Botanica Wellness Sanctuary
1940 E 18th Ave
Denver, Co 80206
720.398.2050

Acupuncture Information Sheet

Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date	First Name	Last Name	Social Security Number
_____ / _____ / _____			— —

Gender	Date of Birth	Age	Marital Status
M F	_____ / _____ / _____		**Single Married Separated Divorced**

Street Address	City	State	Zip

Phone (Daytime) – **Home Work Mobile** *Circle One*	Alternate Phone # – **Home Work Mobile** *Circle One*
( )	( )

Place of Employment	Occupation	Phone Numbers of Emergency Contact
----------	----------	Primary ( ) Alternate ( )

Circle Insurance Coverage (Please circle one)

None Workers' Comp Auto Injury Health Insurance Company_____

E-Mail:

How did you hear about us? *Please circle one and write the name*

Current Patient: _____ Doctor: _____Advertisement: _____ Friend: _____Insurance: _____ Other: _____

Chief Health Concern: _____
How long? _____ How often: _____
What caused this (accident, lifestyle, drug, etc.)? _____
Describe the worst it can be: _____
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? _____
Get temporary relief? _____ Fixes problem? _____ Causes side effects? _____
How does this affect your life? _____
Affect your family? _____ Affect your sleep? _____
Affect your work? _____ Affect your hobbies? _____
What is your goal/plan if the problem continues 5/10/20 years? _____

Health Concern #2: _____
How long? _____ How often: _____
What caused this (accident, lifestyle, drug, etc.)? _____
Describe the worst it can be: _____
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? _____
Get temporary relief? _____ Fixes problem? _____ Causes side effects? _____
How does this affect your life? _____
Affect your family? _____ Affect your sleep? _____
Affect your work? _____ Affect your hobbies? _____
What is your goal/plan if the problem continues 5/10/20 years? _____

Other Concerns:
3) _____ 4) _____

On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better_____
Have you had acupuncture before? _____
If yes, where/who _____
Any concerns or fears about the needles? _____
If yes, what? _____
What are your goals of your acupuncture visits?

1. _____
2. _____
3. _____

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.		**ALLERGIES** Medications, Seasonal, Environmental, Food.

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops and nose sprays. NOTE: If need more space, use page 4.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

SYMPTOMS – **NOTE: For each symptom you currently have, rate its severity from 1- 5 (5 being the worst). LEAVE BLANK IF NOT APPLICABLE.**

LIVER / GALLBLADDER

_____ Irritability / Anger
_____ Depression / Stress
_____ Headaches / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness
_____ Blurred Vision
_____ Feeling of Lump in Throat
_____ Clenching of Teeth at Night
_____ Muscle Cramping / Twitching
_____ Tension
_____ Joints/Neck/Shoulder Pain/Tight
_____ Poor Circulation
_____ Soft / Brittle Nails
_____ Emotional Eater

KIDNEY / URINARY BLADDER

_____ Urinary Problems
_____ Bladder Infection
_____ Lack of Bladder Control
_____ Weakness / Pain in Lower Back
_____ Decrease Bone Density
_____ Feel Cold Easily
_____ Low Sex Drive
_____ Excess Sexual Desire
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities
_____ Craving / Avoiding Salty Foods
_____ Fear
_____ Hot Flush / Night Sweating

HEART / SMALL INTESTINES

_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life

LUNG / LARGE INTESTINE

_____ Dry Cough
_____ Cough with Sputum
_____ Nasal Discharge
_____ Post-Nasal Drip
_____ Sinus Infection / Congestion
_____ Itchy, Red or Painful Throat
_____ Dry Mouth / Throat / Nose
_____ Skin Rashes / Hives
_____ Snoring
_____ Grief / Sadness
_____ Shortness of Breath
_____ Allergies / Asthma
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever Comes & Goes
_____ Smoke Cigarettes

SPLEEN / STOMACH

_____ Heaviness Anywhere in Body
_____ Fatigue / Worse After Eating
_____ Hard to Get Up in the Morning
_____ Edema (Swelling)
_____ Muscles Feel Tired Often
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____ Decreased / Increased Appetite
_____ Crave Sweets
_____ Hypoglycemia
_____ Difficulty Digesting Oily Foods
_____ Nausea / Vomiting
_____ Gas / Belching
_____ Insulin Sensitivity
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over-Thinking
_____ Tendency to Gain Weight
_____ Brain Foggy

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "**C**" under the appropriate person's column. "**P**" should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the reverse side of this form.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
AIDS / HIV											
Alcohol											
Anxiety											
Arthritis											
Asthma / Hay Fever / Allergy											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Tobacco											
Weight Problem											
Other Emotional Problems:_____											
Other:_____											

If any of the above family members are deceased, please list their age at death and cause.

