Ponder Natural Health **Patient Intake** PNH072905

Full Name		Sex ☐ F ☐ M	Date:
Date of Birth	Age	Occupation	
Home Phone	Work Phone	Cell Phone	
Address	City	State	Zip
Emergency Contact & Phone		Marital Status	# of children
Family Physician		Chiropractor	
Do you have health insurance? ☐ Yes ☐ No		Name of insurance company	
Does your insurance cover acupuncture?		Have you ever had acupuncture before?	
How did you hear about our clinic?	☐ Friends/Family _____		
☐ Yellow Pages	☐ Referred By _____		
☐ Web Site	☐ Advertisement (where?)		
Would you like to receive our newsletter? ☐ Yes ☐ No	Email:		

Check all of the following conditions that apply:

☐ Pregnant or trying ☐ Nursing ☐ Pacemaker ☐ High Blood Pressure ☐ Heart Disease

☐ Diabetes ☐ Nerve/Seizure disorder ☐ Kidney Dialysis

What would you like us to help you with?

When did the problem(s) begin?

Have you been given a diagnosis for this problem? If so, what?

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally

What treatments have you tried for the above conditions? (surgery, medications, injections, physical therapy, chiropractic, acupuncture, herbs, nutritional supplements)

What makes the problem better?

What makes it worse?

List any allergies, food sensitivities or cravings that you have.

List any accidents, surgeries or hospitalizations (with approx dates)

Please indicate the use and frequency of the following: Tobacco _____ Coffee/Tea _____

Alcohol _____ Recreational Drugs: _____ Exercise: _____

Current Weight _____ Weight a year ago _____

Describe your current overall health condition: ☐ Good ☐ Fair ☐ Poor ☐ Chronically ill

Indicate any significant illnesses **You** have **had**:

☐ Cancer ☐ Diabetes ☐ Hepatitis ☐ Emotional Disorders

☐ High Blood Pressure ☐ Seizures ☐ Rheumatic Fever ☐ Heart Disease

☐ Infectious Disease _____

☐ Sexually Transmitted Diseases _____

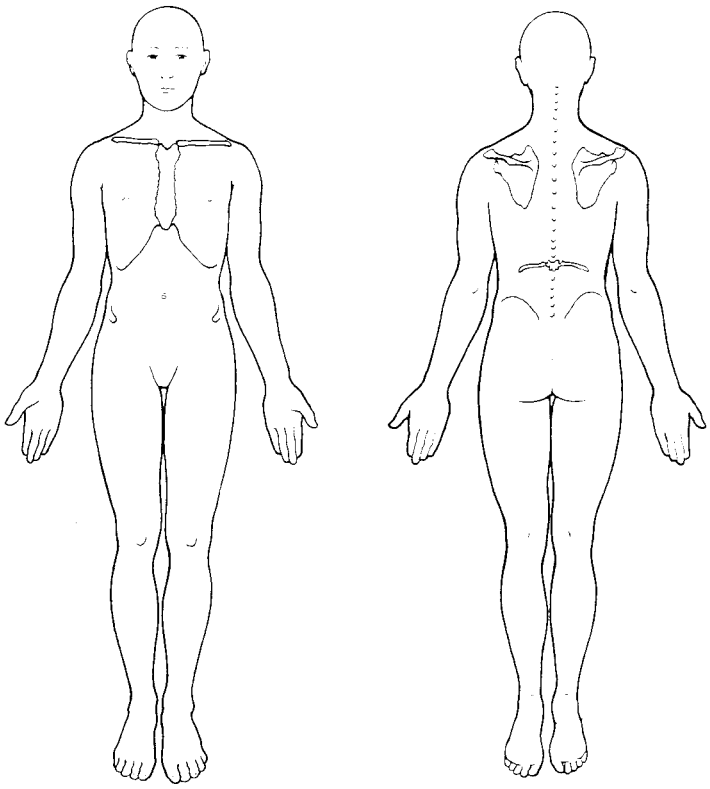
☐ Others: _____

List any major diseases or health problems in your **Family**

What else would you like to add?

