Sherri Giamarvo, L.Ac. • 445 Union Blvd, Suite 302, Lakewood, CO 80228 • (303) 989-6409

PATIENT INTAKE FORM

Name:_____ Preferred Name:_____

Address:_____ City/ZIP: _____

Mobile Phone: _____Home: _____Work: _____

Email:_____

Date of Birth: _____Age:_____ Height: _____ Weight: _____

Gender Identity: Male____ Female____Non-binary____ Sex assigned at Birth: Male ____Female ____

Marital Status M/S/D/W/P(partnered) (Please circle). Name of spouse/partner:_____

# of Children:_____ Ages: _____ Living arrangement:

Occupation: _____Employer: _____

Who referred you? _____ Internet Search? _____

Have you received acupuncture before? When/what for? _____

Do you have a pacemaker or any other implanted cardiac device? Y/N

Are you pregnant? Y/N/Unsure HIV positive? Y/N Hepatitis C positive? Y/N

Emergency contact: _____ Phone:_____

Unless other arrangements are made in advance, payment is due at the time services are rendered in the form of cash, check, or credit card. Do you need a receipt for flex-plan/insurance? (Please circle which)

Please make every effort to notify us in advance of any need to change an appointment. We request 24 hours notice so that someone else may use the time we had set aside for you. Failure to keep your scheduled appointment or to call less than 24 hours in advance to cancel or change your appointment may result in a regular office visit charge.

I have read and understand the above and accept responsibility for all charges related to services rendered by Sherri Giamarvo, L.Ac.:

Signature _____ Date _____

HEALTH HISTORY

Main complaint(s) for which you are seeking treatment today: _____

_____

_____

List any other concerning health problems you have now: _____

_____

_____

List any accidents, surgeries, hospitalizations and their dates: _____

_____

_____

List any allergies known to pollens, foods, and prescriptions: _____

List any health disorders or illnesses that have commonly occurred in blood relatives (parents/siblings):

_____

_____

Please check any significant illnesses YOU have had:

Cancer____ Heart Disease ____ Rheumatic Fever_____ Sexually Transmitted Diseases _____

AIDS____ Diabetes_____ High blood pressure _____ Emotional disorders _____

Eating Disorders _____ Hepatitis _____ Seizures _____ Glandular diseases _____

Addiction Disorders: _____ Other:_____

List any prescription medications you currently take and the dosage: _____

_____

_____

List any nutritional or herbal supplements you take:

_____

_____

_____

Lifestyle:

Do you use tobacco? ____ Marijuana? ____ Alcohol? ____ Drinks per week? _____

Other recreational substances: _____

Coffee/Tea/Other caffeine? What kind and how much per day? _____

Hobbies: _____

Exercise (what, how often, how long): _____

_____

Sexual Orientation: Straight____ Homosexual____ Bisexual____ Other____

Emotions:

How do you feel about the following factors in your life:

Spouse/Partner GREAT/GOOD/ FAIR /POOR/ BAD COMMENTS: _____

Family GREAT/GOOD/ FAIR /POOR/ BAD COMMENTS: _____

Diet GREAT/GOOD/ FAIR /POOR/ BAD COMMENTS: _____

Self GREAT/GOOD/ FAIR /POOR/ BAD COMMENTS: _____

Work GREAT/GOOD/ FAIR /POOR/ BAD COMMENTS: _____

Please circle words below that describe how you frequently feel emotionally: Frustration, melancholy, anger, over-thinking, worry, fearful, depression, helpless, hopelessness, anxiety, stuck in a rut, overwhelmed, exhausted, easily irritated, over-excited. Other: _____

How would you describe your emotional life as a child? _____

Significant emotional traumas in past: Physical, Sexual or Emotional Abuse: _____

Family deaths (who?)_____

Emotional Events (Please note divorce, accidents, death of family/friends, etc): _____

_____

Body temperature: Tendency to feel HOT/COLD/BOTH (circle one and comment if necessary): _____

_____

Sleep: # of hours/night on average_____ Trouble falling asleep _____ Waking often _____

Trouble getting back to sleep_____ Waking hot in the night _____ Night sweats _____ Palpitations _____