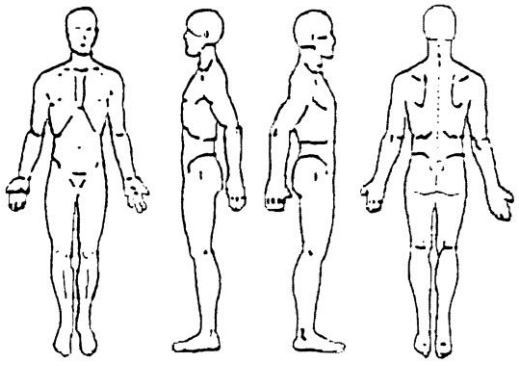
_____

MUSCULOSKELETAL

☐ Muscle Cramps – Where? ☐ Muscle Pain / Rheumatism – Where? ☐ Arthritis – Where?

☐ Joint Swelling – Where? ☐ Tendonitis – Where? ☐ Bursitis – Where?

Please mark problem areas on diagram:



Describe Pain and Location

☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Other:_____

☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Other:_____

☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Other:_____

Women Only

Hysterectomy – Ovaries Removed? ☐ Yes ☐ No

Could You be Pregnant Now? ☐ Yes ☐ No

Number Of: ___ Pregnancies ___ Miscarriages
___ Births ___ Abortions

Post-menopausal Bleeding ☐ Yes ☐ No

When did your last period start? _____

Number of days for monthly cycle? _____

Number of days bleeding lasts? _____

Describe Menstrual Flow:

☐ Heavy ☐ Moderate ☐ Light ☐ None

Color of Menstrual Flow:

☐ Dark ☐ Bright Red ☐ Slightly Reddish

Birth Control:

☐ None ☐ IUD ☐ Birth Control Pills

☐ Spermicides ☐ Barriers

Do You Suffer From:

☐ Cramping *(Mark as appropriate)*

- ☐ Severe ☐ Moderate
- ☐ Mild ☐ Before Period
- ☐ During Period ☐ After Period

☐ Clotting *(Mark as appropriate)*

- ☐ Bright in Color ☐ Dark in Color

☐ Bleeding Between Periods ☐ Infertility

☐ Pelvic Inflam. Disease ☐ Ovarian Cysts

☐ Endometriosis ☐ Hot Flashes

☐ Mastitis ☐ Breast Cysts

☐ Yeast Infection / Vaginitis / Other Discharge

☐ Premenstrual Syndrome *(Mark as appropriate)*

- ☐ Fluid Retention ☐ Cravings
- ☐ Fluctuating Emotions ☐ Irritability
- ☐ Tenderness in Breasts ☐ Depression
- ☐ Fatigue

Men Only

☐ Impotence ☐ Weak Erection

☐ Discharge from Penis ☐ Prostate Problems

☐ Testicular Pain or Lump ☐ Infertility

☐ Premature Ejaculation ☐ Low Sex Drive

Men and Women

Supplements

Name	Purpose	How Long

Diet

What kinds (circle)	How much per day/week
Sugar: Candy	
Cookies / Baked goods	
Regular Soda / Diet Soda	
Chocolate	
Diary: Milk	
Cheese	
Yogurt	
Ice-cream	
White Flour: Bread	
Pasta	
Coffee	
Alcohol	
Protein 50g per day?	
Eggs	
Dark green/vegetables	
Fruits	
Eat Breakfast?	
Eat fast food / on the run?	

Additional Notes

_____

_____

_____

_____

Thank you for completing this form. Your time is greatly appreciated and we value this opportunity to serve you!

