Acupuncture & Oriental Medicine
Patti Polman, Lic. AC
N.C.C.A. Certified
3760 Vance st. suite 100
Wheatridge, Co. 80033
303.433.5006

Name _____ Date_____
Date of Birth _____ Age____ _____
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 $150
Return Visits $100
*Herbs are additional and vary in price.

Pediatrics*
Infants-3 years $25 (15 min)
4-12 years $50 (30 min)
13-18 years $75 (45 min)

Seniors (age 65+)*
New Patient $135
Return Visit $90

Insurance
If acupuncture is a covered service through your insurance provider, I will provide a superbill for you to submit to your insurance for reimbursement as I do not submit to insurance companies as a service.

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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_____

Disclosure Statement

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

Toyo Hari Meridian Therapy Training 2004

PROFESSIONAL ORGANIZATIONS

Acupuncture Association of Colorado - since 1993
Toyo Hari Association - since 2004

CERTIFICATIONS, LICENSES and REGISTRATONS

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 or 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? _____

Have you had COVID? _____ 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:

Family Medical History
Please indicate any illness or disorders that have occurred in your immediate family (including parents, siblings, & grandparents)

__Diabetes __Cancer __High Blood Pressure __Heart Disease

__Stroke __Seizures __Asthma __Allergies __Substance Abuse

__Other_____

Primary Complaint
Please include: description of complaint, location, date and/or time of onset, cause (if known), frequency of problem, factors aggravating symptoms, factors alleviating symptoms, etc.

	Yes	No
Have you ever had this condition or one like it before?	☐	☐
Have you ever been treated for this condition before?	☐	☐

When? _____ By Whom? _____

Has your condition improved, stayed the same or gotten worse? _____

Is there pain associated with this condition? ☐ ☐

Please describe the pain (stabbing, burning, stitching, drawing, boring, dull ache, fixed, wandering, colicky, spasmodic, distending, etc.)_____

_____

Is your pain affected by applying heat or cold? _____

Is the pain better with rest or activity? _____

Is the problem affected by climate, weather changes, etc? ☐ ☐

If so, what weather aggravates it? _____

What are the possible emotional or stress factors related to the condition/problem?

Is there a time of day or night when the condition/problem is worse? _____

Are there any other symptoms that manifest with the Primary Complaint?

Secondary Complaints

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

__ Are you fatigued or do you fatigue easily
__ Do you need to take naps
__ Do you generally feel cold
__ Do you have cold feet
__ Do you have cold hands
__ Do you catch colds frequently
__ Do you have energy slumps at certain times
__ Do you wake up tired in the morning
__ Do you feel energized after exercise

__ Do you ever have low-grade fever
__ Do your hands and cheeks warm up
__ Do your feet get warm during the night
__ Do you perspire easily without exertion
__ Do you ever wake up sweating at night
__ Do you feel tired after meals
__ Do you have excess/nervous energy
__ Does your energy pick up after you get up and move about in the morning

Appetite & Digestion

__ Has your appetite changed lately
__ Do you have a poor appetite
__ Do you have poor digestion
__ Do you have epigastric (stomach) distention
__ Do you have abdominal (intestinal) distention
__ Do you experience belching/hiccups
__ Do you have heartburn
__ Are you hungry all/most of the time
__ Do you have gurgling sounds in your intestines
__ Do you have a nervous stomach

__ Do you have intestinal gas
__ Do you experience a bitter taste
__ Do you have acid regurgitation
__ Do you crave particular foods
__Sweet __Salty
__Bitter __Sour
__ Hot or spicy
__ Are you hungry but fill up on little
__ Do you experience bad breath
__ 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

__ How much water do you drink each day
__ Are you very thirsty
__ Are you thirsty but do not drink or take only small sips
__ Do your mouth and lips tend to be dry
__ Do you experience frequent sore throats or hoarseness

__ Do you have dry eyes
__ Do you have a dry nose
__ Do you have dry skin
__ Do you have dry hair
__ Do you have clammy/damp skin
__ Do you have frequent nosebleeds

Do you prefer your drinks: __cold __warm/hot __room temperature

Stools & Urine

Are your stools:
__ unusually hard
__ unusually loose
__ alternately loose/hard

Is your urine:
__unusually dark & scanty
__ unusually clear & profuse

__ Do you have bowel movements less than 5x/week
__ More than twice a day
__ Is there any blood or pus in your stools
__ Are your stools unusually light/dark in color
__ Do you have any undigested food in your stool
__ Do you feel a constant straining & urge to go
__ Do you have hemorrhoids
__ Do you have explosive gas
__ Do you have a burning sensation in your anus
__ Do you have a feeling of being unfinished after the stool is discharged
__ Do you experience abdominal pain/cramps
__ Is abdominal discomfort relieved after passing the stool

