



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
- _____ Depression / Stress
- _____ Headaches / Migraines
- _____ Visual Problems
- _____ Red / Dry / Itchy Eyes
- _____ Gall Stones
- _____ Dizziness
- _____ Blurred Vision
- _____ Feeling of Lump in Throat
- _____ Clenching of Teeth at Night
- _____ Muscle Cramping / Twitching
- _____ Tension
- _____ Joints/Neck/Shoulder
- _____ Pain/Tight
- _____ Poor Circulation
- _____ Soft / Brittle Nails
- _____ Emotional Eater
- _____ Bad Taste

- _____ Poor Memory
- _____ Loss of Hair
- _____ Hearing Problems
- _____ Cavities
- _____ Fear
- _____ Hot Flash/ Night Sweating
- _____ Do you crave: Salty

- _____ Low Resistance to Colds or Flu
- _____ Sneezing
- _____ Mild Fever Comes & goes
- _____ Smokes Cigarettes
- _____ Emphysema
- _____ Bronchitis
- _____ Black / Blood in Stools
- _____ Constipation
- _____ IBS
- _____ Colitis/ Spastic Colon
- _____ Diarrhea
- _____ Do you Crave : Pungent

HEART/SMALL INTESTINE

- _____ Heart Palpitations
- _____ Chest Pain
- _____ Insomnia / Sleep Problems
- _____ Easily Startled
- _____ Restlessness / Agitation
- _____ Vivid Dreams

SPLEEN / STOMACH

- _____ Heaviness Anywhere in the Body
- _____ Energy on a Scale of 1(**low**) –10 (**high**)
- _____ Hard to get up in the Morning
- _____ Muscles Feel Tired Often
- _____ Edema (swelling) hands feet
- _____ Easily Bruising & Bleeding
- _____ Bad Breath
- _____ Nausea/ Vomiting
- _____ Difficulty Digesting Fatty Foods
- _____ Nausea/ Vomiting
- _____ Gas / Belching
- _____ Hemorrhoids
- _____ Constipation
- _____ Diarrhea
- _____ Abdominal Pain
- _____ Indigestion / Heartburn
- _____ Over - Thinking
- _____ Tendency to Gain Weight
- _____ Brain Foggy
- _____ Do you Crave: Sweet

LUNG / LARGE INTESTINE

- _____ Bloody Cough
- _____ Dry Cough
- _____ Cough with Sputum
- _____ Nasal Discharge / Circle Color -
- _____ White Yellow Green
- _____ Post Nasal Drip / Circle Color:
- _____ White Yellow Green
- _____ Sinus Infection/ Congestion
- _____ Itchy, Red, or Painful Throat
- _____ Dry Mouth/ Throat/ Nose
- _____ Skin Rashes / Hives
- _____ Snoring
- _____ Grief / Sadness
- _____ Shortness of Breath
- _____ Allergies / Asthma

KIDNEY/ URINARY BLADDER

- _____ Urinary Problems
- _____ Bladder Infection
- _____ Dropped Bladder
- _____ Incontinence
- _____ Lack of Bladder Control
- _____ Weakness/ Pain in Low Back
- _____ Decrease Bone Density
- _____ Feel Cold Easily
- _____ Cold Hands
- _____ Cold Feet
- _____ Low Sex Drive / Libido
- _____ Excess Sexual Desire

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 of 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 removal of wisdom teeth)

Date or Age	Type of Surgery	Location of Scar

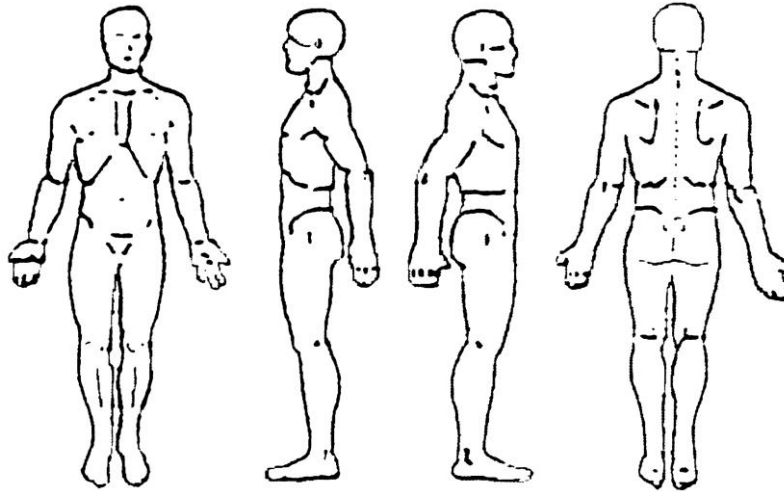
MUSCULOSKELETAL

- 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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Male Fertility Form

Date ____/____/____	Date of Birth ____/____/____	Age	Body Type	Height:	Weight:	Complexion:	Occupation
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Name of your doctor/ Fertility Specialist: RMFC / CCRM / FCC / Conceptions / CU / Other OBGYN doctor
 Start Date: _____ (Month/ Year)

Western Diagnosis: _____

1. Results for Sperm Analysis:

Date	Count	Morphology	Motility	Volume

2. Do we have a copy of your Semen Analysis? Y / N

3. Other Procedures/ Date:

Varicocele	Vasectomy	Vasectomy Reversal	SDFA / SCSPA	Others

4. Do you take any of these Supplements and/or Vitamins?

# of Months on Vitamins	Male Vitamins	Mega Man	Fish Oil	L - Carnitine	L - Arginine	Antioxidants	EWA Complete List

Other: _____

5. Couples ART(Assisted Reproductive Technique) Plans:

IUI	Clomid	IVF	PGD/CCS	TESA	Other

6. Have you fathered children? Y / N If so, how many _____

7. How many times per week do you ejaculate?

During Intercourse: _____ During Masturbation: _____

9. Male Health

Infection	Chlamydia,	Erectile Dysfunction	Ejaculation Problems	Retrograde Ejaculation	Prostate
	Y / N	Y / N	Y / N	Y / N	Y / N

10. Male Health Continued

Antisperm Antibodies	DNA Integrity SDFA	High Cholesterol	Diabetes (fasting, glucose)	Other
Y / N	Y / N	Y / N	Y / N	

11. Is your Spouse currently being treated by us? Y / N

12. Spouse's Name: _____

13. Western Diagnosis of Spouse: _____



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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.

