CORTEZ FAMILY ACUPUNCTURE INC

Andrew Parks, L.Ac, MSOM

1 W 1st Street Cortez, CO 81321
aparks@cortezacupuncture.com
tel: (970) 565-0230 | fax: (970) 565-3463

PATIENT INFORMATION TODAY'S DATE:_____

NAME: _____ MARRIED SINGLE OTHER (CIRCLE)

GENDER: ☐ MALE ☐ FEMALE ☐ NONBINARY ☐ RATHER NOT SAY

PARENT / GUARDIAN'S NAME (if being filled out by parent or guardian):_____

EMPLOYER:_____ OCCUPATION:_____

DATE of BIRTH:_____AGE _____ PLACE of BIRTH:_____

TEL. NUMBER: WORK:_____HOME:_____CELL:_____

ADDRESS:_____

CITY:_____STATE:_____ ZIP:_____

E-MAIL_____ SOCIAL SECURITY #_____

PRIMARY CARE PHYSICIAN:_____

SPECIALIST PHYSICIAN(S):_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____

EMERGENCY CONTACT TEL. NUMBER:_____

HAVE YOU RECEIVED ACUPUNCTURE / CHINESE HERBS / ORIENTAL MEDICINE IN THE PAST? Y / N

IF YES, BY WHOM?_____ FOR WHAT CONDITION?_____

HOW DID YOU HEAR ABOUT THIS OFFICE?_____

REFERRED BY:_____

DO YOU HAVE ANY OF THE FOLLOWING CONCERNS REGARDING TREATMENT?

☐ **COST**
☐ **FEAR OF TREATMENT**
☐ **HOW IT WORKS**
☐ **SIDE EFFECTS**
☐ **# OF TREATMENTS NEEDED**
☐ **PRACTITIONER CREDENTIALS**

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Patient's Name (*Please PRINT*)_____

IT IS AGREED: With regard to medical care and services, Andrew Parks, LAc, MSOM will provide services to the patient, and to the best of his skill and knowledge of medical care in the light of circumstance, which is possible and practical. Andrew Parks, LAc, MSOM will discuss all treatments that you are to receive, prior to performing such. You have the right to decline any treatment method that is offered to you if you feel any physical or emotional discomfort or have had a reaction to similar treatment methods in the past.

I hereby authorize the Andrew Parks, LAc, MSOM to administer any style of Traditional East Asian Medicine treatment relevant to my acupuncture diagnosis and treatment. I understand the nature of the treatment and I have been informed that I have the right to refuse any form of treatment. I understand that no guarantee can be made concerning the results of my treatment.

Patient's/Guardian's Signature _____ **Date** _____

Authorization to Release Information to Physician (OPTIONAL): I hereby authorize my physician and/ or

healthcare provider(s) _____to release to this office and this office
(Write ALL to release to all requesting medical providers)
to them any medical or other information acquired concerning my condition or other disabilities. A photostat of this authorization shall be as valid as the original.

Patient's/Guardian's Signature _____ **Date** _____

IF YOU ARE HAVING THIS OFFICE SUBMIT YOUR INSURANCE CLAIMS:

1) I hereby irrevocably assign the insurance benefit payments to which I am entitled directly to Cortez Family Acupuncture, Inc. A photostat of this authorization is accepted with the same authority as the original.
2) I hereby authorize my physician and/ or to release to this office and this office to my insurance carrier any medical or other information acquired concerning my condition or other disabilities.
3) I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this acupuncturist's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount to be paid directly to this acupuncturist's office will be credited to my account or receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment unless otherwise superseded by contracts between my insurer and Cortez Family Acupuncture, Inc. regarding balance billing patients. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's/Guardian's Signature _____ **Date** _____

Person responsible for the account if not patient:_____

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HEALTH HISTORY QUESTIONNAIRE

All information that is provided will be kept strictly confidential and will not be released to any party without your specific written authorization. Please do not hesitate to ask any questions or express any concerns or, if you do not understand any question contained herein. If you wish to discuss an item that is not addressed in this form, please note it in the 'Comments' section at the end.