Excessive dreaming _____ Waking in morning feeling unrested _____ Sleep apnea _____

Please put a check mark by symptoms which you FREQUENTLY experience: (more than once per week) and put two check marks by those which you experience daily:

___Lack of appetite

___Excessive appetite

___Loose stools or diarrhea

___Vomiting

___Burping or Heartburn

___Gassiness/Bloating

___Feeling of food retention In stomach

___Constipation

___Abdominal pain

___ Hemorrhoids

___ Insomnia

___Nightmares

___Heart Palpitations

___Mentally restless

___Anxiety attacks

___Chest pain

___Restless legs

___Cough

___Shortness of Breath

___No sense of smell

___Nasal/Sinus problems

___Unexplained sadness

___Sadness from a loss

___Asthma/wheezing

___Tendency to catch colds

___Recent antibiotics

___Allergies/hay fever

___Bronchitis

___Skin problems

___ Itching (where?) _____

___Eye problems

___Trouble digesting oily foods

___Gallstones

___Grey colored stools

___Soft/brittle nails

___Easily agitated/angered

___General irritability

___Tightness or pain in chest

___Headaches

___Bitter taste in mouth

___Spasms or twitching of muscles

___Difficulty making plans

___Low back pain

___Knee problems

___Joint pain (where?)

_____

___Other pain (where?)

_____

___ Gout

___ Recurrent urinary tract infections

___Hearing loss

___ Sciatica

___Ears ringing

___Night sweats

___Kidney Stones

___Decreased sex drive

___Hair loss

___Urinary problems

___Fertility issues

___Hi or Low blood pressure

___High cholesterol (#____)

___Hot palms or soles of feet

___Thirsty

___Fatigue

___Fluid retention

___Blood in stools

___Easily bruised

___Difficulty stopping bleeding

___Dizziness

___Numbness

___Sudden weight gain

___Sudden weight loss

OB/GYN

Are you pregnant? YES/NO/POSSIBLY. Past miscarriages? (dates) _____

Past abortions? (dates) _____ Premenstrual pain or discomfort? _____

Pain with menses? Y/N Excessive bleeding? Y/N Clots in blood? Y/N. Irregular menses? Y/N

No menses? Y/N How many days of flow? _____ Spotting between periods? Y/N

How many days in cycle (day one to day one)? _____

Breast tenderness or swelling? Y/N. If yes, when does it occur? _____

Date of last period: _____History of breast lumps? _____Mastectomy? (date): _____

Hysterectomy? (date): If so, partial or complete? (circle) Vaginal discharge: _____

Menopausal? (Circle) YES/NO/LONG AGO/UNSURE Symptoms: _____

Last OB-GYN exam date _____ Anything unusual? _____

Low iron/anemia? _____ Prolapse? _____

Any significant blood loss in past due to accident, surgery, or childbirth? _____

PROSTATE/UROLOGY

Prostate problems: _____

Recent PSA test? Y/N (Test result): _____

Date of last physical exam: _____ Anything unusual? _____

Frequent nighttime urination? _____ Times per night? _____

Painful or burning urination? _____ Pain or coldness in genital area? _____

Vasectomy? Y/N Date: _____ Reproductive or erectile issues? _____

Tendency for genital itching? _____

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Dear Valued Patient,

This notice describes my office's policy regarding how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.
SAFEGUARDS IN PLACE AT MY OFFICE INCLUDE:

*Policies and procedures as outlined in this notice for handling and releasing information.

*Locking file cabinets providing limited access to where information is stored.

*Requirements for third parties to comply with privacy laws.

*All medical files and records are kept on permanent file for seven years

TYPES OF INFORMATION I GATHER AND USE:

Medical history, treatment notes, records of payment, letters, faxes, and notes regarding telephone or personal conversations with other health providers whom you have authorized release of information.

Personal information (name/address/phone, etc) is used only for maintaining a database or for mailings from this office address only.

DISCLOSURE OF YOUR HEALTH INFORMATION: In order to maintain an appropriate level of service on your behalf, I may need to share personal medical information with your other doctors or therapists or health care practitioners that you have authorized on your "Consent" form below. In rare cases, this information may also be disclosed to an insurance company or attorney's office if jointly requested by them and you. Calls regarding your appointments may be made to any/all telephone numbers you have provided in your health intake form unless you specifically ask, in writing, to NOT have calls or messages left at certain numbers.

