

# Cindy Haxel Acupuncture

MSTCM, Dipl.Ac., L.Ac.



## Health History

Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but may play a major role in diagnosis and treatment. All information is strictly confidential.

Date: \_\_\_/\_\_\_/\_\_\_

### General Patient Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

To retain your privacy, may we contact you or leave messages at these phone numbers? Y/N

If No, what is the best way to reach you? \_\_\_\_\_

Email address: \_\_\_\_\_ Would you like to be on our email list? Y/N

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Guardian (if under 18 years old): \_\_\_\_\_

Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Family/Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last medical exam: \_\_\_/\_\_\_/\_\_\_ Type (physical, pap, etc.): \_\_\_\_\_

#### Emergency Contact

Name/Relationship/Phone: \_\_\_\_\_

Have you ever been treated by acupuncture or oriental medicine before? Y/N

Main conditions/symptoms that brought you here today (list in order of significance)

1) \_\_\_\_\_ 4) \_\_\_\_\_

2) \_\_\_\_\_ 5) \_\_\_\_\_

3) \_\_\_\_\_ 6) \_\_\_\_\_

How long ago did these problems begin? \_\_\_\_\_

To what extent do these problems affect your daily activities? \_\_\_\_\_

What kinds of treatments have you already tried? \_\_\_\_\_

How well have they worked? \_\_\_\_\_

What are your personal health goals? \_\_\_\_\_

\_\_\_\_\_

II. PAST MEDICAL HISTORY

How was your childhood health? \_\_\_\_\_

List all Hospitalizations, Surgeries, Auto Accidents, Trauma, Falls: \_\_\_\_\_

**Family History**

Please indicate if a patient or a close relative (parent, grandparent, sibling) has had any of the following:

	Self	Relative
<input type="checkbox"/> Allergies                    Type		
<input type="checkbox"/> Anemia		
<input type="checkbox"/> Arthritis                    Type		
<input type="checkbox"/> Asthma		
<input type="checkbox"/> Birth Defects                Describe		
<input type="checkbox"/> Bleeding Disease          Type		
<input type="checkbox"/> Cancer                      Type		
<input type="checkbox"/> CVA/Stroke		
<input type="checkbox"/> Depression		
<input type="checkbox"/> Type I Diabetes (Insulin dependent)		
<input type="checkbox"/> Type II Diabetes		
<input type="checkbox"/> Eczema		
<input type="checkbox"/> Emphysema		
<input type="checkbox"/> Epilepsy		
<input type="checkbox"/> Glaucoma		
<input type="checkbox"/> Heart Disease              Type		
<input type="checkbox"/> Hemophilia		
<input type="checkbox"/> Hepatitis		
<input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> High Fever (frequent)		
<input type="checkbox"/> HIV/AIDS		
<input type="checkbox"/> Jaundice		
<input type="checkbox"/> Juvenile Arthritis		
<input type="checkbox"/> Kidney Disease            Type		
<input type="checkbox"/> Liver Disease              Type		
<input type="checkbox"/> Lung Disease              Type		
<input type="checkbox"/> Measles		
<input type="checkbox"/> Meningitis		
<input type="checkbox"/> Mental Illness		
<input type="checkbox"/> Migraines		
<input type="checkbox"/> Mononucleosis		
<input type="checkbox"/> Nervous Disease		
<input type="checkbox"/> Pacemaker		
<input type="checkbox"/> Pneumonia		
<input type="checkbox"/> Psoriasis		
<input type="checkbox"/> Rheumatic Fever		
<input type="checkbox"/> Rubella		
<input type="checkbox"/> Scarlet Fever		
<input type="checkbox"/> Seizures		
<input type="checkbox"/> Spleen Disease            Type		
<input type="checkbox"/> Stomach Disease          Type		
<input type="checkbox"/> Stroke		
<input type="checkbox"/> Thyroid Disease          Type		
<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Vein conditions            Type		
<input type="checkbox"/> Other		
<input type="checkbox"/> Family Medical History is unknown		

III. PATIENT PROFILE

Please list all medications taken in the last 3 months (including drugs, vitamins and herbs): \_\_\_\_\_

\_\_\_\_\_

Occupational Stress (chemical, physical, psychological, etc.): \_\_\_\_\_

Do you have a regular exercise program? Y/N If yes, describe: \_\_\_\_\_

Are you on a restricted diet? Y/N If yes, describe: \_\_\_\_\_

How much water do you drink daily? \_\_\_\_\_

How many caffeinated drinks do you drink per day (coffee, tea, soda)? \_\_\_\_\_

How many alcoholic drinks do you drink per week? \_\_\_\_\_

Do you smoke? Y/N If yes, how many cigarettes per day? \_\_\_\_\_

**Pain Conditions—Please fill out the following if you experience pain on a regular basis:**

Describe any areas of pain in the body and the location of any scars on the body: \_\_\_\_\_

\_\_\_\_\_

Is the pain sensation (circle all that apply):

Sharp                  Burning                  Aching                  Cramping                  Dull                  Moving                  Fixed

Other:

\_\_\_\_\_

Do any of the following lessen the pain (circle all that apply):

Pressure                  Cold                  Heat                  Exercise

Other:

\_\_\_\_\_

Do any of the following worsen the pain (circle all that apply):

Pressure                  Cold                  Heat                  Exercise

Other:

