



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 \_\_\_ Other\_\_\_

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

Your living arrangement: \_\_\_\_\_ # of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

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: \_\_\_\_\_

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List any other concerning health problems you have now: \_\_\_\_\_

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List any accidents, surgeries, hospitalizations and their dates: \_\_\_\_\_

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List any allergies known to pollens, foods, and prescriptions: \_\_\_\_\_

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

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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: \_\_\_\_\_

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List any nutritional or herbal supplements you take:

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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 \_\_\_\_

SYMPTOM SURVEY

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:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Lack of appetite                        | <input type="checkbox"/> Tendency to catch colds        | <input type="checkbox"/> Gout                               |
| <input type="checkbox"/> Excessive appetite                      | <input type="checkbox"/> Recent antibiotics             | <input type="checkbox"/> Recurrent urinary tract infections |
| <input type="checkbox"/> Loose stools or diarrhea                | <input type="checkbox"/> Allergies/hay fever            | <input type="checkbox"/> Hearing loss                       |
| <input type="checkbox"/> Vomiting                                | <input type="checkbox"/> Bronchitis                     | <input type="checkbox"/> Sciatica                           |
| <input type="checkbox"/> Burping or Heartburn                    | <input type="checkbox"/> Skin problems                  | <input type="checkbox"/> Ears ringing                       |
| <input type="checkbox"/> Gassiness/Bloating                      | <input type="checkbox"/> Itching (where?) _____         | <input type="checkbox"/> Night sweats                       |
| <input type="checkbox"/> Feeling of food retention<br>In stomach | <input type="checkbox"/> Eye problems                   | <input type="checkbox"/> Kidney Stones                      |
| <input type="checkbox"/> Constipation                            | <input type="checkbox"/> Trouble digesting oily foods   | <input type="checkbox"/> Decreased sex drive                |
| <input type="checkbox"/> Abdominal pain                          | <input type="checkbox"/> Gallstones                     | <input type="checkbox"/> Hair loss                          |
| <input type="checkbox"/> Hemorrhoids                             | <input type="checkbox"/> Grey colored stools            | <input type="checkbox"/> Urinary problems                   |
| <input type="checkbox"/> Insomnia                                | <input type="checkbox"/> Soft/brittle nails             | <input type="checkbox"/> Fertility issues                   |
| <input type="checkbox"/> Nightmares                              | <input type="checkbox"/> Easily agitated/angered        | <input type="checkbox"/> Hi or Low blood pressure           |
| <input type="checkbox"/> Heart Palpitations                      | <input type="checkbox"/> General irritability           | <input type="checkbox"/> High cholesterol (#____)           |
| <input type="checkbox"/> Mentally restless                       | <input type="checkbox"/> Tightness or pain in chest     | <input type="checkbox"/> Hot palms or soles of feet         |
| <input type="checkbox"/> Anxiety attacks                         | <input type="checkbox"/> Headaches                      | <input type="checkbox"/> Thirsty                            |
| <input type="checkbox"/> Chest pain                              | <input type="checkbox"/> Bitter taste in mouth          | <input type="checkbox"/> Fatigue                            |
| <input type="checkbox"/> Restless legs                           | <input type="checkbox"/> Spasms or twitching of muscles | <input type="checkbox"/> Fluid retention                    |
| <input type="checkbox"/> Cough                                   | <input type="checkbox"/> Difficulty making plans        | <input type="checkbox"/> Blood in stools                    |
| <input type="checkbox"/> Shortness of Breath                     | <input type="checkbox"/> Low back pain                  | <input type="checkbox"/> Easily bruised                     |
| <input type="checkbox"/> No sense of smell                       | <input type="checkbox"/> Knee problems                  | <input type="checkbox"/> Difficulty stopping bleeding       |
| <input type="checkbox"/> Nasal/Sinus problems                    | <input type="checkbox"/> Joint pain (where?) _____      | <input type="checkbox"/> Dizziness                          |
| <input type="checkbox"/> Unexplained sadness                     | _____   | <input type="checkbox"/> Numbness                           |
| <input type="checkbox"/> Sadness from a loss                     | <input type="checkbox"/> Other pain (where?) _____      | <input type="checkbox"/> Sudden weight gain                 |
| <input type="checkbox"/> Asthma/wheezing                         | _____   | <input type="checkbox"/> 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? \_\_\_\_\_

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 gastrointestinal 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	\$145
Follow-up Consultation and Treatment	\$105
Prepaid Series of (6) Acupuncture Treatments @ \$100	\$600

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: \_\_\_\_\_