PATIENT NAME:_____ **DATE**_____

If filled out by someone other than patient: _____ _____
Name **Relationship**

MAIN COMPLAINT:

Please provide details of your main complaint._____

_____

_____

When did this condition begin?_____

Has this condition been diagnosed by an MD? **Yes / No** MD Name?_____

Diagnosis:_____

What treatments have you tried for this condition?_____

_____

What makes this condition better? (heat, rest, exercise, etc)_____

_____

What makes this condition worse? (cold, stress, exercise, etc)_____

_____

Please list any other complaints that you would like to address:_____

_____

_____

CURRENT MEDICATIONS:

Please list any prescribed or over-the-counter drug you are currently taking / taken in past 12 months (continue on back if necessary):

1:_____Dose:_____Purpose:_____
2:_____Dose:_____Purpose:_____
3:_____Dose:_____Purpose:_____
4:_____Dose:_____Purpose:_____
5:_____Dose:_____Purpose:_____
6:_____Dose:_____Purpose:_____

Vitamins / Mineral / Herbal Supplements:

1:_____Dose:_____Purpose:_____
2:_____Dose:_____Purpose:_____

HEALTH HISTORY QUESTIONNAIRE

Current Weight_____ **Height** _____

Do you smoke or chew tobacco? **Yes / No** Since what age?_____How much per day?_____ _____

Do you drink **coffee**? **Yes / No** #Cups / day?_____ Regular / Decaf? **Soda** / **Energy Drinks**? **Yes / No** #_____

Do you drink alcohol? **Yes / No** Drinks per week?_____What type? Wine / Beer / Other_____

Do you use recreational drugs? **Yes / No** What type?_____How often?_____

TRAVEL:

Have you traveled to another country within the past 2 years? **Yes / No** If yes, please list dates and locations:

Date:_____Location_____
Date:_____Location_____
Did you get food poisoning? **Yes / No** Other illnesses?_____

DIET and EXERCISE:

Are you a vegetarian? **Yes / No** If yes, for how long?_____If yes, do you eat cheese or drink milk?_____

Have you ever been on a restricted diet? **Yes / No** If yes, what kind?_____

Do you have food allergies? **Yes / No** If yes, to which foods?_____

Do you crave: Candy? **Yes / No** Chocolate? **Yes / No** Salty food? **Yes / No**

Are you constantly hungry? **Yes / No** Thirsty? **Yes / No**

Any significant weight ☐GAIN or ☐LOSS within the past 6 months? **Yes / No.** If yes, how much (lbs)?_____ _____

Do you have a regular exercise program? **Yes / No** Please describe:_____

PAST MEDICAL HISTORY: Please note any conditions that you have had (if past please include dates)

When checking off a complaint, write "C" for current complaint, "P" for past, and "O" for occasional

☐ Allergies	☐ Chronic Fatigue/ Epstein-Barr	☐ Heart Disease	☐ Measles / Mumps	☐ Scarlet Fever
☐ Anemia	☐ Covid-19	☐ Hepatitis	☐ Meniere's	☐ Seizures
☐ Appendicitis	☐ COPD	☐ Herpes (Genital)	☐ Migraines	☐ Sexually Transmitted Disease
☐ Arteriosclerosis	☐ Diabetes	☐ Herpes (Oral)	☐ Mononucleosis	☐ Shingles
☐ Arrhythmia	☐ Emphysema	☐ High Blood Pressure	☐ MS	☐ Substance Abuse
☐ Asthma	☐ Endometriosis	☐ Genital Warts	☐ Paralysis	☐ Stroke
☐ Birth Trauma	☐ Epilepsy	☐ Gallbladder Issues	☐ Pleurisy	☐ Thyroid Disorders
☐ Cancer	☐ Fibromyalgia	☐ Kidney Stones	☐ Polio	☐ Tuberculosis
☐ Chicken Pox	☐ Gout	☐ Kidney Disease	☐ Pneumonia	☐ Ulcers
		☐ Lyme Disease	☐ Rheumatic Fever	