Please indicate on the diagrams
Where you are experiencing discomfort.

Sharp pain = X Ache = A Numbness = O



On a scale of 1 to 10, what is your discomfort today?

(None) 1 2 3 4 5 6 7 8 9 10 (Severe)

On a scale of 1 to 10, what is your typical discomfort over the last week or so?

(None) 1 2 3 4 5 6 7 8 9 10 (Severe)

_____ _____

Signature Date

Ponder Natural Health **Patient Symptom Survey** pnh071907

Patient: _____ Date: _____

Rarely / Never | Occasionally | Frequently

- ☐ ☐ ☐ lack of appetite
- ☐ ☐ ☐ excessive appetite
- ☐ ☐ ☐ loose stool or diarrhea
- ☐ ☐ ☐ digestive problems
- ☐ ☐ ☐ abdominal pain
- ☐ ☐ ☐ vomiting
- ☐ ☐ ☐ belching or burping
- ☐ ☐ ☐ heartburn
- ☐ ☐ ☐ feeling of retention of food in the stomach
- ☐ ☐ ☐ bruise easily
- ☐ ☐ ☐ blood in stool / tarry stool

- ☐ ☐ ☐ insomnia
- ☐ ☐ ☐ heart palpitations
- ☐ ☐ ☐ cold hands or feet
- ☐ ☐ ☐ nightmares
- ☐ ☐ ☐ angina / chest pains

Do you have a pacemaker?
Yes: ____ No ____

- ☐ ☐ ☐ cough
- ☐ ☐ ☐ asthma
- ☐ ☐ ☐ chest pain
- ☐ ☐ ☐ shortness of breath
- ☐ ☐ ☐ decreased sense of smell
- ☐ ☐ ☐ nasal problems
- ☐ ☐ ☐ skin problems
- ☐ ☐ ☐ feeling of claustrophobia
- ☐ ☐ ☐ catch colds easily
- ☐ ☐ ☐ bronchitis
- ☐ ☐ ☐ constipation
- ☐ ☐ ☐ hemorrhoids
- ☐ ☐ ☐ recent use of antibiotics
- ☐ ☐ ☐ intestinal problems (colitis, diverticulitis or irritable bowel syndrome)

Rarely / Never | Occasionally | Frequently

- ☐ ☐ ☐ eye problems
- ☐ ☐ ☐ jaundice (yellowish eyes or skin)
- ☐ ☐ ☐ hepatitis
- ☐ ☐ ☐ difficulty digesting oily foods
- ☐ ☐ ☐ gallstones
- ☐ ☐ ☐ light colored stools
- ☐ ☐ ☐ soft or brittle nails
- ☐ ☐ ☐ easily angered or agitated
- ☐ ☐ ☐ spasms/twitching of muscles
- ☐ ☐ ☐ difficulty making plans or decisions

- ☐ ☐ ☐ low back pain
- ☐ ☐ ☐ sciatic pain
- ☐ ☐ ☐ knee problems
- ☐ ☐ ☐ hearing impairment
- ☐ ☐ ☐ ear ringing
- ☐ ☐ ☐ kidney stones
- ☐ ☐ ☐ decreased sex drive
- ☐ ☐ ☐ hair loss
- ☐ ☐ ☐ urinary frequency
- ☐ ☐ ☐ painful or burning urination

- ☐ ☐ ☐ fatigue
- ☐ ☐ ☐ edema
- ☐ ☐ ☐ feel cold, hard to get warm
- ☐ ☐ ☐ dry mouth or thirst
- ☐ ☐ ☐ night sweats
- ☐ ☐ ☐ poor memory/concentration
- ☐ ☐ ☐ headaches
- ☐ ☐ ☐ dry skin or brittle nails
- ☐ ☐ ☐ allergies
- ☐ ☐ ☐ feeling of heaviness
- ☐ ☐ ☐ dizziness
- ☐ ☐ ☐ tendency to faint easily
- ☐ ☐ ☐ high blood pressure
- ☐ ☐ ☐ high cholesterol levels
- ☐ ☐ ☐ sudden weight change

