

Acupuncture & Oriental Medicine

Patti Polman, Lic. AC

N.C.C.A. Certified

3441 Tennyson Street

Denver, CO 80212

303-433-5006

303-433-5016 fax

Name _____ Date _____

Date of Birth _____ Age _____ S.S# _____

Address _____ Phone _____

City _____ State _____ Zip _____

Employer _____ Phone _____

Occupation _____

Marital Status _____ Number of Children _____

Personal Physician _____ Phone _____

Emergency Contact _____ Phone _____

Relationship _____ Referred By _____

Clinic Policy

The first office visit is 1.5 hours in length; please complete this form before the office visit to allow sufficient time for reviewing your history, addressing your concerns, and performing an acupuncture treatment. Return office visits are generally 1 hour in length.

If you need to cancel an appointment, we ask that you give 24 hours notice. If less than 24 hours notice is given for a cancelled appointment or an appointment is missed, the full fee will be billed to you.

Payment for services will be due at the time of the visit. Cash and checks are acceptable forms of payment. Upon request, an invoice with the procedure and diagnosis codes can be printed for submitting to your insurance company or to your cafeteria plan. Prepayment for services is allowed as a convenience if desired.

Fee Schedule-Adults*

New Patient \$110

Return Visits \$75

*Herbs are additional
and vary in price.

Pediatrics*

Infants-3 years \$25 (15 min)

4-12 years \$37 (30 min)

13-18 years \$65 (45 min)

Seniors (age 65+)*

New Patient \$100

Return Visit \$65

Insurance

Your insurance company can be billed if I am on their provider list; however, you are ultimately responsible for any remaining balance. If after 90 days, your insurance has not made payment on your account, you will be asked to pay the remaining balance in full.

Signature

I have read and understood the above terms and agree to the conditions listed above. I have been informed of your privacy and understand the terms therein.

Signed _____ Date _____

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This disclosure is in compliance with the State of Colorado, Department of Regulatory Agencies Senate Bill 92-6. All rules and regulations set forth by the Department of Health are strictly adhered to by this clinician; including proper cleaning and sterilization of equipment and office.

The Department of Regulatory Agencies regulates the practice of acupuncture. Any complaints should be directed to: Director of the Division of Registrations, Department of Regulatory Agencies, 1560 Broadway, Suite 1340, Denver, CO 80202-5140, Telephone: 303-894-7851.

Patients are entitled to receive information about the methods of therapy, techniques used, and the duration of therapy, if known. Patients may seek a second opinion and 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 Registrations in the Department of Regulatory Agencies.

Patti L. Polman, Dipl. Ac. (N.C.C.A.)

EDUCATION

Colorado School of Traditional Chinese Medicine- Denver, CO

3-Year Program- Diploma Traditional Chinese Medicine 1994

Blue Poppy Press Gynecology Certificate Program

September 1996- completed April 1997

6 weeks of study at Hunan TCM teaching hospital in Chengsha, China-Gynecology Dept.

Hari Style Acupuncture- ongoing continued studies of gentle Japanese style acupuncture with Kuahara sensei

Indiana University of South Bend, Indiana

Dental Hygiene Program- 2-year program (additionally 1 year pre-requisites at Ball State University) program completed 1977

Toyo Hari Meridian Therapy Training 2004

PROFESSIONAL ORGANIZATIONS

Acupuncture Association of Colorado - since 1993

Toyo Hari Association - since 2004

CERTIFICATIONS, LICENSES and REGISTRATIONS

National Commission for the Certification of Acupuncturists

Certified Acupuncturists- Dipl. Ac. (N.C.C.A.) 1995

Certified Herbalist- (N.C.C.A.) 1998

Colorado Department of Regulatory Agencies

Registered Acupuncturist

Colorado Department of Regulatory Agencies

Registered Dental Hygienist 1981-Current

Signed _____ Date _____

General Information	YES	NO
Have you ever had acupuncture before?	—	—
Are you now or could you be pregnant?	—	—
Date of conception: _____		
Do you have a history of miscarriage?	—	—
Do you have a pacemaker, heart arrhythmia, or other heart condition?	—	—
Have you ever had blood-clotting problems, or problems with bleeding?	—	—
Are you on blood-thinning medications?	—	—
Do you take aspirin regularly?	—	—
Have you ever been diagnosed with Hepatitis?	—	—
HIV?	—	—
AIDS?	—	—
TB?	—	—
If so, when? _____		