YOUR RIGHTS TO YOUR HEALTH INFORMATION: You have the right to request an alternate address or method of contacting you. You may request, in writing, a copy of your confidential health file and an accounting of authorized disclosures made on your behalf.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____

I hereby acknowledge that I have read this copy of the office's Notice of Privacy Practices

Signature: _____ Date: _____

I hereby give my permission for a free release and exchange of information regarding my medical condition and treatment between Sherri Giamarvo, L.Ac. and the following doctors or therapists, if necessary. All information shared is strictly confidential and will only be released with knowledge and permission by me for the sake of maximizing my treatment:

_____

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, by the below named acupuncturist and/or other licensed acupuncturist who, in the future, may treat me as a back-up for the acupuncturist named below.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxa, cupping, gua-sha, electrical stim, Chinese or Western herbs, and nutritional counseling.

I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture treatments and procedures for my condition. I do not expect the acupuncturist to be able to anticipate unusual risks and complications, and I wish to rely on the acupuncturist to exercise good judgment on my behalf during the course of the treatment, based on the facts then known. The herbs and nutritional supplements which may be recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the acupuncturist immediately.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites which could last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping or gua-sha.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent. 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 the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment.

Patient's Name (printed) _____Date: _____

Signature of Patient (or Patient's Representative): _____

Relationship to patient if Representative _____

NAME OF TREATING ACUPUNCTURIST/CLINIC
Sherri Giamarvo, L.Ac.
Luna Acupuncture
445 Union Blvd. #302
Lakewood, CO 80228
(303) 989-6409

COLORADO MANDATORY DISCLOSURE STATEMENT

Sherri Giamarvo, L.Ac., Dipl.Ac. (NCCAOM)
445 Union Blvd, Suite 302 Lakewood, CO 80228
303-989-6409

By law, as a prospective client in this clinic, you are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy if known. You may seek a second opinion from another health care provider or terminate therapy at any time.

FEE SCHEDULE:

Initial Consultation and Treatment	$125
Follow-up Consultation and Treatment	$85
Prepaid Series of (6) Acupuncture Treatments @ $80	$480
Seniors (over 65) and Full Time Students Follow-up	$75
Seniors (over 65) and Full Time Students Prepaid Series of 6 @ $70	$420
Children's (12 and under) Initial Consultation and Treatment	$75
Children's (12 and under) Follow-up Treatment	$60

ACUPUNCTURE AND ORIENTAL MEDICINE EDUCATION:
Diploma in Traditional Chinese Medicine, Colorado School of Traditional Chinese Medicine, Denver, CO. A three year, 1800 hour program in Traditional Chinese Medicine and adjunctive therapies (including tui na, Chinese herbal medicine, cupping, bleeding, moxibustion, acupressure, electracupuncture, plum blossom, gua sha, intradermal needles, auricular acupuncture, and dietary/lifestyle recommendations).

ACADEMIC DEGREES:
B.A. in Economics, University of Colorado at Boulder, 1989.

PROFESSIONAL CERTIFICATIONS AND LICENSURE:
National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Dipl. Ac.
Colorado State Acupuncture License #781
Council of Colleges of Acupuncture and Oriental Medicine Clean Needle Technique
American Heart Association CPR for Healthcare Providers
Member Acupuncture Association of Colorado

None of the above licenses or certification have ever been suspended or revoked at any time.
As a practitioner of Acupuncture and Oriental Medicine, I comply with the rules and regulations promulgated by the Colorado Department of Public Health and Environment with respect Article 29.5, including those related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices. In a professional healthcare relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Professions and Occupations at the Department of Regulatory Agencies. The practice of acupuncture is regulated by the Department of Regulatory Agencies. In the event contract is necessary, please write to the Office of Acupuncture Licensure, 1560 Broadway, #1350, Denver, CO 80202, or call 303-894-7800.

Please acknowledge that you, the patient, have read this document:

Patient's Signature: _____Date: _____