Rarely / Never | Occasionally | Frequently

For Men Only

- ☐ ☐ ☐ prostate problems
- ☐ ☐ ☐ pain or coldness in the genital area
- ☐ ☐ ☐ Other: _____

For Women Only

are you pregnant?
Yes: ____ No ____

- ☐ ☐ ☐ pre-menstrual pain or discomfort
- ☐ ☐ ☐ menstrual pain or discomfort
- ☐ ☐ ☐ swelling or pain in breasts
- ☐ ☐ ☐ Clotting

Flow: Scanty ☐ Med ☐ Heavy ☐
Color of blood: _____

- ☐ ☐ ☐ irregular menstrual cycle
- ☐ ☐ ☐ vaginal discharge

Color: _____
Odor (if any) _____
Other: _____

Nbr. of Pregnancies _____
Nbr. of live births _____
Abortions-Miscarriage _____
Age of first period _____
Date of last period _____
last gynecological exam: _____
Results: _____

Prescriptions and Supplements

List any medications, herbs, or supplements you are currently taking

Drug or Supplement Name	Reason for taking	Dosage	When started	(Note date when discontinue)

Ponder Natural Health
475 Lewis Street - Suite 207, PO Box 232, Pagosa Springs, CO 81147
Phone: 970.264.1172 Fax: 661.458.1638 Email: info@PonderHealth.com

INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturists/practitioners on staff at the Ponder Natural Health clinic: acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle, and orthopedic testing; modes of manual or physical therapy such as bodywork, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; the prescription of herbal medicines and dietary supplements; dietary recommendation; exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with my practitioner, and/or with other clinic personnel the nature and purpose of acupuncture and Oriental Medicine procedures. Although I am aware that acupuncture and the other procedures used in Oriental Medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Oriental Medicine there are some risks of treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pneumothorax (punctured lung), puncture of other organs, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms, general aches, sprains, strains, dislocation, fractures, disc injuries, and strokes. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts known, to be in my interest. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I have read, or have had read to me, this informed consent form. I have also had an 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 seek treatment at the clinic.

_____	_____
Patient's name (please print)	Patient's signature
_____	_____
Date signed	Witness
_____	_____
Print name of patient's representative (if applicable)	Relationship or authority of Representative
_____	_____
Signature of patient's representative (if applicable)	Date Signed

Please sign front and back of this sheet

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COLORADO MANDATORY DISCLOSURE STATEMENT

Education and Experience

Braxton Ponder earned his Master of Acupuncture and Oriental Medicine degree (MAOM) from the Academy of Oriental Medicine at Austin in 2005, after commencing his studies at the International Institute of Oriental Medicine. This four-year program consisted of over 3000 hours of education including more than 1,000 hours of clinical practice. Braxton is also certified as a Diplomate in Oriental Medicine (Dipl. O.M.) by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). This includes certification in Clean Needle Technique and Chinese Herbology.

Braxton's training includes adjunctive therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations. His nutritional training includes continuing education credits in Advanced Nutrition Therapeutics. Braxton has also taken advanced training in Trigger Point therapy as part of the continuing medical education program of the University of New Mexico School of Medicine, and has completed certification as a yoga instructor and personal fitness trainer.

Braxton is a member of the Acupuncture Association of Colorado and is a Licensed Acupuncturist in Colorado. None of his licenses or certificates has ever been suspended or revoked.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule **(Discounted for Payment at Time of Service)**

Initial Consultation and Treatment $90 + cost of herbs
(Includes Acupuncture and Evaluation billing codes 97810, 97811, 99201)

Follow-up Treatment $70 + cost of herbs
(Includes Acupuncture billing codes 97810, 97811)

Herbal/Nutritional Consultation only $55 + cost of herbs
(Billing code 97803)

Patient's Rights

- 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 Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-2440.

I have read and understand this document.

_____ _____

Patient's or Guardian's Signature Date

Please sign front and back of this sheet

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