__Do you wake at night to urinate
__ Do you experience dribbling urine
__ Do you have an urgency to urinate
__ Do you urinate more than 6x/day
__ Do you experience burning w/urination
__ Do you experience incontinence
__ Is your urine cloudy
__ Do you have blood in your urine
__ Does your urine have a strong odor

Sleep

__ Are you easily startled
__ Do you dream excessively
__ Do you wake early and have trouble getting back to sleep
__ Do you experience insomnia

__ Do you have restless/fitful sleep
__ Do you have trouble getting to sleep

If so, do you awake at the same time most nights? _____ What time?_____

Emotional/Cognitive

__ Do you experience an emotion/pattern often or excessively
If so, which emotions/patterns?

__ anger __ fear __ worry __ sadness/grief
__ joy __ depression __ cry easily __ frustration

__ mood-swings __ poor memory __ easily irritable __ foggy thinking __ explosive outbursts
__ difficulty making decisions
__ obsessive/repetitive thinking
__ tendency to hold things in

If you experience mood-swings, are they related to eating/not-eating? _____
If you are female and have mood-swings, are they related to your menstrual cycle? _____

Chronic Pain

__ Do you suffer from chronic or occasional backache or neck-ache
__ Do you suffer from chronic or occasional joint pain
If so, which joints? _____
__ Do any muscles ache or cramp __ Do you get muscle twitches or spasms
__ Is your pain worse with certain weather conditions. If so, what weather?_____
__ Do you get headaches/migraines often
If so, what is the location of the pain? (frontal, occipital, temporal, vertex, center of brain)
_____

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

General

__ Do you experience dizziness or vertigo
__ Do you have tinnitus (ear ringing)
__ Do you have any hearing loss
__ Any unusual hair loss or premature graying
__ Are your teeth getting looser/decay problems
__ Do you have gum problems/bleeding
__ Do you have an aversion to cold
__ Do you have tingling or numbness sensations
__ Are you color blind
__ Do you feel you sweat more than normal
__ Does your sweat have a particularly strong odor

__ Do you have heart palpitations
__ Do you have an irregular heartbeat
__ Do you bruise easily
__ Do you ever have shortness of breath
__ Do you have shallow breathing
__ Do you have blurred vision
__ Do you experience night blindness
__ Do you have chest pain/oppression
__ Do you feel you sweat less than normal
__ Does your sweat stain clothing yellow
__ Do you have earaches/discharge from your ears

__ Do you have a high stress level
__ Do you often feel a lump in your throat
__ Do you exercise regularly
__ Do you grind your teeth
__ Do you clench your jaws

__ Do you get mouth/tongue sores
__ Do you sigh a lot
__ Do you have an aversion to heat
__ Do you have an aversion to wind
__ Do your face or eyes get red

__ Do you have jaw pain or TMJ
__ Do you experience tremors
__ Do you have flank or rib pain/discomfort

__ Have you had recent rapid weight gain/loss
__ Do you have frequent nausea
__ Do you prefer warm/cold foods
__ Are your eyes sensitive to light
__ Do you get frequent colds/flu

__ Do you have acne
__ Do you have skin rashes/itching
__ Do cuts heal slowly

__ Are your nails brittle/break easily
__ Do your nails have ridges, spots or lines
__ Do your eyes tear or strain easily
__ Does your eye/eyes frequently twitch
__ Do you have pale color under eyelids

Men Only
__ Do you have reduced sexual drive
__ Do you experience premature ejaculation
__ Do you have ejaculations during your sleep

__ Do you experience impotence
__ Do you have genital pain
__ Do you have unusual discharge

Men Only cont.
__ Are you having any prostate problems
__ Do you have dribbling urine

__ Do you have painful/burning urination
__ Do you have an uneven force in your stream of urine

Women Only	Yes	No
Do you have regular pap tests	☐	☐
Do you receive or give yourself regular Breast exams	☐	☐

Do you have a history of:
__ Amenorrhea
__ Ectopic pregnancy
__ Uterine fibroids
__ Leukorrhea
__ Menstrual cramps
__ Pelvic Inflammatory Disease
__ Irregular periods
__ Chronic vaginal or yeast infections
__ Ovarian cysts
__ Endometriosis
__ Reduced sexual drive

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	☐	☐	_____