KELLIE KRASOVEC, L.Ac.

Health History Questionnaire

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. If I sincerely believe your condition will not respond satisfactorily, I will not accept your case. If you have any questions, please ask. If you have anything you wish to bring to my attention which is not asked on this form, please note it in the *Comments* section. Thank You.

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Height: _____Weight: _____Gender/Pronouns: _____

_____ Employer: _____

_____ Occupation: _____

Phone: _____ Hm/Wk/Cell Had Acupuncture previously? YES NO

Email:_____ Like to receive monthly newsletter? YES NO

Spouse's Name: _____ Marital Status: _____

Physician: _____ Referred to this office by: _____

In Emergency, Notify: _____ *Relationship:* _____ *Phone:* _____

Main problem you would like help with: _____

_____

When did the problem begin (be specific): _____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)?

_____

_____

Have you been given a diagnosis for the problem? If so, what?

_____

What kind of treatments have you tried or are using? _____

_____

Past Medical History – please note dates: Hypo/Hyper/Hashimoto's Thyroid:_____

Cancer: _____ Chemo/Radiation: (dates)_____

HIV/AIDS: _____ Lyme/Parasites: _____ Autoimmune Dx: _____

Venereal Disease: _____ High Blood Pressure: _____ Rheumatic Fever: _____

Hepatitis: _____ Heart Disease: _____ Diabetes: Type I / Type II _____

Mono/EBV/CFS: _____ Kidney/Gallstones: _____ Chx Pox/Shingles: _____

Surgeries (types & dates): _____

_____

Significant Traumas: _____

_____

Significant Dental Work: _____

Scars & Locations: _____

Allergies (drugs, chemicals, foods, etc.) _____

_____

Occupational Stress (chemical, physical, psychological) _____

Birth History (prolonged labor, forceps, premature, etc.) _____

FAMILY Medical History

□ Cancer _____ □ Heart Disease _____ □ Asthma _____
□ Diabetes _____ □ Stroke _____ □ Allergies _____
□ High Blood Pressure _____ □ Seizures _____ □ Depression/Anxiety _____
Other:_____

Medications/Supplements

What medications and/or supplements are you currently taking? _____

_____

Have you had any courses of antibiotics recently? □ Many □ A few □ 1 or 2 □ None Why? _____

Habits

Do you have a regular exercise program? Please describe: _____

_____

Are you or have you been on a restricted diet? What kind and why? _____

_____

Please indicate usage per day or per week:

Cigarettes	_____ per Day/Week/Month	Tea	_____ per Day/Week/Month
Alcohol	_____ per Day/Week/Month	Soft Drinks	_____ per Day/Week/Month
Drugs	_____ per Day/Week/Month	Sugar	_____ per Day/Week/Month
Coffee	_____ per Day/Week/Month	Water	_____ per Day/Week/Month

Please describe your average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Do you suffer from any of the following?

Check all that apply, and for each note if it is current or past.

General

□ Recurrent Infections
□ Night Sweats
□ Sweat easily
□ Bleed or bruise easily
□ Strong thirst (prefer hot or cold?)
□ Thirst with no desire to drink
□ Fatigue
□ Sudden energy drops
Time of day_____
□ Poor Sleep
□ Tremors
□ Poor Balance
□ Edema
□ Underweight
□ Overweight

Skin

□ Rashes
□ Itching
□ Eczema
□ Oozing
□ Pimples
□ Dry skin / scalp
□ Recent moles
□ Changes in hair/skin
□ Other _____

Head/Eyes/Ears/Nose/Throat

□ Headaches
Where _____
When _____
□ Migraines
□ Dizziness
□ Discharge from ear
□ Poor hearing
□ Ringing in ears
□ Blurry vision
□ Night blindness
□ Color blindness
□ Spots in front of eyes
□ Eye Pain
□ Excessive Tearing
□ Squint
□ Glasses
□ Sore eyes
□ Facial Pain
□ Nose bleeds
□ Nasal discharge
□ Blocked nose
□ Snoring
□ Grinding teeth
□ Teeth problems
□ Recurrent sore throat
□ Hoarseness
□ Tonsillitis
□ Swollen glands
□ Sores on lips/mouth
□ Other _____

