

Date \_\_\_\_\_

## Personal Information

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Email (to be used for appointment reminders only) \_\_\_\_\_

Best phone number at which to reach you \_\_\_\_\_

Day/Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status \_\_\_\_\_

Number and Ages of Children \_\_\_\_\_

Occupation \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance \_\_\_\_\_

Does your insurance policy cover acupuncture? \_\_\_\_\_

\*If yes, I can provide you with a superbill so you can bill them directly.

Person to notify in an emergency \_\_\_\_\_

Phone number \_\_\_\_\_

Referred to this office by \_\_\_\_\_

## Confidential Patient History

Reason for seeking medical care today \_\_\_\_\_

Describe your current symptoms \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long have you had the symptoms? \_\_\_\_\_

How did this condition develop? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had this condition or a similar condition before? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you received treatment for this condition?    Yes    No

What was the diagnosis? \_\_\_\_\_

Describe the treatment you received \_\_\_\_\_

\_\_\_\_\_

Treatment results \_\_\_\_\_

Other conditions you are concerned about: \_\_\_\_\_

\_\_\_\_\_

Please list surgeries and major illnesses you have had including dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list ALL medications you are taking:

Medication	Dosage	For what condition?	For how long?

Please indicate if you have had any of the following:

Cancer \_\_\_\_\_ Stroke \_\_\_\_\_ Diabetes \_\_\_\_\_ High Blood Pressure \_\_\_\_\_  
 Seizures \_\_\_\_\_ Heart Disease \_\_\_\_\_ Arthritis \_\_\_\_\_ Asthma \_\_\_\_\_  
 kidney stones \_\_\_\_\_ Ulcers \_\_\_\_\_ Alcoholism \_\_\_\_\_ Mental Illness \_\_\_\_\_  
 AIDS \_\_\_\_\_ Autoimmune disease \_\_\_\_\_ Gallstones \_\_\_\_\_  
 Hepatitis \_\_\_\_\_  
 Thyroid disease \_\_\_\_\_ Venereal disease \_\_\_\_\_

Describe your average daily diet:

Breakfast	Lunch	Dinner
_____	_____	_____
_____	_____	_____

Describe your daily usage of the following:

Coffee, tea \_\_\_\_\_ Sodas, diet or regular \_\_\_\_\_  
 Alcohol \_\_\_\_\_ Tobacco \_\_\_\_\_  
 Recreational drugs \_\_\_\_\_

Describe your exercise regimen \_\_\_\_\_

## Symptom Review

Put one check by a symptom you sometimes experience, use two checks for those which often occur, and three checks for symptoms that are a major concern.

### HEAD AND FACE

- Headaches
- Dizziness
- Memory loss
- Other

### EYES

- Blurred vision
- Eyelid problem
- Pain
- Red, itchy eyes
- Other

### EARS

- Poor hearing
- Earaches
- Discharges
- Ringing
- Other

### NOSE

- Frequent colds
- Sinus trouble
- Bleeding
- Other

### MOUTH

- Gum problems
- Teeth problems
- Tongue problems
- Lip problems
- Jaw problems
- Unusual tastes
- Other

### THROAT

- Sore throat
- Hoarseness
- Difficulty in swallowing
- Other

### RESPIRATION

- Difficulty inhaling
- Difficulty exhaling
- Pain
- Cough
- Phlegm

- Other

### HEART AND THORAX

- Palpitations
- High blood pressure
- Chest tightness
- Low blood pressure
- Difficulty lying flat
- Other

### CIRCULATION

- Bruise easily
- Bleed easily
- Cold limbs
- Other

### GASTROINTESTINAL

- Excess thirst
- Never thirsty
- Excess appetite
- Digestive pain
- Nausea
- Diarrhea
- Constipation
- Hemorrhoids
- Colon problems
- Other

### URINATION

- Frequent
- Difficulty
- Painful
- Nocturnal urination
- Bleeding
- Other

### SKIN

- Rashes
- Dryness
- Moles or lumps that change
- Excess sweat
- Night sweat
- Rarely sweat
- Other

