Julianne Ambrosia, L.Ac, Dipl. OM

Intake and Health History

This is a CONFIDENTIAL questionnaire. This will help me determine the best course of treatment. If you have any questions please ask.

Name:_____

Address:_____

City:_____Zip:_____

Phone Number:_____ Cell Number:_____

Email Address:_____

Occupation:_____ Work Number:_____

Emergency Contact:_____ Number:_____

Who may I thank for referring you to my office? _____

Sex: _____ Height: _____ Weight:_____ Birthday:_____ Age:____

Marital Status: _____ Number of Children: _____

Have you received acupuncture before: _____With whom?_____

Please list any medications, OTC medications, supplements, vitamins, or herbs you are currently taking. Please use the back of page if necessary:

Medication	Dosage	Reason	How Long

Please indicate any major illnesses/conditions you or a blood relative (parent, sibling, grandparent) have had:

Illness/Condition:	Who?	Date (approximate)
Cancer:		
Hepatitis:		
High Blood Pressure:		
Rheumatic Fever:		
Infectious Disease:		
Diabetes:		
Heart Disease:		
Seizures:		
Emotional Disorders:		
Tuberculosis:		
Gonorrhea:		
Syphilis:		
HIV:		
AIDS:		
HPV:		
Chlamydia:		
Herpes:		

Do you drink alcohol? _____If yes, how frequent? _____
Do you smoke?_____ If yes, how many per day? _____
Do you drink coffee? _____ If yes, how many cups per day? _____
Do you take recreational drugs? _____If yes, what and frequency?_____
Do you drink soda/pop? _____If yes, how often? _____
How often do you eat out? _____
How many 8 oz glasses of water do you drink per day? _____
Do you prefer your water hot, cold, or room temperature? _____

What is your reason for seeking treatment? _____
_____
_____

What other treatment therapies have you sought for this? _____
_____
_____

Do you have a Latex allergy? _____
Do you have any allergies to medications? _____
Do you have any food allergies or sensitivities? _____
_____

Please list any major illnesses, surgeries, accidents with dates. _____
_____
_____

Diet:

How many times a day do you eat? _____
Are there any foods you exclude from your diet? _____
What foods are in a typical breakfast, lunch, dinner, snack(s) for you?
_____
_____
_____
_____

Sleep:

What time do you go to bed? _____ What time do you wake? _____

Average number of hours of sleep? _____ Do you feel rested when you wake? ___

Do you have problems falling asleep? ____ If yes, please explain_____

_____

Do you wake during the night? ____ How many times? _____ What causes you to wake? _____

Women Only:

Are you pregnant? _____ if yes how many weeks along? _____

if no, are you trying to get pregnant? _____

# of pregnancies ___ # of live births ____ # of miscarriages ___ # of abortions ___

Have you been diagnosed with:

Ovarian cysts: _____ Fibroids: _____ Fibrocystic Breast: _____ PID: _____

Endometriosis: _____ Other: _____

Number of days between periods: _____ Number of days of flow: _____

Color of flow: _____

Are there clots?: _____ If yes, what size?(dime, nickel, quarter): _____

Do you experience PMS symptoms?: ____ If yes, please describe: _____

_____

Average number of tampons/pads used per day:

1st: _____ 2nd: _____ 3rd: _____ 4th: _____ 5th: _____ 6th: _____ 7th: _____

Symptoms Survey (for everyone):

Please mark the following symptoms with:
(X) if you experience them occasionally
(+) if you experience them frequently
( ) leave blank if you do not experience them

( ) high cholesterol
( ) high blood pressure
( ) intolerance to weather
( ) numbness/tingling
( ) cold hands/feet
( ) recent use of antibiotics
( ) nightmares
( ) vivid dreams
( ) heart palpitations
( ) irregular heart beat
( ) ear ringing/tinnitus
( ) lack of appetite
( ) excessive appetite
( ) soft/brittle nails
( ) sudden weight loss/gain
( ) diarrhea/loose stools
( ) constipation
( ) hemorrhoids
( ) acid reflux/heart burn
( ) burping/belching
( ) vaginal discharge
( ) abdominal pain/cramping
( ) indigestion/digestive problems
( ) difficulty digesting
( ) easily angered/agitated
( ) laughing for no reason
( ) difficulty making decisions

