Colorado Mandatory Disclosure and Informed Consent
Inspiration Point Acupuncture and Wellness

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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. The practice of acupuncture is regulated by the Director of Regulations, Colorado Department of Regulatory Agencies. If you have any comments, questions, or complaints, contact the Acupuncturists Registrations Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 849-2440. The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. The patient may seek a second opinion from another healthcare 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 Registration in the Department of Regulatory Agencies. 1560 Broadway, Suite 1350, Denver, CO, 80202. Telephone 303.894.2440.

Clinic Fee Schedule (due at time of service)

- Initial Intake Consultation and Treatment: $135 + Cost of herbs
- Follow-up Treatment: $95 + Cost of herbs
- Facial Rejuvenation: $165 + (depending on full course of treatment)
- Microneedling: $250 + (depending on full course of treatment)

*If you are interested in EFT please ask Anne for a more in-depth fee schedule

Insurance: We do not bill insurance. Upon request, we will provide you with a receipt for your insurance company.

24-hour notice is required for change of appointment or cancellation. If you are unable to give 24-hour notice, we will do our best to fill your space but if we are unable to do so, you will be charged a $50 fee for that appointment.

Practitoner Education, Certification, and Experience

- Master of Science in Acupuncture and Oriental Medicine from South Baylo University (2001). This four-year program consisted of 3800 hours of education including 1000 hours of clinical practice.
- NCCAOM Diplomate in Acupuncture (2000).
- California State Licensed Acupuncturist (2001-2008).
- Colorado Licensed Acupuncturist #1473 (2008-present).
- Anne's training includes adjunctive therapies such as facial rejuvenation, tui na, acupressure, cupping, ariculotherapy, aroma acupoint therapy, drug detoxification as well as dietary and lifestyle recommendations. She is certified in neuroacupuncture, facial rejuvenation, drug detoxification, injection therapy and EFT (emotional freedom technique).

Informed Consent

- I hereby request and consent to the performance of acupuncture procedures by my acupuncturist, Anne Woods-Tinkum. I have been informed that acupuncture is a safe method of treatment but that it may have side effects including discomfort, pain, dizziness, bruising, or numbness at site of procedure. Unusual and rare risks of acupuncture include nerve damage, organ/lung puncture, infection, and spontaneous miscarriage. Other side effects and risks may occur. If I suspect that I am pregnant, I will immediately inform the acupuncturist.
- I have discussed the nature and purpose of acupuncture procedures with the acupuncturist(s) named above. I understand that there are no guarantees regarding cure or improvement of my condition. I understand that 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 me outside of these facilities. I do not expect the acupuncturist to anticipate and explain all possible risks and complications, and I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist judges to be in my best interest based upon the facts then known. I understand that I have the choice to accept or reject treatment at any time.
- I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to all terms and conditions stipulated by this document. I intend this from to cover the entire course of treatment for my condition and for any future conditions(s) for which I seek treatment.

Signature Of Patient or Person authorized to consent	Relationship or Authority Representative	Date

Anne Woods-Tinkum, L.Ac | New Patient Intake Form

Please fill out this questionnaire. All answers are confidential. Please print clearly in ink.

Name_____**Preferred Pronoun**_____**Date**_____

Address_____**City**_____**State**_____ **Zip**_____

Phone_____**Email Address**_____

Age_____**Height**_____**Weight**_____**Occupation**_____

Referred By_____**Reason For Visit**_____

Other Concerns_____

How long have you had this condition?_____**Have you experienced this before?**_____

What seemed to be the inital cause?_____

What seems to make it better?_____

What seems to make it worse?_____

Does it bother your: Sleep_____**Work**_____**Other (What?)**_____

Family History: Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	Self	Parent/Gaurdian	Spouse/Partner	Children
Cancer/Tumors				
Diabetes				
Depression				
Stroke				
Seizures				
Drug Abuse				
Allergies				
Hepatitis				
Anemia				
High Blood Pressure				
Kidney Disorders				
Thyroid Disorders				
Other				

Personal Lifestyle Habits (How much, How many, How often)

Cigarettes (Packs)_____**Coffee/Tea (Cups)**_____**Alcohol (Drinks/Weekly)**_____

Marijuana & Other Recreational Drugs_____**Other forms of Self-Medicating**_____

Dietary Restrictions_____

Food Cravings_____

Diet: What might you eat for a day?

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Exercise_____

What non-work related activities do you enjoy? (reading, meditating, TV, music, etc.)_____

Lifestyle Satisfaction (Optional): Rate options from 1-10 (0=very unsatisfied & 10=very satisfied

___Physical Health
___Mental Health
___Relationships
___Family
___Sexuality
___Gender
___Career
___Spirituality
___Community Connection

Medicines

Prescription Drugs currently taking	**For What Condition?**

Over-the-Counter Meds/Supplements	**For What Condition?**

Major Hospitalizations: Write the most recent hospitalization (serious medical illness or operation) below:

Year_____**Operation/Illness**_____

Year_____**Operation/Illness**_____

Year_____**Operation/Illness**_____

Date of last physical examination_____**Name of Physician**_____

Have you ever been treated with acupuncture and/or Chinese herbal medicine before?_____

Please Put "C" for Current Condition or "P" for Past Condition.

