

1053 Main Ave., Suite 101 | Durango, CO 81301

Tel: 970.426.2464 | info@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 |  |

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

Medications

|  |  |
| --- | --- |
| □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** | **SKIN AND HAIR** | **HEAD, EYES, EARS, NOSE,THROAT** |
|  |  |  |
| □ Poor appetite | □ Rashes | □ Grinding teeth |
| □ Fever | □ Itching | □ Dental problems |
| □ Sweat easily | □ Dandruff | □ Concussion |
| □ Localized weakness | □ Change in hair or skin | □ Eye strain |
| □ Bleed or bruise easily | □ Ulcerations | □ Night blindness |
| □ Peculiar taste or smells | □ Eczema | □ Blurry vision |
| □ Strong thirst (cold or hot) | □ Hair loss | □ Poor hearing |
| □ Low thirst | □ Hives | □ Nose bleeds |
| □ Sudden energy drop | □ Acne | □ Facial pain |
| What time of day?\_\_\_\_\_\_\_\_\_\_ | □ Recent moles | □ Jaw clicks |
| □ Poor sleeping | □ Other hair or skin problems | □ Migraines |
| □ Chills or tremors |  | □ Eye pain |
| □ Poor balance |  | □ Color blindness |
| □ Fatigue | **HEAD, EYES, EARS,NOSE, THROAT** | □ Earaches |
| □ Night sweats |  | □ Spots in eyes |
| □ Cravings | □ Dizziness | □ Recurrent sore throat |
| □ Weight gain/loss | □ Glasses | □ Lip or tongue sores |
|  | □ Poor vision | □ Headaches |
|  | □ Cataracts | □ Other head or neck problems |
|  | □ Ringing in ears |  |
|  | □ Sinus problems |  |

|  |  |  |
| --- | --- | --- |
| **CARDIOVASCULAR** | **GENITO-URINARY** | **NEUROPSYCHOLOGICAL** |
|  |  |  |
| □ High blood pressure | □ Pain during urination | □ Seizures |
| □ Irregular heartbeat | □ Urgency to urinate | □ Areas of numbness |
| □ Cold hands or feet | □ Decrease in flow | □ Concussion |
| □ Blood clots | □ Frequent urination | □ Bad temper |
| □ Low blood pressure | □ Unable to hold urine | □ Dizziness |
| □ Dizziness | □ Blood in urine | □ Lack of coordination |
| □ Swelling of hands or feet | □ Kidney stones | □ Depression |
| □ Phlebitis | □ Impotency | □ Easily susceptible to stress |
| □ Chest pain | □ Genital sores | □ Loss of balance |
| □ Fainting | □ Other genital or urinary problems: | □ Poor memory |
| □ Difficulty in breathing | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Anxiety |
| □ Other heart or blood vessel problems | □ Do you wake up to urinate?  If so, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Other neurological or psychological problems |
|  | □ Any particular color to your urine: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **RESPIRATORY** |  |  |
|  |  |  |
| □ Cough | **PREGNANCY & GYNECOLOGY** |  |
| □ Bronchitis |  |  |
| □ Difficulty in breathing when lying down | □ Number of pregnancies \_\_\_\_\_\_\_\_\_ |  |
| □ Production of phlegm | □ Number of births \_\_\_\_\_\_\_\_\_ |  |
| What color? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Premature births \_\_\_\_\_\_\_\_\_ |  |
| □ Coughing blood | □ Miscarriages \_\_\_\_\_\_\_\_\_ |  |
| □ Pneumonia | □ Abortions \_\_\_\_\_\_\_\_\_ |  |
| □ Asthma | □ Age at first menses \_\_\_\_\_\_\_\_\_ |  |
| □ Pain while breathing deeply | □ # days between periods \_\_\_\_\_\_\_\_\_ |  |
| □ Other lung problems: | □ Duration \_\_\_\_\_\_\_\_\_ |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ First date of last period \_\_\_\_\_\_\_\_\_ |  |
|  | □ Unusual character |  |
| **GASTROINTESTINAL** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | □ Painful periods |  |
| □ Nausea | □ Vaginal discharge |  |
| □ Constipation | □ PMS |  |
| □ Black stools | □ Clots |  |
| □ Bad breath | □ Vaginal sores |  |
| □ Abdominal pain or cramps | □ Irregular periods |  |
| □ Chronic laxative use | □ Last Pap \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| □ Vomiting | □ Breast lumps |  |
| □ Gas | □ Birth control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| □ Blood in stools |  |  |
| □ Rectal pain | **MUSCULOSKELETAL** |  |
| □ Diarrhea |  |  |
| □ Belching | □ Neck pain |  |
| □ Indigestion | □ Back pain |  |
| □ Hemorrhoids | □ Hand/wrist pain |  |
| □ Other stomach or intestinal | □ Muscle pain |  |
| problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Muscle weakness |  |
|  | □ Shoulder pain |  |
|  | □ Knee pain |  |
|  | □ Foot/ankle pain |  |
|  | □ Hip pain |  |
|  |  |  |

**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, please notify your practitioner at every visit when herbs are prescribed.**

**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

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**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 - $160 Herbal Consultations - $50

Follow-up Appointments - $90 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 business-hours notice and appointments missed with no notification will be charged in full for that 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](mailto: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)