PROVIDER NOTICE OF PRIVACY PRACTICES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY. DEBRA KUHN GERSON, L.AC., DIPL. OM, FABORM, JILL ZUNDELEVICH, L. AC., DACM, AND ALL OTHER HEALTH CARE PROVIDERS ARE REQUIRED TO INFORM YOU, THE PATIENT, HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THE FOLLOWING ALSO OUTLINES HOW YOU CAN ACCESS YOUR HEALTH CARE INFORMATION.

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW.

As your health care provider, I use your health information for evaluation, treatment, to obtain payment for treatment and to evaluate the quality of care that you receive. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers via paper mail, electronic mail, fax or other methods.
We may use your health care information without your authorization for the following reasons:

1. Public health safety
2. Auditing purposes
3. Emergencies
4. At the request of your insurance carrier
5. When required by law

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time.

If at any time we change our policies in regard to your medical information, you will be informed with a new "Notice of Privacy Practices" form and will be asked to sign it.

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information is corrected or added to your medical record.

If you have any questions or concerns about your medical records, please contact Botanica Wellness Sanctuary, Inc. at 720-398-2050, or you can file a written complaint with the U.S. Department of Health and Human Services. Botanica Wellness Sanctuary, Inc. is required by law to protect your medical information and to provide this notice to you, along with your signature acknowledging your receipt of this information.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Botanica Wellness Sanctuary, Inc. to release any information required to process this claim to any insurance company or attorney in this case. I also authorized any insurance company or medical provider to release my medical records to Integrative Health, Inc. This information is to be used for the purpose of processing my claim for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original copy.

PAYMENT AGREEMENT

I hereby authorize my insurance benefits to be paid directly to Botanica Wellness Sanctuary. I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by Debra Kuhn Gerson, L.Ac., Dipl. OM, FABORM or Jill Zundelevich, L. Ac., DACM, I must pay charges and services not covered by any insurance or other third-party payer and/or not paid to Botanica Wellness Sanctuary for any reason within a time period Botanica Wellness Sanctuary deems reasonable. The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third-party responsible for payment of the charges.

CANCELLATION NOTICE

Kindly give a 24 hour notice of cancellation. Late cancellations are subject to a 50% cancellation fee.

Patient's Name (Print): _____

Signature: _____ Date Signed: _____

Debra Kuhn Gerson, L. Ac., Dipl. OM, FABORM
Jill Zundelevich, L. Ac., DACM
Botanica Wellness Sanctuary
1940 E 18th Ave. Denver, CO 80206
Ph: (720) 398-2050

Colorado Mandatory Disclosure and Consent Form for Acupuncture

Debra L. Kuhn Gerson and Jill Zundelevich have training and experience in the recommendation and application of adjunctive therapies and herbs as defined by Traditional Oriental Medicine. Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body, by well-trained, licensed acupuncturists. Acupressure, acupuncture, moxabustion, cupping, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis or treatment of any disease or injury.

I understand that complications may result from acupuncture treatment. Among these possible complications are areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia, or coumadin use. Please use caution walking with bare feet in the treatment room. I, the patient, further understand and agree to hold harmless, indemnify and protect against court action the individual acupuncturist/therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

We gladly accept auto claims, workman's comp, and insurance as payment. Insurance coverage depends on your plan. Please call ahead of time to find out what your acupuncture benefits are.

Our discounted time-of-service fee schedule is $135 for Initial Acupuncture Session (non-Fertility related), $150 Initial Fertility Acupuncture Session and $85 for Follow-up Acupuncture Sessions.

Colorado law requires all acupuncturists provide the following information to clients on their first visit:

Education, Experience, Degrees, Certificates, Credentials, Licenses, Certificates, and Registrations:
Debra Kuhn Gerson, L.Ac., Dipl. OM, FABORM and Jill Zundelevich, L. Ac., DACM have been licensed by the state of Colorado, which requires that they graduate from an approved institution (a four year program), and pass the National Board Exam (NCCAOM) for acupuncture and oriental medicine. Debra Kuhn Gerson, L.Ac., Dipl. OM, FABORM and Jill Zundelevich, L. Ac., DACM have never had any license, registration, or certification issued by any local, state or national healthcare agency, revoked or suspended.

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. We are trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental medicine concepts

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.