### NEUROLOGICAL

- Nervousness
- Tremors
- Convulsions
- Numbness or tingling
- Poor coordination
- Nerve pain or neuralgia
- Other

### SLEEP

- Insomnia
- Drowsiness
- Excess dreams
- Other

### ENERGY LEVELS

- Low
- High
- Other

### MUSCULOSKELETAL

- Neck pain
- Shoulder pain
- Elbow pain
- Wrist pain
- Back pain
- Leg pain
- Knee pain
- Ankle pain
- Foot pain
- Other

### REPRODUCTIVE

- cramps
- PMS
- infertility
- frequent miscarriage
- endometriosis
- amenorrhea
- < 25 day cycle
- > 35 day cycle

## DISCLOSURE FORM

Rachel Hendricks Blunk, L Ac, Inc  
2601 S. Lemay Ave #25  
Fort Collins, CO 80525  
(970) 223-4422

Our usual and customary fees are:

Initial Acupuncture Treatment (includes exam)	\$165
Subsequent Acupuncture Treatment (includes exam)	\$100
Re-exam after more than one year + Treatment	\$125

Pre-paid packages are available:

6 treatments x \$95 each = \$570 (5% discount)  
12 treatments for for \$90 each = \$1080 (10% discount)

### Education, Experience, Degrees, Certificates and Credentials

University of California, Berkeley BA in Integrative Biology	1988-1992
Pacific College of Oriental Medicine, San Diego, CA Masters of Traditional Oriental Medicine (MTOM)	1994-1998
USCC for TCM Special Study at Shandong University of Traditional Chinese Medicine, Jinan, China	1999
Continuing education with Dr. Randine Lewis in infertility	2004
Continuing education with Jane Lyttleton in infertility	2007
International Fertility Symposium, Vancouver, Canada	2015, 2016, 2017, 2018

### Licenses, Certificates, and Registrations in Acupuncture and Herbology

Council of Colleges of Acupuncture and Oriental Medicine Clean Needle Technique Course	January 1998
National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Diplomate in Acupuncture (Dipl Ac)	June 1998
National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Diplomate in Chinese Herbology (Dipl CH)	June 1998
Licensed Acupuncturist in the State of California (LAc)	June 1999- May 2011
Certificate of Completion of Study in Acupuncture, Tui Na, and Herbology at Shandong University of Traditional Chinese Medicine, Jinan, China	June 1999

Licensed Acupuncturist in the State of Colorado (LAc)

July 1999

Fellow, American Board of Oriental Reproductive Medicine

April 2009

This office complies with all rules and regulations promulgated by the Colorado Department of Health related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices. This office uses only single-use disposable needles, and disposes of them in a manner consistent with OSHA and Colorado State regulations.

The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies.  
Bruce M. Douglas, Director of the Division of Registrations  
1560 Broadway, Suite 1545, Denver, CO 80202 (303) 894-2464

Each patient who visits this office is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

**Occasionally a patient may experience mild bruising at the site of needle insertion, which heals quickly. Please tell Rachel if you have any conditions which may inhibit blood clotting, such as hemophilia, daily aspirin use, or daily coumadin use.**

Each patient may seek a second opinion from another health care professional or may terminate therapy at any time.

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.

**24 hours notice is required for cancellation of a scheduled appointment, or the patient will be billed for the missed appointment.**

I hereby give permission to the acupuncturist to release any information requested by my insurance company, physicians or other health care providers acquired in the course of my examination and treatment. I hereby authorize and direct my insurance benefits to be paid directly to the acupuncturist. I am financially responsible for non-covered services. I hereby give permission to the acupuncturist to administer treatment and perform such general procedures as she may deem necessary in the diagnosis and/or treatment of my condition. I have read and understand and agree to the above disclosure statement. I understand my rights and responsibilities as a patient:

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian's Signature (if patient is a minor)

\_\_\_\_\_  
Date