( ) cough
( ) shortness of breath
( ) low back pain/weakness
( ) decreased sense of smell
( ) nasal problems
( ) acne
( ) rashes
( ) bronchitis
( ) frequent colds/flu
( ) colitis/diverticulitis
( ) Carpal Tunnel Syndrome
( ) decreased vision
( ) floaters in vision
( ) dry/itchy/red eyes
( ) spasms/twitching of muscles
( ) knee pain/weakness
( ) decreased hearing
( ) urinary problems
( ) kidney stones
( ) gallstones
( ) blood in stool
( ) black tarry stool
( ) bruise easily
( ) light colored stool
( ) sciatic pain
( ) mental restlessness
( ) difficulty digesting oily/greasy foods

( ) asthma
( ) allergies
( ) hay fever
( ) fainting
( ) headache
( ) migraine
( ) dizziness
( ) insomnia
( ) vomiting
( ) nausea
( ) chest pain
( ) angina
( ) edema
( ) fatigue
( ) hair loss
( ) gas
( ) TMJ
( ) IBS

Mandatory Disclosure Statement, Informed Consent, and Cancelation Policy

Julianne Ambrosia, L.Ac, Dipl. OM.
Advanced Chiropractic Clinic, LLC
19641 Parker Square Drive, Suite J
Parker, CO 80134

This disclosure statement is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Statute Title 12 Article 29.5. All rules and regulations set forth by the Department of Health are strictly adhered to including proper cleaning, sterilization, and sanitation of equipment and office.

Education and Experience:

Julianne Ambrosia, L.Ac, Dipl OM completed her Masters of Traditional Chinese Medicine degree from the Colorado School for Traditional Chinese Medicine. The four year program consists of 2,850 hours of education including 990 hours of clinical practice. Julianne's training includes acupuncture, internal medicine, moxibustion, tui na, cupping, Chinese nutrition, auriculotherapy, and energetic exercise. The National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) certified Julianne as a Diplomat of Oriental Medicine and Acupuncture in April of 2009. Julianne is a licensed acupuncturist and is licensed as a Diplomat of Oriental Medicine through the State of Colorado. Neither of these licensure have been revoked or suspended. Julianne is a member of the Acupuncture Association of Colorado. She has also received her Clean Needle Technique certification. Ambrosia Acupuncture LLC complies with the rules and regulations set forth by the Colorado Department of Health, including the use of single-use, disposable, factory-sterilized needles. Also this includes the proper cleaning and sanitation of Ambrosia Acupuncture LLC's clinic and proper disposal of used needles.

Fee Schedule:

Initial Intake and Treatment (1st time visit)	$120 + the cost of herbal medicine
Follow-up Treatments	$65 + the cost of herbal medicine
Herbal Consultation Only	$45 + the cost of herbal medicine
Traumeel Injection	$25
B12 Injection	$25
Cosmetic Injections	$100
Cupping	$40
Essential Oil Consultation Only	$45 + the cost of oils

Informed Consent:

I hereby consent to treatment with the use of acupuncture, Traditional Chinese Medicine (TCM), and injection procedures by my Julianne Ambrosia, L.Ac, Dipl. OM. I have been informed that acupuncture, TCM, and injections are safe methods of treatment but that it may have side effects including pain, bruising, and numbness at site of needle, discomfort, and dizziness. Extremely rare risks include nerve damage, organ puncture, possibility of miscarriage, burns from moxibustion or heating lamps, and infection. Other side effects and risk may occur. If I suspect I am pregnant I will immediately inform Julianne Ambrosia, L.Ac, Dipl. OM . I understand that there are no guarantees regarding the improvement of my condition. I understand there may be limitations to the care provided and that, in my best interest, I may be referred to another acupuncture practitioner or other healthcare provider who may be more qualified to treat my condition. I do not expect Julianne Ambrosia, L.Ac, Dipl. OM to explain or anticipate all risks or complications. I permit Julianne Ambrosia, L.Ac, Dipl. OM to determine and/or alter the course of treatment which is based upon the known facts. I understand that I have the right to accept or reject treatment at any time.

I have read and understand the above consent. Also, I have had the opportunity to ask questions regarding this consent. By signing below, I am agreeing to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition (s) for which I seek treatment.

Patient's Rights:

***In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registration in the Department of Regulatory Agencies (DORA).

***The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of the therapy (if known).

***The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.

***The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies (DORA). The Director's address and telephone number is:

Director, Division of Registrations
Acupuncturists Licensure
1560 Broadway, Suite 1350
Denver, CO 80202
(303) 894-7800

_____ _____

Patient's or Guardian's Signature Date

_____ _____

Signature Acknowledging the Receipt of HIPPA Policy Date