Prescription Medications

Please list any prescription medications you are currently taking and what they are for:

Vitamins/Supplements

Please list any vitamins or other supplements you are taking:

Surgical History

Please list all surgeries and approximate age:

Major Accidents/Injuries

Please list any major accidents (include head injuries, fractures, deep cuts, serious sprains, etc.) Indicate date or age:

Questions Concerning General Condition

Please check any of the following that *presently* apply to you. (Use 2 checks for areas of major concern; leave blank if it does not apply to you.)

Energy Levels

- | | |
|---|--|
| <input type="checkbox"/> Are you fatigued or do you fatigue easily | <input type="checkbox"/> Do you ever have low-grade fever |
| <input type="checkbox"/> Do you need to take naps | <input type="checkbox"/> Do your hands and cheeks warm up |
| <input type="checkbox"/> Do you generally feel cold | <input type="checkbox"/> Do your feet get warm during the night |
| <input type="checkbox"/> Do you have cold feet | <input type="checkbox"/> Do you perspire easily without exertion |
| <input type="checkbox"/> Do you have cold hands | <input type="checkbox"/> Do you ever wake up sweating at night |
| <input type="checkbox"/> Do you catch colds frequently | <input type="checkbox"/> Do you feel tired after meals |
| <input type="checkbox"/> Do you have energy slumps at certain times | <input type="checkbox"/> Do you have excess/nervous energy |
| <input type="checkbox"/> Do you wake up tired in the morning | <input type="checkbox"/> Does your energy pick up after you get up |
| <input type="checkbox"/> Do you feel energized after exercise | <input type="checkbox"/> and move about in the morning |

Appetite & Digestion

- | | |
|---|--|
| <input type="checkbox"/> Has your appetite changed lately | <input type="checkbox"/> Do you have intestinal gas |
| <input type="checkbox"/> Do you have a poor appetite | <input type="checkbox"/> Do you experience a bitter taste |
| <input type="checkbox"/> Do you have poor digestion | <input type="checkbox"/> Do you have acid regurgitation |
| <input type="checkbox"/> Do you have epigastric (stomach) distention | <input type="checkbox"/> Do you crave particular foods |
| <input type="checkbox"/> Do you have abdominal (intestinal) distention | <input type="checkbox"/> Sweet <input type="checkbox"/> Salty |
| <input type="checkbox"/> Do you experience belching/hiccups | <input type="checkbox"/> Bitter <input type="checkbox"/> Sour |
| <input type="checkbox"/> Do you have heartburn | <input type="checkbox"/> Hot or spicy |
| <input type="checkbox"/> Are you hungry all/most of the time | <input type="checkbox"/> Are you hungry but fill up on little |
| <input type="checkbox"/> Do you have gurgling sounds in your intestines | <input type="checkbox"/> Do you experience bad breath |
| <input type="checkbox"/> Do you have a nervous stomach | <input type="checkbox"/> Do you feel foggy or low if you miss a meal |
- Do you eat 3 meals/day at regular times _____
- Do you feel your diet is balanced _____

Please list what you generally eat in order of preference:

Thirst & Dryness

- | | |
|---|--|
| <input type="checkbox"/> How much water do you drink each day | <input type="checkbox"/> Do you have dry eyes |
| <input type="checkbox"/> Are you very thirsty | <input type="checkbox"/> Do you have a dry nose |
| <input type="checkbox"/> Are you thirsty but do not drink or take only small sips | <input type="checkbox"/> Do you have dry skin |
| <input type="checkbox"/> Do your mouth and lips tend to be dry | <input type="checkbox"/> Do you have dry hair |
| <input type="checkbox"/> Do you experience frequent sore throats or hoarseness | <input type="checkbox"/> Do you have clammy/damp skin |
| <input type="checkbox"/> Do you prefer your drinks: <input type="checkbox"/> cold <input type="checkbox"/> warm/hot <input type="checkbox"/> room temperature | <input type="checkbox"/> Do you have frequent nosebleeds |

