1053 Main Ave., Suite 105 | Durango, CO 81301
Tel: 970.426.2464 | todd@rootandbranchmedicine.com

HEALTH HISTORY QUESTIONNAIRE

TODAY'S DATE: _________

Home Telephone #	Alternate Telephone #

Would you like to join our e-mailing list to receive clinic updates? _______ YES ________ NO
(We will not share your information with any third parties)

Last Name	First Name	Nickname	Height	Weight
Address		City, State, Zip		
Email Address	Gender	Age	DOB	Place of Birth
Emergency Contact Name		Relationship	Telephone	
Employer Name		Social Security No.		
Family Physician	Telephone #	Referred By		

Have you been treated by acupuncture or oriental medicine before? ☐ **YES** ☐ **NO**

Have you had massage therapy or chiropractic treatment before? ☐ **YES** ☐ **NO**

Main problem(s) you would like to be treated for:
How long ago did this problem begin (please be specific)?
To what extent does this problem interfere with your daily activities?
Have you been given a diagnosis for this problem? If so, describe:
What kinds of treatment have you tried?

PAST MEDICAL HISTORY (please include dates)

☐ Cancer		☐ Rheumatic Fever	
☐ Diabetes		☐ Thyroid Disease	
☐ Hepatitis		☐ Seizures	
☐ High Blood Pressure		☐ STDs	

☐ Other	
☐ Surgeries (type & date)	
☐ Significant Trauma (auto accidents, falls, etc.)	
☐ Significant Dental Work	
☐ Birth History	(Prolonged labor, c-section, etc.)
☐ Allergies	

FAMILY MEDICAL HISTORY

☐ Cancer		☐ Heart Disease	
☐ Diabetes		☐ Thyroid Disease	
☐ Asthma		☐ Seizures	
☐ High Blood Pressure		☐ Stroke	

Medications

(Please include any taken within the last two months, including vitamins, herbs, etc.)

☐Occupational stress	
☐ Regular exercise program	
☐ Restricted diet	
☐ Smoke	Number of cigarettes per day:
☐Coffee/tea/soda	Number of servings per week:
☐Alcohol	Number of servings per week:
☐ Non-medicinal drug use	

Describe your average daily diet.

Morning	
Afternoon	
Evening	

PLEASE CHECK ANY SYMPTOMS YOU HAVE HAD IN THE PAST THREE MONTHS

GENERAL

- ☐ Poor appetite
- ☐ Fever
- ☐ Sweat easily
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar taste or smells
- ☐ Strong thirst (cold or hot)
- ☐ Low thirst
- ☐ Sudden energy drop
  What time of day?___________
- ☐ Poor sleeping
- ☐ Chills or tremors
- ☐ Poor balance
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cravings
- ☐ Weight gain/loss

SKIN AND HAIR

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Hair loss
- ☐ Hives
- ☐ Acne
- ☐ Recent moles
- ☐ Other hair or skin problems

HEAD, EYES, EARS,NOSE, THROAT

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems

HEAD, EYES, EARS, NOSE,THROAT

- ☐ Grinding teeth
- ☐ Dental problems
- ☐ Concussion
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in eyes
- ☐ Recurrent sore throat
- ☐ Lip or tongue sores
- ☐ Headaches
- ☐ Other head or neck problems

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands or feet
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Difficulty in breathing
- ☐ Other heart or blood vessel problems

RESPIRATORY

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficulty in breathing when lying down
- ☐ Production of phlegm
  What color? _______________
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain while breathing deeply
- ☐ Other lung problems:

____

GASTROINTESTINAL

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Other stomach or intestinal problems: ______________________

GENITO-URINARY

- ☐ Pain during urination
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Impotency
- ☐ Genital sores
- ☐ Other genital or urinary problems:

  ____
- ☐ Do you wake up to urinate?
  If so, how often? _______________
- ☐ Any particular color to your urine:

PREGNANCY & GYNECOLOGY

- ☐ Number of pregnancies __________
- ☐ Number of births __________
- ☐ Premature births __________
- ☐ Miscarriages __________
- ☐ Abortions __________
- ☐ Age at first menses __________
- ☐ # days between periods __________
- ☐ Duration __________
- ☐ First date of last period __________
- ☐ Unusual character

  ____
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ PMS
- ☐ Clots
- ☐ Vaginal sores
- ☐ Irregular periods
- ☐ Last Pap ____________________
- ☐ Breast lumps
- ☐ Birth control: _________________