Other: _____

_____

Please list all surgeries and dates of surgeries:

1:_____Date:_____
2:_____Date:_____
3:_____Date:_____
4:_____Date:_____

Please describe all major traumas including auto accidents, falls, etc. (continue on back if needed):
1:_____Date:_____
2:_____Date:_____
3:_____Date:_____
4:_____Date:_____
5:_____Date:_____

GENERAL:
Do you have allergies to any drugs or chemicals? **Yes / No** If yes, please list:_____
Have you been vaccinated recently? **Yes / No** If yes, for what?_____
Do you feel safe in your home environment? **Yes / No**
Do you feel safe in your work environment? **Yes / No**
Do you have a heart condition? **Yes / No**
Are you a hemophiliac? **Yes / No**
Do you have a pacemaker or use a heart monitor? **Yes / No**
Are you pregnant? **Yes / No**
Have you ever seriously considered suicide? **Yes / No**
Have you ever attempted suicide? **Yes / No**

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS IN THE PAST 3 MONTHS:

Poor Appetite_____	Poor Sleep_____	Fatigue_____	Fevers_____
Chills_____	Tremors_____	Cravings_____	Strong Thirst_____
Localized Weakness_____	Poor Balance_____	Change in Appetite_____	
Bleed or Bruise Easily_____	Sudden Energy Drop_____		

Do you often get FEVERS, or tend to feel HOT? **Yes / No**. If yes, when and where on your body?

_____

Do you get CHILLED easily? **Yes / No.** If yes, when and where on your body?_____

Please describe your energy throughout the day:_____

What time are you most energetic?_____Least energetic?_____Sudden energy drop?_____

Please describe any occupational stresses (chemical, physical, psychological, etc):_____

Do you sweat easily during the day with little or no activity? **Yes / No** Please describe:_____

_____

Do you sweat at night? **Yes / No** Do you sweat in specific areas of your body?_____

Do you notice any unusual tastes in your mouth (metallic, sweet, sour, etc)?_____

How much water do you drink per day?_____ Do you usually like hot, room temperature or cold drinks (circle)?

SKIN and HAIR:

Rashes_____	Itching_____	Dandruff_____	Ulcerations_____
Eczema_____	Hives_____	Pimples_____	Recent Moles_____
Hair Loss_____	Skin or Hair Texture Changes_____		

Other skin problems:_____

HEAD, EYES, EARS, NOSE, and THROAT:

Dizziness_____	Glasses/Contacts_____	Poor Vision_____	Cataracts_____
Ringing in the ears_____	Grind teeth_____	Sinus Problems_____	Concussions_____
Eye Strain_____	Night Blindness_____	Blurry Vision_____	Poor Hearing_____
TMJ_____	Nose Bleeds_____	Migraines_____	Eye Pain_____
Runny/Stuffed Nose_____	Earaches_____	Spots / Floaters _____	Sores on Lips or Tongue_____

Do you get headaches? **Yes / No** When do you get them?_____
What part of the head is affected? Temples / Top / Back / Behind the Eyes / Other_____
Please detail any other head or neck problems:_____

CIRCULATORY:

High Blood Pressure_____	Chest Pains_____	Fainting_____	Aneurisms _____
Low Blood Pressure_____	Blood Clots_____	Phlebitis_____	Swollen Hands_____
Swollen Feet_____	Difficulty Breathing_____		Irregular Heart Beat_____

Please detail any other heart or blood vessel problems:_____
_____

RESPIRATORY:

Cough_____	Asthma_____	Cough Up Blood_____	Pneumonia_____
Bronchitis_____	Pain With Deep Breaths_____	Difficulty Breathing When Laying Down_____	
Production of Phlegm_____	What color?_____		