General
__Insomnia
__Dreams/Nightmares
__Irritability
__Depression
__Mood Swings
__Fatigue
__Poor Memory
__Strongly like cold drinks
__Strongly like hot drinks
__Recent Weight Loss/Gain
__Cold Hands/Feet

Head & Neck
__Headaches
__Migraines
__Dizziness
__Stiff Neck
__Fainting
__Swollen Glands

Musculoskeletal
__Joint Pain/Disorder
__Sore Muscles
__Weak Muscles
__Difficulty Walking
__Neck/Shoulder Pain
__Upper Back Pain
__Lower Back Pain
__Rib Pain
__Limited Range of Motion
__Other (Describe)

Ears
__Hearing Loss
__Ringing
__Infections
__Earache
__Hearing Aids
__Vertigo

Nose, Throat, & Mouth
__Sinus Infection
__Hay Fever/Allergies
__Frequent Sore Throat
__Difficulty Swallowing
__Mouth & Tongue Ulcers
__Nosebleeds
__Frequent Colds
__Dry Nose/Mouth
__Congestion/Excess Phlegm
__Loss of Voice
__TMJ
__Facial Pain

Eyes
__Glasses/Contact Lenses
__Blurred Vision
__Poor Night Vision
__Spots/Floaters
__Double Vision
__Inflammation
__Dry Nose/Mouth
__Glaucoma
__Cataracts

Respiratory
__Difficulty Breathing
__Difficulty Breathing While Laying Down
__Wheezing
__Asthma
__Chronic Cough
__Wet Cough
__Dry Cough
__Coughing Up Phlegm
__Coughing Up Blood
__Shortness of Breath
__Tight Chest
__Pneumonia

Cardiovascular
__High Blood Pressure
__Low Blood Pressure
__Chest Pain or Tightness
__Palpitation
__Rapid Heartbeat
__Irregular Heartbeat
__Swollen Ankles
__Poor Circulation
__Anemia
__Phlebitis
__History of Heart Attack

Genito-Urinary
__Pain While Urinating
__Frequent Urination
__Urgent Urination
__Blood In Urine
__Bedwetting
__Wake To Urinate
__Incomplete Urination
__Increased Libido
__Decreased Libido
__Kidney Stones

Neurological
__Seizures
__Concussion/TBI
__Tremors
__Numbness/Tingling
__Pain
__Paralysis
__Poor Coordination
__Other (Describe)

Skin
__Hives
__Rashes
__Night Sweating
__Eczema/Psoriasis
__Dry Skin
__Easy Bruising
__Itching
__Changes in Moles/Lumps

Infectious Diseases
__HIV
__TB
__STD's
__Hepatitis

Reproductive Health Form

Assigned Male At Birth

Do you have or experience any of the following? (Y) for Yes or (N) for No.

__Pain While Urinating
__Urgent Urination
__Burning Urination
__Dribbling After Urination
__Decreased Libido
__Poor Erectile Function
__Swollen Scrotum
__Unable To Hold Urine
__Frequent Urination
__Incomplete Urination
__Scanty Flow
__Low Testosterone
__Painful Testicles
__Coldness In Scrotum
__Blood In Urine
__Copious Flow
__Kidney Stones
__Impotence
__Prostatitis
__Varicocele
__Genital Pain

Do you wake to urinate?_____What Time?_____What color is your urine?_____

Any other problems with either the genital or urinary systems?_____

_____

Any other concerns?_____

_____

Assigned Female At Birth

Age of first meses_____Date of last cycle_____Duration of flow_____

Blood Clots (Yes/No/When)_____Length of Cycle_____Color of Blood_____

Texture of Blood_____Pain(Yes/No/What Kind)_____Irregular?_____

PMS (describe)_____Method of Contraception_____Methods Used In the Past_____

Breast (Lumps, Cysts, Tenderness, Etc.)_____UTIs_____How Frequent_____

Vaginal Infections/Discharges_____Pain/Itching of Genitalia_____

Pap Smear: normal/abnormal_____Date_____Uterine Fibroids_____Endometriosis_____

Are you currently Pregnant?_____Number of Pregnancies_____Number of Live Births_____

Number of Miscarriages_____Number of Abortions_____Number of Premature Births_____

Menopause (Date of Onset)_____Symptoms_____

Hormone Replacement Therapy (Yes/No)_____For How Long?_____

Any Side Effects?_____