



## 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 1<sup>st</sup>, 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

**HEART/SMALL INTESTINE**

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

**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

- \_\_\_\_\_ 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

**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

**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
<b>Age</b>							
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: _____							

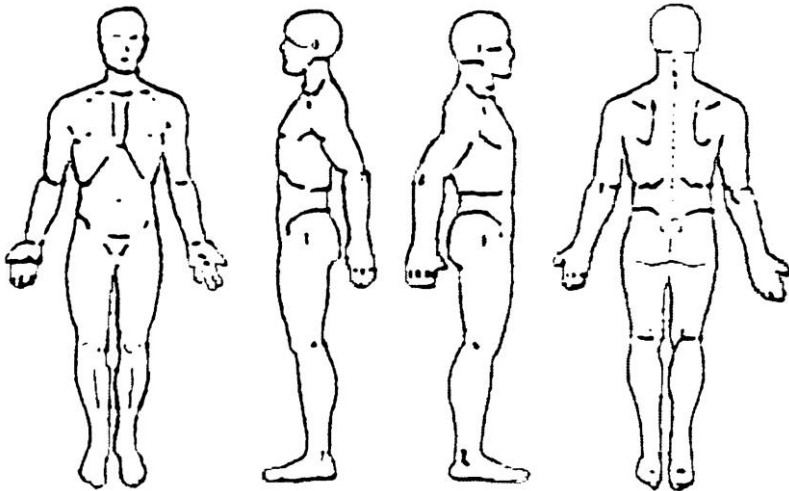
If any of the above family members are deceased, please list their age at death and cause.

**SURGERIES (Including removal of wisdom teeth)**

Date or Age	Type of Surgery	Location of Scar

**MUSCULOSKELETAL**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Muscle Cramps – Where?<br><input type="checkbox"/> Joint Swelling – Where?<br>What Makes this Better? : _____ | <input type="checkbox"/> Muscle Pain / Rheumatism – Where?<br><input type="checkbox"/> Tendonitis – Where? | <input type="checkbox"/> Arthritis – Where?<br><input type="checkbox"/> Bursitis – Where? |
|--|--|---|

<p><b>Location of Pain</b></p> <p>Is the Pain:</p> <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Fixed <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Other: _____ <p><b>Please mark problem areas on diagram:</b></p> <p>Is the Pain Better With:</p> <input type="checkbox"/> R <input type="checkbox"/> H <input type="checkbox"/> M	<p><b>Location of Pain</b></p> <p>Is the Pain:</p> <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Fixed <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Other: _____ <p><b>On a Scale of 1 ( Low ) – 10 (unbearable):</b> _____</p> <p>Is the Pain Better With:</p> <input type="checkbox"/> Activity <input type="checkbox"/> Ice <input type="checkbox"/> Other: _____ <input type="checkbox"/> Chiropractic
	

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



