ACUPUNCTURE NEW PATIENT FORM

Welcome to Millennium Wellness. To help us provide you with the best possible care please fill out this form. This information will remain confidential.

Last name:_____First name:_____MI:_____

Age:_____DOB:_____SSN:_____-_____-_____

Street Adress:_____City:_____State:_____Zip:_____

Phone:_____Email:_____

Emergency Contact:_____Phone:_____

Have you ever had Acupuncture before?_____

Please describe your reason for today's visit:_____

_____

_____

How long have you had this condition?_____

What make it better?_____

What makes it worse?_____

Please list any drugs or supplements that you are taking:_____

_____

_____

_____

Symptom Review

Please 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
- ❑ Other

Ears
- ❑ Hearing difficulty
- ❑ Earaches
- ❑ Discharge
- ❑ Ringing
- ❑ Other

Nose
- ❑ Frequent colds
- ❑ Sinus trouble
- ❑ Bleeding
- ❑ Other

Mouth
- ❑ Dental problems
- ❑ Gum problems
- ❑ Tongue problems
- ❑ Jaw problems
- ❑ Unusual tastes
- ❑ Other

Throat
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Other

Respiration
- ❑ Difficulty inhaling
- ❑ Difficulty exhaling
- ❑ Pain
- ❑ Cough
- ❑ Congestion
- ❑ Other

Heart and Chest
- ❑ Palpitations
- ❑ High blood pressure
- ❑ Tightness in chest
- ❑ Low blood pressure
- ❑ Difficulty lying flat
- ❑ Other

Circulation
- ❑ Bruise easily
- ❑ Bleed easily
- ❑ Cold limbs, hands, or feet
- ❑ Hot palms
- ❑ Other

Gastrointestinal
- ❑ Always thirsty
- ❑ Never thirsty
- ❑ Excessive appetite
- ❑ Low appetite
- ❑ Stomach or abdominal pain
- ❑ Nausea
- ❑ Diarrhea
- ❑ Constipation
- ❑ Rectal bleeding
- ❑ Colon problems
- ❑ Other

Urination
- ❑ Frequent
- ❑ Difficult
- ❑ Painful
- ❑ Nighttime
- ❑ Bleeding
- ❑ Other

Skin
- ❑ Rashes
- ❑ Dryness
- ❑ Moles or lumps that change
- ❑ Lumps that don't change
- ❑ Excessive sweating
- ❑ Night sweating
- ❑ Seldom sweat
- ❑ Other

Please continue on the next page

Neurological
- ❑ Nervousness
- ❑ Tremors
- ❑ Convulsions
- ❑ Numbness or tingling
- ❑ Lack of coordination
- ❑ Nerve pain
- ❑ Other

Sleep
- ❑ Insomnia
- ❑ Drowsiness
- ❑ Excessive dreaming
- ❑ Other

Energy Levels
- ❑ Low
- ❑ High
- ❑ Normal
- ❑ Other

Pain (please describe below)

_____

_____

_____

_____

_____

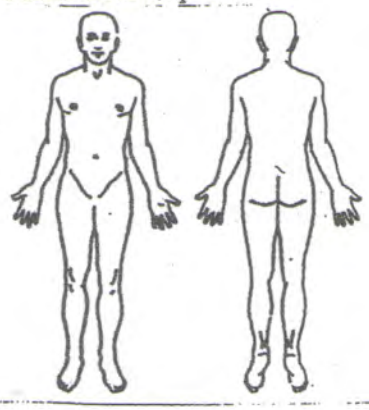
_____

_____

_____

_____

Mark areas of pain:



Women Only

Are you or might you be pregnant? ❑ Yes ❑ No ❑ Maybe. If yes, what month? _____

What method of birth control do you use? _____

Do you have regular PAP tests? ❑ Yes ❑ No. How often? _____

Are you experiencing unusually low or high sexual desire? Other difficulties? _____

Age at first menstruation: _____ Age at menopause: _____

Date of first day of last menstrual cycle: _____

Number of days of last menstruation (bleeding): _____

Usual length of monthly cycle (from first day of bleeding until day before next bleeding): _____

Are your periods…

❑ Irregular: ❑ Short ❑ Long ❑ Variable
❑ Painful: ❑ Before ❑ During ❑ After ❑ Mid-cycle
Relieved by… ❑ Heat ❑ Cold ❑ Pressure
❑ Heavy bleeding
❑ Light bleeding
❑ Dark blood… ❑ Red ❑ Purple ❑ Brown
❑ Light blood
❑ Thick blood
❑ Watery blood
❑ Heavy clotting
❑ Stop and start again
❑ Spotting… ❑ Before ❑ After ❑ Mid-cycle

Do you have any pre-menstrual symptoms?

❑ Painful or swollen breasts
❑ Irritability
❑ Depression
❑ Crying
❑ Food cravings: _____
❑ Nausea
❑ Cramps or pain
❑ Other: _____

Vaginal discharge

❑ Normal
❑ Watery
❑ Thick
❑ Yellow
❑ Clear or white
❑ Bad odor
❑ Itching
❑ Dryness
❑ Other: _____

Gynecological surgeries or problems (please describe)

❑ Ovaries: _____
❑ Uterus: _____
❑ Fallopian Tubes: _____
❑ Vagina: _____
❑ Breasts: _____
❑ Other: _____

Pregnancies

Total number: _____
Number of children: _____
Abortions or miscarriages: _____
Complications: _____
How long ago was your last pregnancy? _____

Men Only

Do you experience…

❑ Reduced libido
❑ Excessive libido
❑ Premature ejaculation
❑ Seminal emission (spontaneous ejaculation without sexual stimulation)
❑ Urinary frequency
❑ Impotence
❑ Genital discharge
❑ Pain associated with genitals
❑ Other: _____

Thank you for taking the time to complete this form.

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive healing modality to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, _____, have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

Signature _____ Date _____

Millennium
Wellness

Mandatory Disclosure Statement

Christin Hawbaker holds a Master's Degree in Traditional Chinese Medicine. This is a 3 ½ year 2,800 hour program that includes Acupuncture and Chinese Herbal Medicine. Christin has training in Sports Injuries, Internal Medicine, Gynecology, Infertility, Pediatrics, and General Practice of Chinese Medicine.

Christin is certified with the National Certification Commission for Acupuncture and Oriental Medicine. She is registered by the state of Colorado to practice Acupuncture and Traditional Chinese Medicine. Christin is also certified in Swedish and Deep Tissue Massage Therapy.

At Millennium Wellness we only use sterile, disposable needles. We are in compliance with the standards set forth by the Department of Public Health. No license, certificate or registrations has ever been revoked or suspended.

Fee Schedule:

Acupuncture New Patient: $85.00	Massage 60 min - $65.00
Acupuncture Established Patient: $65.00	Massage 30 min - $45.00
Acupuncture Child under 18: $45.00	Facials Single Visit: $95.00
Acussage: (Acupuncture + Massage) $85.00	Facial Package of 6 visits: $499.00

I. You are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy.

II. You are entitled to seek a second opinion from another healthcare provider, or terminate therapy at any time.

III. Sexual intimacy is never appropriate in a professional relationship 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:
Colorado Department of Regulatory Agencies
1560 Broadway, Suite 1340
Denver, CO 80202-5146
303-894-7851