Is the pain: __dull/achy __stabbing __burning __empty
 __ like a band wrapped around your head
 __ pressure behind the eyeballs
 __ other _____

General

- | | |
|--|--|
| <input type="checkbox"/> Do you experience dizziness or vertigo | <input type="checkbox"/> Do you have heart palpitations |
| <input type="checkbox"/> Do you have tinnitus (ear ringing) | <input type="checkbox"/> Do you have an irregular heartbeat |
| <input type="checkbox"/> Do you have any hearing loss | <input type="checkbox"/> Do you bruise easily |
| <input type="checkbox"/> Any unusual hair loss or premature graying | <input type="checkbox"/> Do you ever have shortness of breath |
| <input type="checkbox"/> Are your teeth getting looser/decay problems | <input type="checkbox"/> Do you have shallow breathing |
| <input type="checkbox"/> Do you have gum problems/bleeding | <input type="checkbox"/> Do you have blurred vision |
| <input type="checkbox"/> Do you have an aversion to cold | <input type="checkbox"/> Do you experience night blindness |
| <input type="checkbox"/> Do you have tingling or numbness sensations | <input type="checkbox"/> Do you have chest pain/oppression |
| <input type="checkbox"/> Are you color blind | <input type="checkbox"/> Do you feel you sweat less than normal |
| <input type="checkbox"/> Do you feel you sweat more than normal | <input type="checkbox"/> Does your sweat stain clothing yellow |
| <input type="checkbox"/> Does your sweat have a particularly strong odor | <input type="checkbox"/> Do you have earaches/discharge from your ears |
|
 |
 |
| <input type="checkbox"/> Do you have a high stress level | <input type="checkbox"/> Do you get mouth/tongue sores |
| <input type="checkbox"/> Do you often feel a lump in your throat | <input type="checkbox"/> Do you sigh a lot |
| <input type="checkbox"/> Do you exercise regularly | <input type="checkbox"/> Do you have an aversion to heat |
| <input type="checkbox"/> Do you grind your teeth | <input type="checkbox"/> Do you have an aversion to wind |
| <input type="checkbox"/> Do you clench your jaws | <input type="checkbox"/> Do your face or eyes get red |
| <input type="checkbox"/> Do you have jaw pain or TMJ | <input type="checkbox"/> Do you have acne |
| <input type="checkbox"/> Do you experience tremors | <input type="checkbox"/> Do you have skin rashes/itching |
| <input type="checkbox"/> Do you have flank or rib pain/discomfort | <input type="checkbox"/> Do cuts heal slowly |
|
 |
 |
| <input type="checkbox"/> Have you had recent rapid weight gain/loss | <input type="checkbox"/> Are your nails brittle/break easily |
| <input type="checkbox"/> Do you have frequent nausea | <input type="checkbox"/> Do your nails have ridges, spots or lines |
| <input type="checkbox"/> Do you prefer warm/cold foods | <input type="checkbox"/> Do your eyes tear or strain easily |
| <input type="checkbox"/> Are your eyes sensitive to light | <input type="checkbox"/> Does your eye/eyes frequently twitch |
| <input type="checkbox"/> Do you get frequent colds/flu | <input type="checkbox"/> Do you have pale color under eyelids |

Men Only

- | | |
|---|--|
| <input type="checkbox"/> Do you have reduced sexual drive | <input type="checkbox"/> Do you experience impotence |
| <input type="checkbox"/> Do you experience premature ejaculation | <input type="checkbox"/> Do you have genital pain |
| <input type="checkbox"/> Do you have ejaculations during your sleep | <input type="checkbox"/> Do you have unusual discharge |
| <input type="checkbox"/> Are you having any prostate problems | <input type="checkbox"/> Do you have painful/burning urination |
| <input type="checkbox"/> Do you have dribbling urine | <input type="checkbox"/> Do you have an uneven force in your stream of urine |