\_\_\_\_\_

**Diet:**

Please describe your diet in general. Include any dietary restrictions (i.e. vegetarian, gluten-free, etc.), also, mention any bad dietary habits such as excessive fast food, high sugar intake, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any other problems you'd like to discuss? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Women only:**

Are you still menstruating? Y/N If no – reason: menopause / hysterectomy / ablation / other \_\_\_\_\_

Do you practice birth control? Y/N Method: \_\_\_\_\_ Issues: \_\_\_\_\_

Is there a chance you may be pregnant now? Y/N

Vaginal discharge: Y/N Frequent? Y/N Color? \_\_\_\_\_ Odor? \_\_\_\_\_

Regular menstrual cycle? Y/N Total days bleeding: \_\_\_\_\_ Total days of cycle (day 1 – day 1) \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_ Number of children: \_\_\_\_\_

Difficulties with pregnancy? Y/N Describe: \_\_\_\_\_

How long after giving birth until menses returns? \_\_\_\_\_

Age of first menstruation: \_\_\_\_\_ Age of menopause (if applicable): \_\_\_\_\_

Avg # days of flow: \_\_\_\_\_ Avg # days of entire cycle: \_\_\_\_\_ Quantity: Light / Medium / Heavy

Uterine bleeding/spotting between periods? Y/N How much and how often? \_\_\_\_\_

Do you experience any of the following pre-menstrual or menstrual syndromes (circle all that apply)?

- |                       |                   |                 |           |
|-----------------------|-------------------|-----------------|-----------|
| Breast Swelling       | Breast Tenderness | Clotting        | Cramping  |
| Food cravings         | Headaches         | Low Back Pain   | Migraines |
| Nausea                | Vomiting          | Water Retention |           |
| Other issues:         |                   |                 |           |
| Anxiety               | Depression        | Irritability    |           |
| Other emotions: _____ |                   |                 |           |

**Men only:**

Swollen testes      Testicular pain      Impotence      Premature ejaculation

Feeling of coldness or numbness in external genitalia

Other (describe): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Acupuncturist Signature: \_\_\_\_\_

**For clients that will be using medical insurance only:**

I authorize the release of any medical or other information necessary to process this claim. i also request payment of government benefits either to myself or to the party who accepts assignment below.

Patient Signature: \_\_\_\_\_

Acupuncturist Signature: \_\_\_\_\_

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Patient Signature: \_\_\_\_\_

Acupuncturist Signature: \_\_\_\_\_

# Cindy Haxel Acupuncture

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## Mandatory Disclosure

### Education and Experience

Cindy Haxel earned her Master of Science in Traditional Chinese Medicine from the Colorado School of Traditional Chinese Medicine in August 2007. This 4-year program consists of 2850 hours of education including 1080 hours of clinical practice. She was certified as a Diplomate in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in September 2007. This includes certification in Clean Needle Technique.

Cindy's training includes adjunctive therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy, and diet and lifestyle recommendations. She also has specialized training in Cosmetic Acupuncture and Pediatrics.

Cindy is a member of the American Association of Oriental Medicine. She received her acupuncture license in Colorado in 2007. Her license, certificates, or registrations have never been suspended or revoked.

This clinic complies with the rules and regulates promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are used.

### Fee Schedule

	Per session	Discount Packages *
Cosmetic Acupuncture	\$120	\$1000 for 10 sessions
Initial Intake / 90 minute	\$95	
Follow-up Treatment / 60 minute	\$65	\$360 for 6 sessions
Children / Herbal Consult / 30 minute	\$50	\$250 for 6 sessions

\* The patient may terminate this treatment at any time and any unused treatments will be refunded at the discounted rate.

### Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- If at any time the patient wishes to terminate treatment and they have purchased a discount package they will be refunded in full for any unused treatments at the discounted rate.
- 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.

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.

I have read and understand this document.

\_\_\_\_\_  
Patients (Guardian's) Signature

\_\_\_\_\_  
Date

*Cindy Haxel Acupuncture*

*MSTCM, Dipl.Ac., L.Ac.*



## *HIPPA Acknowledgment & Consent*

### **Cindy Haxel Acupuncture protects Your Health Information and Privacy**

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation or with other medical practitioners that you authorize.

Safeguards in place at this office include:

- Limited access to facilities where information is stored
- Policies and procedures for handling information
- Requirements for third parties to contractually comply with privacy laws
- All medical files and records are kept on permanent file

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us
- From your medical history, treatment notes, all test results, and any communication records to or from other health care practitioners
- From health care providers, insurance companies, workman's comp and your employer, and other third party administrators

In certain states, you may be able to access and correct personal information we have collected about you.

We value our relationships, and respect your right to privacy. If you have questions at all about our privacy policies, please call us at 303-956-5817.

I give Cindy Haxel my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices of the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient, parent or legal guardian

If signed by patient representative, state relationship to patient \_\_\_\_\_

*Cindy Haxel Acupuncture*  
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**INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE**

I hereby request and consent to the performance of acupuncture and other procedures within the scope of practice of acupuncture on me (or the patient named below for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including but not limited to, a punctured lung, infection, and bruising. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment that is in my best interest, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

*To be completed by the patient or patient's legal representative:*

\_\_\_\_\_  
Print patient's name

\_\_\_\_\_  
Signature of patient or patient's legal representative

\_\_\_\_\_  
Date

Relationship to patient, if patient's legal representative: \_\_\_\_\_