In a professional relationship sexual intimacy is never appropriate and should be reported to the Director of the Divisions of Registrations in the Department of Regulatory Agencies: The Colorado Department of Regulatory Agencies regulates the practice of acupuncture. Send inquiries to the attention of: Director of the Professions and Occupations, Acupuncturist Licensure, 1560 Broadway, Suite 1350 Denver, CO 80202. Phone: (303) 894-7800 Email: dora_acupunctureboard@state.co.us. Each patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. If you have any questions about any part of your treatments, billing statements, etc., please ask the office manager and tell your provider.

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient.

Patient's Name (Print): _____

_____ _____

Signature of patient or legal guardian **Date Signed**

Debra Kuhn Gerson, L. Ac., Dipl. OM, FABORM
Jill Zundelevich, L. Ac., DACM
Botanica Wellness Sanctuary
1940 E 18th Ave. Denver, CO 80206

BIOPUNCTURE INFORMED CONSENT

Your treatment at Botanica may include biopuncture or B12 injections. For your convenience, please sign this form. Injections will never be performed without prior discussion with the practitioner.

Whenever a needle is introduced through the skin, inherent risks are present. Although the risks are small, the expected benefit from the procedure must outweigh the possible risks. Make sure that you have a thorough understanding of the expected benefit from the injection. The risks of injection depend on where the injection is made and what is being injected. If the injection is made in a large muscle, the risk of hitting vital structures is very small. Injections in areas of neurovascular bundles (where nerves, veins, and arteries travel together) have a higher risk of injury, and injections in the area of the lung organs have a higher risk of injuring them.

The risks of injections are:

1) Infection: with current standard procedure of sterile needles and antiseptic technique, this risk is very small, but it still exists. Redness and swelling are early stages of infection. Any redness or swelling should be reported immediately to avoid more serious complications of sepsis (bacteria in the blood stream) or osteomyelitis (infection of the bone).
2) Puncture of the nerves, arteries, or veins: this risk varies greatly on the area of injection. When acupuncture point injections are made in the body of large muscles, this risk is very small. In other areas where the structures are larger and running together, the risk is increased. A nerve may be permanently damaged or bleeding may occur with puncture of a vein or artery.
3) Puncture of a lung or vital organ: injections in this area of the chest could puncture a lung in which the serious complication of a tension pneumothorax could occur. In this condition, the lung leaks air into the lung cavity progressively compressing the heart and lung. The person becomes short of breath, which can advance to death if untreated. Puncture of other vital organs is extremely unlikely and depends on the site of injection.
4) Allergic reaction the injected substance: allergic reactions to homeopathic substances have not been reported, and, in fact, they are used to treat allergic conditions. However, the possibility still exits. An allergic reaction is usually hives, but a lung reaction could occur with severe shortness of breath, or the most serious reaction of anaphylaxis. In anaphylaxis, there is an acute onset of shock, and this is a serious life-threatening emergency that could result in death.

INFORMED CONSENT AND AGREEMENT

I, _____, hereby request and consent to injection therapy on my body, in order to enhance the effect of stimulating an acupuncture point. I understand that I will only be injected with substances that fall within the scope of Licensed Acupuncturists in Colorado. I understand the risks involved. I do not expect my practitioner to be able to anticipate all risks and complications. By signing this form, I agree to accept all the risks and release all liabilities from Debra Kuhn Gerson, L. Ac Dipl. OM and all other practitioners who may treat me.

Patient Signature (or Representative)_____Relationship_____Date_____

Debra Kuhn Gerson, L. Ac., Dipl. OM, FABORM
Jill Zundelevich, L. Ac., DACM
Botanica Wellness Sanctuary
1940 E 18th Ave. Denver, CO 80206

BOTANICA WELLNESS SANCTUARY

CONSENT FOR PURPOSE OF TREATMENT & HEALTHCARE OPERATIONS

In this document, "I" and "my" refer to the patient/client.

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy 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 working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not.
I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

_____	_____
Print Name of Patient	Print Name of Acupuncturist
X_____	X_____
Signature of Patient (or Representative)	Signature of Acupuncturist
_____	_____
Print Name of Patient Representative	Print Name of Witness/Translator
X_____	_____
Date Consent Completed	Signature of Witness/Translator