Women Only

- | | | |
|--|-----|----|
| Do you have regular pap tests | Yes | No |
| Do you receive or give yourself regular Breast exams | — | — |

Do you have a history of:

- | | | |
|--|--|---|
| <input type="checkbox"/> Amenorrhea | <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> Ectopic pregnancy | <input type="checkbox"/> Pelvic Inflammatory Disease | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Reduced sexual drive |
| <input type="checkbox"/> Leukorrhea | <input type="checkbox"/> Chronic vaginal or yeast infections | |

Birth Control History

Birth control pills _____

Number of years _____

IUD _____

Number of years _____

Abortion(s) _____

Number _____

Following birth, abortion or miscarriage, were there any health problems? If so, please explain.

Menstrual History

Are you presently pregnant? _____

Number of children _____

Age of menarche _____

Are you presently suffering from menopausal disorder? _____ hot flashes ___ night-sweats ___

Have you had a hysterectomy? _____

Please give the following information about your periods. If you no longer have periods, indicate what they were like before they stopped.

	Yes	No
Is your period regular?	___	___
Are your periods painful?	___	___
Do you bleed excessively?	___	___
Do you bleed too little/scanty?	___	___
Do you discharge clots?	___	___
Do you have headaches before your period?	___	___
Do you get headaches after you bleed?	___	___
Do you experience tightness in your chest?	___	___
Do you experience low backache?	___	___
Do you tend to sigh a lot?	___	___
How many days between your periods? _____		
How many days do your periods last? _____		
Is your menstrual blood bright red, pale red, dark red or rusty colored? _____		
Do you suffer form premenstrual syndrome (PMS)?		
___ Breast distention/swelling	___ Breast lumps	___ Water retention
___ Emotional changes	___ Irritability	___ Breast tenderness
___ Pain/cramps relieved by bleeding	___ Pain/cramps made worse by bleeding	
Other: _____		

Disease History

During your mother’s pregnancy, did she:

___ Drink alcohol

___ Smoke cigarettes

___ Suffer serious illness

___ Take medications

Were there complications with your delivery? Please explain:

Please indicate if you have had any of the following:

	Past	Present		Past	Present
Allergies	___	___			
Angina	___	___	Heart Murmur	___	___
Anemia	___	___	Heart Attack	___	___
Arthritis	___	___	Heat Stroke	___	___
Asthma	___	___	Hepatitis	___	___
Blood Pressure problems	___	___	Irritable Bowel Syndrome	___	___
Cancer	___	___	Kidney Stones	___	___

Candida	—	—	Mental Illness	—	—
Chronic cough	—	—	Mononucleosis	—	—
Cold Sores	—	—	Prostate problems	—	—
Diabetes	—	—	Serious or prolonged fever	—	—
Eating Disorders	—	—	Shingles	—	—
Edema	—	—	Sinus infections	—	—
Epilepsy	—	—	Skin problems	—	—
Epstein-Barr Syndrome	—	—	Ulcers	—	—
Food Allergies	—	—	Venereal Disease	—	—
Gallstones	—	—	Varicose Veins	—	—
Genital Herpes	—	—	Irregular Heartbeat/Arrhythmia	—	—
Giardia	—	—	High cholesterol	—	—
Other:	_____				—

Drug History

Please indicate past or present use of the following:

	Past	Present	Years usage
Anti-depressants	—	—	_____
Antibiotics	—	—	_____
Estrogen/birth-control pills	—	—	_____
Pain medication	—	—	_____
Prednisone/other steroids	—	—	_____
Sleeping pills	—	—	_____
Tagamet/other antacids	—	—	_____
Thyroid medication	—	—	_____
Valium/tranquilizers	—	—	_____
Alcohol (in excess)	—	—	_____
Tobacco	—	—	_____