before	1 Week Before	2-3 Days Before
Breast Tenderness			
Depression			
Fatigue			
Low Back Pain			
Face Break Out			
Other			

14. Menstrual History

Symptoms (please check each day)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6-7
Do you have Back Pain?						
Cramps (Light, Medium, Severe)						
Color (Light Red / Red / Dark Red / Brown)						
How Heavy is Flow (Light, Normal, Heavy)						
Is there Clotting?						
Is there Spotting?						

15. Is partner currently being treated by us?

Y / N

16. Partner's Name _____

17. Western Diagnosis of the partner: _____

18. Do we have copies of labs / sperm analysis

Y / N

19. Results for Sperm Analysis:

Date	Count	Morphology	Motility	Volume

20. Male Reproductive History/ Date:

Varicocele	Vasectomy	Vasectomy Reversal	SDSA/ DNA	Anti- Sperm Antibodies	Others

21. Following Fertility:

Basal Body Temperature Chart	Y / N	Avoid Ice cold Foods.....	Y / N
Timed Sex	Y / N	Avoid Tampons.....	Y / N
Stress Reduction	Y / N	Femoral Massage	Y / N
Diet Principals :		Visualization.....	Y / N
<input type="checkbox"/> Yin		Meditation	Y / N
<input type="checkbox"/> Yang		Yoga	Y / N
<input type="checkbox"/> Blood		Qi Gong.....	Y / N
<input type="checkbox"/> Qi		Deep Breathing.....	Y / N
<u>Ovulation</u>		Journaling.....	Y / N
(LH) Luteinizing Hormone Sticks	Y / N	Foot Soaks.....	Y / N
(OPK) Ovulation Predictor Kit	Y / N	Feminine Hygiene.....	Y / N
Relationship / Sex	Y / N	Detox.....	Y / N
		Type of Detox	
		Feng Shui.....	Y / N



Diane Cridennda, L.Ac. NCCAOM FABORM
1422 North Hancock Suite 5 South
Colorado Springs, CO 80903
P (719) 520-5056 • F (719)-520-5222
info@EastWindsAcupuncture .com

NEW PATIENTS: Please do not come hungry.
Do not scrub, scrape or brush your tongue.
We need to see it in its natural state.
It is Ok to brush your teeth. Plan to be here **at least 2**
hours for your initial intake and treatment.

Disclosure & Fee Schedule

Acupuncture Fee Schedule: fees due upon service

\$135.00 Initial Visit (health history, evaluation & treatment)
\$80.00 Follow-up Acupuncture Visit
\$70.00 Herbal Consult
\$130.00 Lab Interpretation & Consult
\$85.00 Pre or Post transfer during office hours
\$100.00 On Call (outside of office hours)
\$160.00 On Site IVF pre or post transfer
\$15.00 Per 15 minutes phone/email consultation
\$70.00 Initial Visit for Pediatrics
\$50.00 Sho Ni Shin/ Gua Sha (Pediatrics)
\$ 1.00 /per min. Moxa/Cupping & other
Acupuncture Modalities

Discount Packages

100% transferable and 100% refundable**

24 Visits \$1,560 (\$65 per treatment)
12 Visits \$840 (\$70 per treatment)
6 Visits \$450 (\$75 per treatment)

Herbs & Supplements

purchased separately*

All sales on Herbs and or Supplements are final.
All Special Order herbs or supplements require
payment in full prior to ordering and are subject to a
50% restocking fee if returned.

CANCELLATION POLICY:

We reserve the right to charge you for appointments cancelled or broken without 24 hours advance notice.

If you are more than 10 minutes late for an appointment, and it can't be rescheduled the same day, you have the option of accepting a shortened acupuncture session, or paying for a missed appointment.

We allow a one-time grace with a GOOD reason.

PROFESSIONAL AND ETHICAL STANDARDS:

You, the patient are entitled to receive information regarding methods of therapy, techniques used and duration of therapy. As a patient you may seek a second opinion from another health care professional, and may terminate therapy at any time. In a professional relationship, sexual intimacy is not appropriate and should be reported to the division of regulations (address provided below)

The practice of acupuncture is regulated by the Department of Regulatory Agencies. Questions or complaints should be addressed to:

**Jenny Davis- Office of Acupuncture Licensing
1560 Broadway, Suite 1340, Denver, Colorado 80202-5140
303-894-7851 fax 303-894-7802**

We comply with all rules and regulations promulgated by the Department of Health and Environment, especially those related to proper sanitation of acupuncture offices. We use disposable needles only.

PATIENT POLICY:

We will recommend a treatment plan according to your specific needs. Some conditions require more treatments than others. In order for you to experience a successful course of treatment for your problems, it is important that you commit to and follow this treatment plan

TREATMENT:

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation of symptoms or disorders.

I understand that complications may result from an acupuncture treatment. Among these possible complications are: areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothroax, and aggravation of present symptoms. Being tired, hungry, or stressed can on occasion make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia or Coumadin use. Please use caution when walking with bare feet in the treatment room.

