



Red & White
HOLISTIC HEALTH CARE CENTER, INC.

5150 West 80th Avenue
Westminster, CO 80030
(303) 429-4325
www.red-white.net

Patient Intake Form

Name _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____

Email Address _____

Birth date _____ Age _____ Height _____ Weight _____ Sex _____

Marital status _____ Number & ages of children _____

Occupation _____

Employer's name and address _____

Personal physician _____

Date of last physical examination _____

Insurance company _____ Policy # _____

Social security # _____ Driver's license # _____

In emergency

Contact _____ Relationship _____ Phone _____

Referred by _____ Have you ever had acupuncture before Y N

Massage, acupressure, acupuncture, reflexology, preventative or corrective exercise, and 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 of treatment of any disease or injury. We recommend that you consult your physician, for any serious conditions and get at least two medical opinions. It is your right and responsibility for your own body.

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, (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

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.

Client further understands and agrees to hold harmless, to indemnify and protect against court action the individual therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

Signed: _____ Date _____

MAJOR COMPLAINT (Reason for Visit) _____

Have you ever had this condition or similar condition before? Y N

Have you ever received treatment for this condition? If yes, when? By whom?

What was the diagnosis? What were the results of the treatment?

Has the condition gotten: Better Worse About the same

What makes it better? _____

What makes it worse? _____

Describe what caused it or how it started: _____

FAMILY MEDICAL HISTORY:

- Cancer Diabetes High or Low Blood Pressure Heart Trouble TB Allergies Kidney Disease
- Epilepsy Asthma Liver Disease Ulcers Sinus Problems Eye Disease Arthritis Alcoholism
- Spinal Problems Mental Disorders Drug Addiction Other _____

PERSONAL MEDICAL HISTORY

(Include date) Major Surgeries - Illnesses - Diseases - Accidents

CONTAGIOUS DISEASES

(Check if you have ever had one of the following):
 HIV+ AIDS Hepatitis Venereal Disease Herpes Other _____

ALLERGIES

(Drugs, chemicals, food, animals, seasonal, etc.)

MEDICATIONS PRESENTLY TAKING:

HABITS:

- Cigarettes Soft Drinks Salt Coffee Alcohol Recreational Drugs Black Tea Sugar
- Stress Artificial Sweeteners Marijuana Occupational Hazards Other

EXERCISE:

Never Little Moderate Heavy Type of Exercise _____

EMOTIONALLY:

- Happy Easily Irritable Difficulty making decisions Angry Cry easily Hurry to do things
- Depression Stressed Restless Other _____

DIET (Typical Foods):

- Beef Eggs Cheese Grains Tofu Pork Bread Margarine Fried Foods Yogurt
- Poultry Milk Ice Cream Sweets Health Foods Fish Butter Vegetables Salads
- Hot Spicy Food Other _____

APPETITE:

Up and down Poor Good Hungry a lot Loss of taste
Do you eat three meals per day: Y N Do you eat at regular hours? Y N
Cravings _____



WEIGHT:

- Normal Underweight Overweight Recent gain Recent loss

ENERGY:

- Up and down Low Normal Excess Low after eating
 Tired in the afternoon Other _____

BODY TEMPERATURE:

- Warm natured Flushed face Feel warmer late afternoon and night Sweat Easily Night Sweats
 Cold natured Warm Palms Alternate chills and fever Profuse Perspiration
 Cold hands and feet Warm soles Normal Other _____

DIGESTION:

- Indigestion Bloating Heartburn Nausea Vomiting Full feeling or distention Belch or burp
 Abdominal pain or cramps Gas Difficulty digesting fatty or oily foods Bitter taste in mouth Gallstones
 Normal Other _____

BOWELS:

- Loose stool Diarrhea Hemorrhoids Constipation Colon problems Pain or cramps Use laxatives
 Normal Other _____

URINATION (three to four times per day is normal):

- Frequent Burning Bladder infections Urgency Nighttime Incontinence
 Kidney stones or infections Normal Other _____

THIRST:

- Less than normal Prefer cold drinks Thirsty but do not drink Prefer hot drinks # per day _____
 Excessive Normal Other _____

SLEEP:

- Difficulty falling asleep Lots of dreams Tired when get up in morning Awake easily Nightmares
 Sleep too much Difficulty going back to sleep Restless Normal Average # of Hours a night _____
 Other _____

HEADACHES - DIZZINESS:

- Headaches Vertigo Bend down and stand up and get dizzy Dizziness Motion sickness
 Poor balance Faint easily Migraines Poor memory Other _____

SKIN:

- Dry Hives Itching Oily Acne Bruise easily Eczema Normal
 Rashes Cuts heal slowly Other _____

HAIR:

- Dry Oily Dandruff Falling out Early grey Normal Other _____

NAILS:

- Soft Spots Grow slowly Ridges and lines Purple Normal
 Break easily Pale Grow fast Other _____

EYES:

- Wear glasses or contacts Eyelids swollen Red Dry Itch Poor night vision Twitch Pain
 Sensitive to light Color blindness Tear easily Normal Other _____

EARS:

- Poor hearing Ringing (high pitch) Ringing (low pitch) Discharges Ear aches Normal
 Other _____

NOSE:

- Stuffy nose Hayfever Sneeze a lot Environmental sensitivity Mucous Bleeding Loss of smell
 Blow nose a lot Sinusitis Rhinitis Normal Other _____

MOUTH & THROAT:

- Dry Gum problems Frequent colds Difficulty swallowing TMJ Feel lump in throat
 Thyroid problems Grind teeth Normal Other _____

RESPIRATORY:

- Shortness of breath Difficulty inhaling Sigh a lot Chest pain Difficulty exhaling Dry cough
 Asthma Difficulty Breathing Cough with phlegm Bronchitis Emphysema Cough with blood
 Tightness in chest Wheezing Normal Other _____



CARDIOVASCULAR - CIRCULATION

- Diagnosed heart problems
- Palpitations
- Low blood pressure
- Bleed easily
- High blood pressure
- High cholesterol
- Murmur
- Varicose veins
- Ankle / Hand swelling
- Chest pain
- Bruise easily
- Irregular heart beat
- Numbness in extremities
- Normal
- Other _____

PAIN:

- Low back
- Shoulder
- Muscle weakness
- Sciatica
- Hands or wrists
- Muscle cramps
- Upper back
- Hips
- Muscle twitching or spasm
- Mid back
- Knees
- Damp weather
- Neck
- Foot or ankle
- Nerve
- Spine
- Arthritis
- Flank area
- Other _____

ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS?

***** FOR FEMALES ONLY (If you are female, please continue filling out the remainder of the form) *****

Are you or might you be pregnant? YES NO MAYBE If yes, approximate date of conception? _____

Are you experiencing reduced sex drive? YES NO Other difficulties? EXPLAIN: _____

Do you have regular pap tests? YES NO How regular? _____

Do you have regular breast exams? YES NO How regular? _____

Do you have facial hair or excess body hair? YES NO

MENSTRUAL CYCLE:

(Please check and explain as applicable)

Age started _____ Days of flow _____ Age stopped _____

How many days from the beginning of your period to the start of your next period? _____

- Irregular Painful
- Heavy flow
- Scanty flow
- Dark Color flow
- Light color flow
- Clotting
- Water Retention
- Abdominal bloating
- Painful or tender breasts
- Breast lumps
- Emotional changes
- Spotting between periods
- Lump in throat feeling
- Constipation and/or diarrhea
- Tightness in chest
- Hormonal problems
- Backache
- Sigh a lot
- Other _____

VAGINAL DISCHARGES:

- Yellow
- Thick
- Bad odor
- White
- Clear
- Other _____

OVULATION SYMPTOMS:

MENOPAUSE PROBLEMS?

PREGNANCIES:

Total number _____ Number of miscarriages _____ Number of children _____ Number of therapeutic abortions _____

PREGNANCY OR CHILDBIRTH COMPLICATIONS:

GYNECOLOGICAL HISTORY AND OPERATIONS

- Ovaries _____
- Uterus _____
- Fallopian tubes _____
- Vagina _____
- Breasts _____
- Other _____

WHAT METHOD OF BIRTH CONTROL DO YOU NOW USE?

WHAT METHOD OF BIRTH CONTROL HAVE YOU USED IN THE PAST?





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Jill M. Morian, Dipl.Ac. (NCCAOM)

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 clinic, including proper cleaning and sterilization of equipment and office.

The practice of Acupuncture is regulated by the Department of Regulatory Agencies. Any complaints should be directed to: Director of the Division of Registrations in the Department of Regulatory Agencies at 1560 Broadway, Suite 1350, Denver, Colorado 80202, Telephone (303) 894-7800.

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.

Jill M. Morian, Dipl.Ac. (NCCAOM)

EDUCATION

Colorado School of Acupuncture and Oriental Medicine - Denver, CO.

3 year program • Diploma Traditional Chinese Medicine 1998

Training included adjunctive therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy and dietary and lifestyle recommendations as defined by traditional oriental medical concepts.

Nambudripad Allergy Elimination Therapy (NAET) - Buena Park, CA.

Basic, Advanced, & MRT certification - 1998-1999 & 2003

Ellen Cutler's BioSet - 1999

Neuro Emotional Technique - 2002

Bach Flower Essence International Education - 2005

Metropolitan State College of Denver - Denver, CO.

Bachelor of Science • Biology • 1995

Bachelor of Science • Chemistry • 1995

PROFESSIONAL ORGANIZATIONS

American Association of Acupuncture and Oriental Medicine - member since 1998

Acupuncture Association of Colorado - member since 1998

CERTIFICATIONS, LICENSES & REGISTRATIONS

National Commission for the Certification of Acupuncture and Oriental Medicine

Certified Acupuncturist • Dipl. Ac (NCCAOM) 1998 to present

Colorado Department of Regulatory Agencies

Registered Acupuncturist • 1998 to present

FEE SCHEDULE

Intake Consultation and Treatment - \$65

Follow-up Treatment -\$45

It will be your responsibility to keep scheduled appointments. The clinic will require notification of cancellation at least 24 hours prior to the appointment. Failure to meet these cancellation terms will result in the assessment of a cancellation fee equal to the treatment amount. This fee will be due at the patient's next appointment.

I have read the above and signed _____ Date _____