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand/wrist pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Hip pain

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Bad temper
- ☐ Dizziness
- ☐ Lack of coordination
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Other neurological or psychological problems

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CONSENT FOR TRADITIONAL CHINESE MEDICINE

I, the undersigned, hereby authorize the practitioners of Root and Branch Medicine to perform the following specific procedures:

Herbal prescriptions: May be given in the form of pills, powders, tinctures, pastes, plasters, or in raw form to be cooked. Cooked herbs may be given to take internally, or externally as a wash. **Herbal formulas may include shell, mineral, and animal products.**

If you do not want animal-based products used in your formula, <u>please notify your practitioner at every visit when herbs are prescribed.</u>

Acupuncture: Insertion of special sterilized needles through the skin into underlying tissues at specific points on the body. Because the needles are sterile and are only used one time, it is not necessary to swab the skin with alcohol prior to insertion; however, feel free to request this from your practitioner.

Tui-Na: A form of massage therapy relying on specific hand techniques, pressure on acupuncture points, and isolated stretching. This technique involves close physical contact, during which the practitioner may be on the treatment table with the patient.

If you are being treated in the tui-na clinic, please make sure that your practitioner is aware of any specific musculoskeletal complaints that you have or other medical conditions for which you have sought treatment.

Cupping: Cups made of glass, bamboo, or other materials are placed on the skin with a vacuum created by heat or other device. Some bruising may result.

Plum Blossom or **Seven Star Hammer:** Light tapping of an area of the body with a small sterile hammer which has seven points.

Gua Sha: Rubbing or scraping of an area of the body with a blunt, round instrument. Some bruising may result.

Moxibustion: Heating an acupoint using stick, string, or ball moxa to create a warming effect.

I RECOGNIZE THE POTENTIAL RISKS AND BENEFITS OF THESE PROCEDURES AS DESCRIBED BELOW:

Potential risks: Discomfort, pain, infection or blistering at the site of the procedure; temporary discoloration of skin; nausea; loose bowel movements; abdominal cramping; and aggravation of symptoms existing prior to the acupuncture treatment. Treatment may also result in other side effects.

Potential benefits: Drugless relief of presenting symptoms and improved balance of bodily energies, which can lead to prevention or elimination of the presenting problem and strengthening of the constitution.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Root and Branch Medicine or any of its personnel regarding cure or improvement of my condition.

I hereby release Root and Branch Medicine and its practitioners from any and all liability which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand I am free to withdraw my consent and to discontinue participation in these procedures at any time.

____ ____________________

Signature of patient or guardian Date

Root and Branch Medicine Patient Disclosure and Authorization Form

The following information pertains to Root and Branch Medicine's practitioners, policies and state-mandated disclosure of acupuncture and Chinese Medicine practices.

- Name of Practitioner: Todd Flemion
  Address: 1053 Main Ave. Suite 101, Durango, CO 81301
  Phone number: 970-426-2464
- Fee Schedule: Initial Appointment - $150 | Herbal Consultations - $40
  Follow-up Appointments - $80 | Herbal Medicines – Prices Vary
  Discounts on appointment fees and alternative payment options may be offered periodically. Root and Branch Medicine accepts some insurance. Confirmation of benefits is necessary 48 hours before appointment time. If benefits are not confirmed prior to appointment, patient will be responsible for full payment at time of appointment. Co-payments or full payment is required at time of treatment. Payments must be by cash, check or credit card. 24 hours notice is required for changes or cancellations. **Appointments cancelled with less than 24 hours notice and appointments missed with no notification will be charged in full for that appointment. Cancellations at the time of a reminder text, will also be considered a late cancellation and will be charged the full amount for a missed appointment**. Payment for a missed visit is to be paid for at or before the next appointment.
- Todd's education in Oriental medicine includes 1 ½ years of study at the Arizona School of Acupuncture and Oriental Medicine and graduation from the Seattle Institute of Oriental Medicine, a 4-year academic program, with a Masters of Acupuncture and Oriental Medicine.
- Todd is licensed by the Colorado Department of Regulatory Agencies as an acupuncturist. Regarding the practice of Chinese Medicine, no license, certificate or registration Todd has held has ever been revoked or suspended.
- Todd complies with all rules and regulations promulgated by the Colorado Department of Public Health and Environment, including those related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices.
- The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies. The address and phone number for the Director of the Division of Registrations within the Department of Regulatory Agencies is:

Director, Division of Registrations
Acupuncturists Licensure
1560 Broadway, Suite 1350
Denver, CO 80202
(303) 894-7800

- As a patient, you are entitled to receive information about the methods of therapy, the techniques used and the duration of any therapies that may be used during your treatments.
- You may seek a second opinion from another health care practitioner or may terminate therapy at any time.
- In a professional relationship such as this, sexual intimacy is never appropriate and should be immediately reported to the Director of the Division of Registrations.
- The practice of Traditional Chinese Medicine includes acupuncture, herbal therapies, dietary therapies, health exercises and medical massage techniques. Todd studied these areas extensively during his 4-year academic program at the Seattle Institute of Oriental Medicine. He also studied tuina (Chinese medical massage) for an additional year at the Arizona School of Acupuncture and Oriental Medicine. Todd has been in private practice in Durango, Colorado since 2008.

By signing below, (1) I acknowledge that I have read and received a copy of this Patient Disclosure Form and Authorization Form, (2) I authorize any applicable payments of insurance benefits made on my behalf to Root and Branch Medicine, and (3) I authorize the release of my medical records to any physician involved in my care as well as any medical information necessary to process claims.

______________________________ ______________________

Patient Signature Date

Root and Branch Medicine
1053 Main Ave. Suite 101
Durango, CO 81301
(970)426-2464

Notice of Privacy Practices

Effective date: November 1, 2008

This notice describes how health information about you as a patient of Root and Branch Medicine may be used and disclosed, and how you can access your health information. Please read this notice carefully.

This notice is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (H1PAA).

Our commitment to your privacy.

Root and Branch Medicine is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated and that we must provide you with the following information.

Use and disclosure of your health information in certain special circumstances.

We will not disclose your health information without your authorization except in the following situations:

1. We will use and disclose your health information while providing, coordinating, or managing your healthcare needs. An example of this would be providing information to an acupuncturist or other healthcare professional in coordinating needed treatment.

2. We will use and disclose your medical information for your reimbursement from your health plan.

3. We will use and disclose your medical information for the administrative aspects of your healthcare inside our practice, to manage our business more efficiently. An example would be an internal quality assessment.

4. In some cases, we may need to disclose your health information to our business associates so they can perform the job we have asked them to do.

5. We may disclose to a family member, personal friend, or any other person you identify, health information relevant to your case.

6. We may disclose your health information to public health authorities and health-oversight agencies which are authorized by law to collect information.

7. We may disclose your health information in response to a court or administrative order pertaining to lawsuits and similar proceedings.

8. We may disclose your health information if we are required to do so by a law-enforcement official.

9. We may disclose your health information to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

10. We may disclose your health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

11. We may disclose your health information to federal officials for intelligence and national security activities authorized by law.

12. We may disclose your health information to correctional institutions or law-enforcement officials, if you are an inmate or under the custody of a law-enforcement official.

13. We may disclose your health information for Workers' Compensation and similar programs.

Your rights regarding your health information.

1. You can request that our practice communicate with you about your health and related Issues in a particular manner, or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.

2. You have the right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, personal friends or any other person identified by you. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to Root and Branch Medicine.

4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by our practice. To request an amendment, your request must be made in writing to Root and Branch Medicine. You must provide us with a reason that supports your request for amendment.

5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time, by contacting the Root and Branch Medicine Privacy Officer.

6. If you believe your privacy rights have been violated, you may file a complaint with Root and Branch Medicine or with the Secretary of the Dept. of Health and Human Services(Colorado)

If you have any questions regarding this notice of our Health Information Privacy Policies, please contact:

Todd Flemion,
Root and Branch Medicine Privacy Officer
todd@rootandbranchmedicine.com
970-426-2464

Acknowledgement of Receipt of Notice of Privacy Practices

Root and Branch Medicine
1053 Main Ave., Suite 101
Durango, CO 81301

I acknowledge that I have been given the opportunity to review a copy of the Notice of Privacy Practices of Root and Branch Medicine, effective November 1, 2008.

Signature (patient or authorized representative): _________________________________

Patient Name :______________________________________ **Birth date :**___________
Maiden or other name (if applicable):____

Date:__________________

Relationship/authority (if signed by authorized representative):____________________

___________________________For office use only____________________

Root and Branch Medicine attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

______ Individual refused to sign

______ Communication barriers prohibited obtaining the acknowledgement

______ Other (Please specify)