Please detail any other lung problems:_____

GASTROINTESTINAL SYSTEM:

Nausea_____	Vomiting_____	Constipation_____	Diarrhea_____
Gas_____	Belching_____	Blood in Stools_____	Indigestion_____
Heartburn_____	Bloating_____	Black Stools_____	Bad Breath_____
Rectal Pain_____	Hemorrhoids_____	Abdominal Pain_____	

How often do you have bowel movements? _____Typically what time of day?_____
Please detail any other problems with your stomach or intestines:_____
_____

UROGENITAL SYSTEM:

Painful Urination_____	Frequent Urination_____	Blood in Urine_____
Urgency to Urinate_____	Unable to Hold Urine_____	Kidney Stones_____
Decreased Urine Flow_____	Burning / Itching Upon Urination_____	Impotency_____

How many times per day do you urinate?_____Do you wake up at night to urinate? **Yes / No**
How many times per night?_____ Is your urine particularly pale, dark, or cloudy?_____
Please detail any other problems with your genital or urinary system:_____
_____

REPRODUCTIVE SYSTEM / GYNECOLOGY (if applicable):

Number of Pregnancies_____	Number of Births_____	Number of Premature Births_____
Number of C-Sections_____	Number of Miscarriages_____	Number of Abortions_____
Age at First Menses_____	Length of Menses_____	Date of 1st Day of Last Menses_____
Irregular Menstruation_____	Vaginal Sores_____	

Vaginal Discharge_____Color_____Consistency_____

Pain with Menstruation **Yes / No** Before_____During_____Following_____

Fatigue with Menstruation **Yes / No** Before_____During_____Following_____

Is your menstrual flow especially heavy or light?_____Are there clots in your flow?_____

Is the color of your menstrual blood especially dark red/brown, bright red, light?_____

Do you experience pre-menstrual or menstrual changes to your body or psyche?_____