Cardiovascular
□ Pacemaker
□ High Blood Pressure
□ Low Blood Pressure
□ Chest discomfort/pain
□ Heart Palpitations
□ Cold hands or feet
□ Swelling of hands or feet
□ Blood Clots
□ Spider veins
□ Fainting
□ Other _____

Respiratory
□ Difficulty breathing
□ Pain with breathing
□ Shallow breathing
□ Shortness of breath
□ Production of phlegm
Color _____
□ Recurrent cough
□ Bronchitis
□ Pneumonia
□ Asthma/Wheezing
□ Tonsils Removed
□ Other _____

Digestion
□ Bad breath
□ Change in appetite
□ Nausea
□ Vomiting
□ Heartburn
□ Indigestion
□ Belching
□ Abdominal pain or cramps
□ Weight gain
□ Weight loss
□ Loose stools / Diarrhea
□ Strong smelling stools
□ Bloody stools
□ Pale stools
□ Green stools
□ Black stools
□ Constipation
□ Alternating Constipation/Diarrhea
□ Pain with passing stools
□ Gas
□ Rectal pain
□ Hemorrhoids
□ Anorexia nervosa
□ Bulimia
□ Other _____

Genito-urinary
□ Pain on urination
□ Urgency with urination
□ Frequent urination
□ Blood in urine
□ Decrease in urinary flow
□ Unable to hold urine
□ Incontinence at night
□ Dribbling urination
□ Kidney stones
□ Prostate problems
□ Impotency
□ Changes in sexual drive
□ Rashes
□ Do you wake at night to urinate?
How many times? _____
□ Other _____

Gynecological
# of pregnancies_____
births_____
premature births_____
abortions_____
Age of 1st menses_____
days between menses_____
Duration of menses_____
1st day of last menses_____
Age of menopause_____
□ Other _____
Date of last PAP_____

□ **PMS**
□ Irregular periods
□ Painful periods
□ Light periods
□ Heavy periods
□ Clots
□ Fibroids
□ Endometriosis
□ Infertility
□ Vaginal discharge
□ Vaginal sores
□ Postcoital bleeding
□ Breast lumps
□ Nipple discharge
□ Other _____

Do you practice birth control?
□ yes □ no
What type and for how long?
_____

Are you pregnant now?
□ yes
□ no
□ don't know/maybe

Musculoskeletal
□ Neck ache/pain
□ Back ache/pain
□ Knee ache/pain
□ Shoulder pain
□ Elbow/Forearm pain
□ Hand/Wrist pain
□ Foot/Ankle pain
□ Joint/Bone problems
□ Torn tissues
□ Prostheses
□ Muscle pain/weakness
□ Hernia
□ Other _____

Neurological
□ Seizures
□ Nerve damage
□ Paralysis _____
□ Stroke _____
□ Sleep disorder
□ Concussion _____
□ Vertigo
□ Lack of coordination
□ Loss of balance
□ Poor memory
□ Difficulty in concentrating

Behavioral
□ Vacant
□ Moody
□ Easily susceptible to stress
□ Aggressive/Bad temper
□ Lose control of emotions
□ Anxiety
□ Panic Attacks
□ Depression
□ Fear
□ Substance abuse
□ Other _____

Have you ever been treated for emotional problems?
□ yes □ no

Have you ever considered or attempted suicide?
□ yes □ no

Please note the severity of your <u>pain</u> or concern right now:

