

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: \$185 + Cost of herbs
 - Follow-up Treatment: \$105 + Cost of herbs
 - Facial Rejuvenation: \$180 + (depending on full course of treatment)
 - Microneedling: \$295 + (depending on full course of treatment)
- Package rates available.

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.

Practitioner 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 initial 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

Digestion

- ☐ Low Appetite
- ☐ Excessive Appetite
- ☐ Abdominal Pain
- ☐ Reflux/GERD
- ☐ Gas/Bloating
- ☐ Constipation
- ☐ Diarrhea
- Other _____

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	☐ Unable To Hold Urine	☐ Blood In Urine
☐ Urgent Urination	☐ Frequent Urination	☐ Copious Flow
☐ Burning Urination	☐ Incomplete Urination	☐ Kidney Stones
☐ Dribbling After Urination	☐ Scanty Flow	☐ Impotence
☐ Decreased Libido	☐ Low Testosterone	☐ Prostatitis
☐ Poor Erectile Function	☐ Painful Testicles	☐ Varicocele
☐ Swollen Scrotum	☐ Coldness In Scrotum	☐ 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 menses _____ 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? _____