GYNECOLOGICAL CONT'D

Do you practice birth control? **Yes / No** What type?_____For how long?_____

Fertility Issues / Concerns: _____

Date of last PAP Smear: _____ Date of onset of menopause:_____

Please detail any other reproductive or gynecological problems:_____

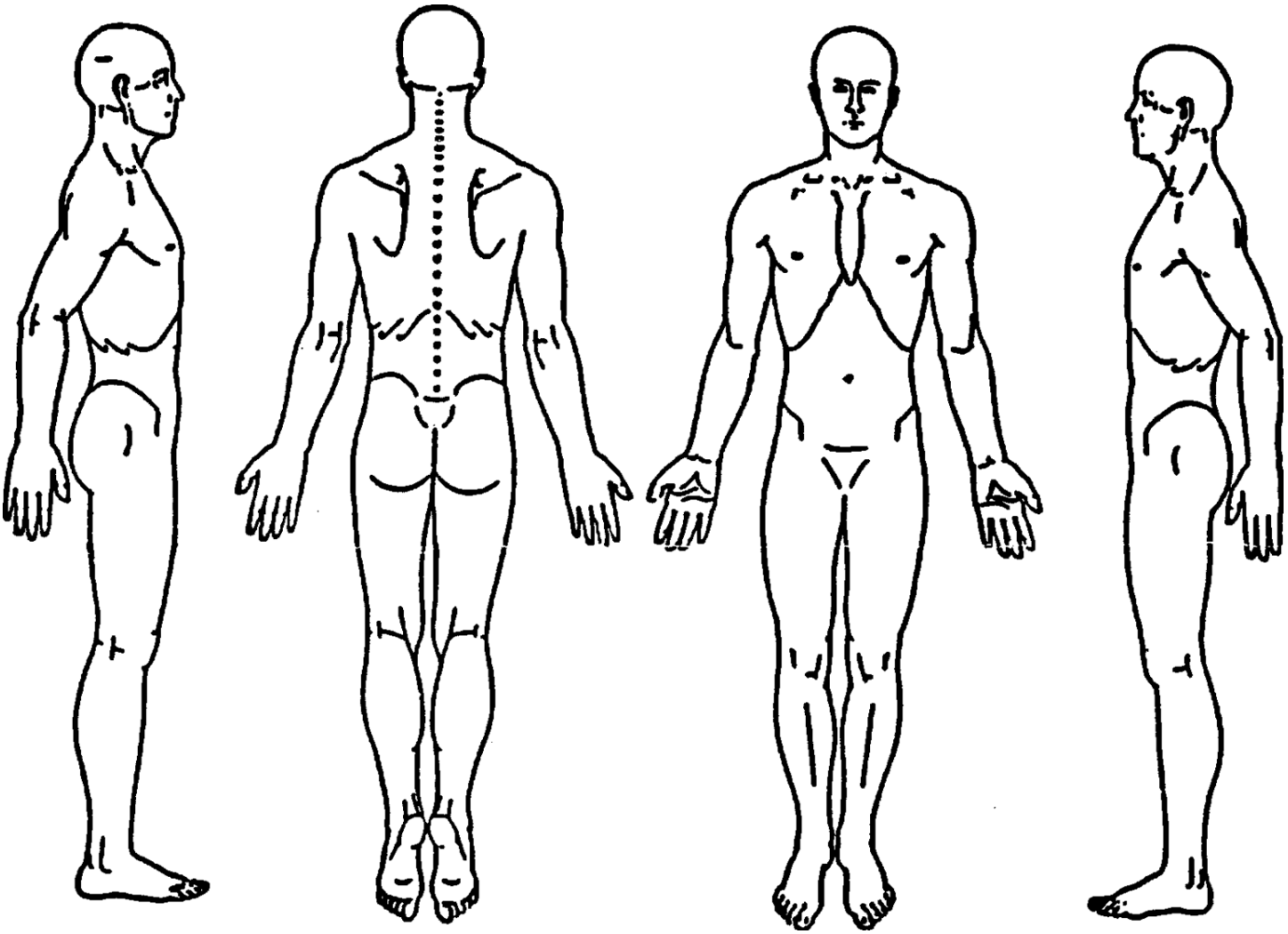
MUSCULOSKELETAL:

Neck Pain_____ Back Pain_____ Knee Pain_____ Muscle Pain_____
Muscle Weakness_____ Hip Pain_____ Shoulder Pain_____ Foot/Ankle Pain_____
Hand/Wrist Pain_____
Other Pain: _____

Please describe the exact location and nature, (sharp, dull, stabbing, hot, cold, etc), of the pain:_____

_____

Please indicate on this image the exact location of your pain using these symbols:
X = pain area **O = numbness, tingling** **Numbers 1-10 = degree of pain (1 is unnoticeable, 10 extreme)**



NEURO/PSYCHOLOGICAL:

Seizures_____	Loss of Balance_____	Concussion_____	Sharp Zapping Pain: _____
Areas of Numbness_____	Poor Memory_____	Anxiety_____	Depression_____
Excess Sleepiness_____	Insomnia_____	Poor Coordination_____	

If you have dizziness, is it mild or severe?_____How long does it last_____
Is the onset sudden or gradual?_____Do other symptoms accompany the dizziness?_____

_____

Do you have difficulty falling asleep? **Yes / No** Do you have difficulty staying asleep? **Yes / No**

How many hours of sleep do you get per night?_____Do you feel rested upon waking? **Yes / No**

Is your sleep disturbed by dreams/nightmares? **Yes / No**

Are there other neurological or psychological issues you would like to discuss?_____

_____

FAMILY HEALTH HISTORY:

Please provide details of any family members who have had any of the following conditions:

Diabetes	Seizures	Heart Disease
Stroke	Asthma	High Blood Pressure
Cancer	Allergies	High Cholesterol

Other:_____

COMMENTS:

Please feel free to make comments or identify other concerns that you would like to discuss:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____Date_____
Patient signature.