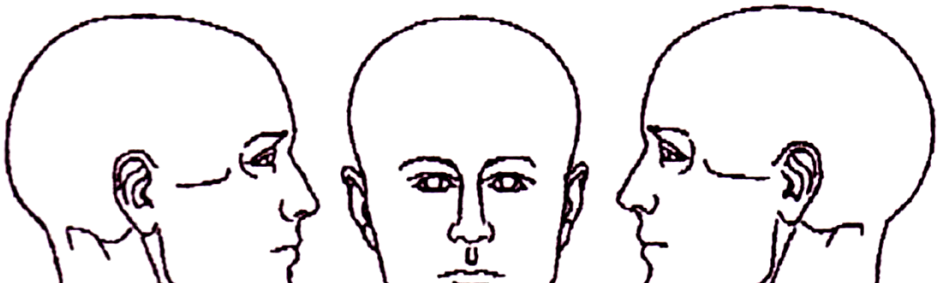
1_____2_____3_____4_____5_____6_____7_____8_____9_____10

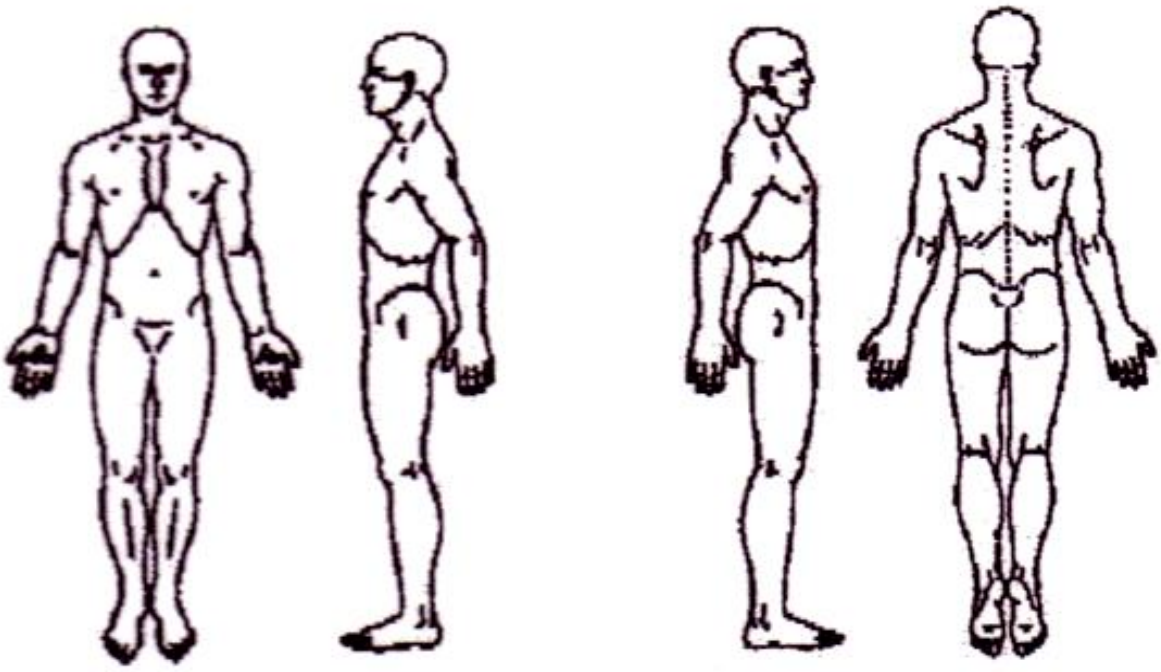
No Problem Worst Imaginable

Please note the greatest degree of severity of this problem within the last week:

1_____2_____3_____4_____5_____6_____7_____8_____9_____10

No Problem Worst Imaginable





Additional Comments:_____

_____

_____

***Email**: At times, The Krasovec Clinic uses email to correspond with patients as a convenience. However, these emails are not encrypted and could theoretically be read by an outside party with the technical skills to intercept such correspondences. By initialing this, you consent to allow Kellie Krasovec and associates to correspond with you via email despite these potential risks.* ***Initial**:* _____

Informed Consent for Acupuncture & Chinese Medicine Treatment

I, the undersigned, hereby request and consent to the performance of acupuncture procedures including, but not limited to, moxibustion, cupping (dry and/or wet), plum blossom, gua sha, electroacupuncture, Tuina (Chinese massage), and Chinese herbal supplements, on me or the patient for whom I am legally responsible, by my acupuncture practitioner. I recognize the potential risk and benefit of this procedure as described below:

Potential Risk:
Discomfort, pain, infection, weakness, fainting, nausea, temporary discoloration or bruising at site of procedure, occasional aggravation of symptoms existing prior to the treatment.

Potential Benefits:
Drugless relief of presenting symptoms and improved balance of the body's circulations, which may lead to prevention or elimination of the presenting problems and strengthen the constitution.

I agree to inform acupuncturist if I become pregnant or if I am potentially pregnant.

I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my presenting condition and for any future conditions for which I seek treatment.

I hereby release associates of Kellie Krasovec from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Print Name of Patient or Patient's Representative Date

_____ _____
Signature of Witness Date

COLORADO MANDATORY DISCLOSURE STATEMENT

Kellie Krasovec, Dipl.Ac., L.Ac.
97 Main Street, W - 202
Riverwalk
Edwards, CO 81632
970.926.6588

INITIAL INTAKE AND TREATMENT:	$235 - $265
FOLLOW-UP TREATMENT:	$180 - $215
AESTHETIC ACUPUNCTURE:	$215 per treatment (includes Celluma)
CELLUMA LIGHT THERAPY:	$30 per 30 minute treatment
HERBAL FORMULAS:	varies

Kellie Krasovec is certified as a Diplomate in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine. She earned her Master of Science in Oriental Medicine in 2005 from Southwest Acupuncture College located in Santa Fe, New Mexico. This four-year program includes 1873 actual classroom hours and 1030 clinical hours. The degree includes training in acupuncture, auriculotherapy, moxibustion, cupping, tuina, Chinese herbology, electrical stimulation and nutritional therapy.

Kellie Krasovec earned three advanced certificates during additional studies in Beijing, China, in 2004 and 2005. Two of these were awarded by the Beijing International Acupuncture Training Centre for programs in Acupuncture and Moxibustion as well as Chinese Herbal Medicine. A third was awarded by Guang An Men Hospital for in-hospital training in Traditional Chinese Medicine. She is also certified as a Facial Rejuvenation practitioner.

Kellie Krasovec is a member of the American Acupuncture Council and is licensed acupuncturist by the state of Colorado.

This practitioner complies with all the rules and regulations promulgated by the Colorado Department of Public Health and Environment, including those related to the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. *Only single-use, disposable, factory-sterilized needles are used*.

As a patient you are entitled to receive information about the methods of therapy, techniques used and duration of such therapy, if known.

As a patient you are entitled to seek a second opinion from another health care professional and may terminate therapy at any time.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies at the following address:

Director, Division of Registrations
Acupuncturists Licensure
1560 Broadway, Suite 1350
Denver, CO 80202
303.894.7800

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

_____ _____

Patient or Guardian's signature Date

Financial Policy

- Payment is due at time of service, unless otherwise arranged prior to treatment.
- Failure to give 24-business hour notice for cancellation of any appointment will result in $180 cancellation fee.
- Failure to notify office and failure to meet appointment without any notice will result In a $180 missed appointment fee.

Any patient wishing to have insurance cover all or a portion of their treatment should contact their insurance provider to learn the coverage boundaries of their policies with respect to Traditional Chinese Medicine including Acupuncture.

- I am able to provide my patients with a Superbill upon request.
- A Superbill is an invoice for your visit that uses standardized codes for all of the treatments performed. This process requires the patient to pay the full cost of the treatment out-of-pocket at the time of the visit. The Superbill can thereafter be submitted to your insurance carrier for full or partial reimbursement depending on your policy.
- Patients wishing to make use of this service should check with their insurance carriers to be sure that Superbills are accepted.
- We are unable to change standardized codes on invoices, if insurance does not approve.

Payment Agreement

(please check and sign)

☐ I understand the above terms and agree to keep my account current by paying with cash, check or a credit card at each visit.

_____ _____

Signature Date

_____

Print Name