INFINITE WELLNESS

INTEGRATIVE THERAPEUTIC MEDICINE

MANDATORY DISCLOSURE

Sabrina Maiden, L.AC. (NCCAOM)
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303-274-7979

This disclosure is in compliance with the State of Colorado Department of Regulatory Agencies which regulates the practice of acupuncture in Colorado. The information in the form is provided to the patient so that he/she may freely choose to participate in this complimentary medicine with full knowledge of the education and professional background of the practitioner. The practice of acupuncture is overseen by the Director, Division of Acupuncturists Registration, 1560 Broadway, Suite 1545, Denver, CO 80202, (303) 894-2464.

As a patient you have the following rights:

1. The right to receive information about the methods of therapy, the techniques used and the duration of the therapy, if known.
2. The right to a second opinion from another health care professional, or to terminate therapy.
3. The understanding that this is a professional relationship and that sexual intimacy is inappropriate and should be reported to the Department of Regulatory Agencies.

Sabrina Maiden is in compliance with any rules and regulations promulgated by the Department of Health with respect to the practice of acupuncture, including those related to the proper cleaning and sanitation of the acupuncture offices and by using single-use, disposable factory-sterilized needles. Needle disposal processes are in compliance with state and local regulations outlining the handling of infectious waste.

EDUCATION

- B.A. in Psychology and Human Services from University of Colorado/Metropolitan State College of Denver (1992-1996)
- Colorado School of Traditional Chinese Medicine, Denver, Colorado (1997-2000): A three year 2260-hour program with a course of study that included over 1000 hours of supervised clinical experience plus 600 hours of training in adjunctive therapies such as the use of Chinese Herbs, cupping, moxibustion, Tui Na, electro-acupuncture, auricular therapy, scalp acupuncture, injection therapy, and dietary, nutritional and lifestyle recommendations. These therapies may be used in conjunction with acupuncture according to traditional Chinese concepts and nutritional medicine.
- Training in Nutritional (American Health Sciences, 2004) and German Biological Medicine (2006-present). Teacher, Educator and Colorado Representative for BioResource, Inc.

CERTIFICATIONS AND LICENSES

- Florida Certificate of Registration/Acupuncturist License AP1980
- Colorado Certificate of Registration/Acupuncturist License # 655
- National Commission for the Certification of Acupuncturists and Oriental Medicine (NCCAOM)

ACTIVE RESEARCH AFFILIATIONS

- Living Systems Information Biofeedback
- Occidental Institute Research Foundation
- International Council of Applied Kinesiology

ORIENTAL MEDICINE

Acupuncture has been explained to me as a treatment of inserting needles through the skin at specific points on the surface of the body to obtain the alleviation or cure of an illness. I understand that there are some possible side effects of acupuncture or herbal medicine, such as hematoma, discomfort, fainting, headache, allergy or aggravation of symptoms, nausea, loose stool, and/or palpitations.

FEE SCHEDULE

Initial Consultation and Treatment	$210 (1 1/2 Hour)
Re-Test/Re-evaluation	$165 (1 Hour)
QI-5 and Acupuncture	$145 (1 Hour)
Acupuncture Treatment	$85 (45 Minutes)
Laser	$20 (per 15 minutes)
Cancellations (24 hour notice)	$75

I have read and understand the above information (please keep your copy for your files).

_____ _____

Signature of patient Date

INFINITE WELLNESS

INTEGRATIVE THERAPEUTIC MEDICINE

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of you privacy rights can be provided to you.

Sabrina Maiden, L.Ac., uses health information about you for your treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Sabrina Maiden, L.Ac., will not disclose your information to others unless you tell her to do so in writing, or unless the law authorizes or requires her to do so.

Sabrina Maiden, L.Ac., may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Sabrina Maiden, L.Ac., may disclose your information for public health activities, health and safety, and governmental functions on order to comply with Workers' Compensation laws and regulations. You have the right to request restrictions, report and retain a copy of your health records, request communications of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records at any time.

You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. (Note: You will not be retaliated against for filing a complaint.)

Sabrina Maiden, L.Ac., must maintain the privacy protected health information, provide you with notice of her legal duties and privacy practices with respect to your health information, abide by the terms of this notice, notify you if she is unable to agree with the requested restriction on how your information is used or disclosed. Sabrina Maiden, L.Ac., will accommodate reasonable requests you make to communicate your health information by alternative means or from alternative locations,

If you have any questions or complaints, please contact Sabrina Maiden, L.Ac., at (303) 274-7979.

_____ _____

Patient Signature Date

INFINITE WELLNESS

INTEGRATIVE THERAPUETIC MEDICINE

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I CONSENT to the use of my health information by Sabrina Maiden, L.Ac., for the purpose of TCM diagnosing, or providing treatment to me, and obtaining payment for my healthcare bills or to conduct healthcare operations.

I UNDERSTAND I have the right to request a restriction as to how my health information is used or disclosed. The doctor is not required to agree to my request for restrictions, however, if Sabrina Maiden, L.Ac., agrees to a restriction, the restriction is binding.

I UNDERSTAND I have the right to review Sabrina Maiden's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the duties of Sabrina Maiden with respect to my healthcare information.

Sabrina Maiden, L.Ac., reserves the right to change the Notice of Privacy Practices and I have the right to revoke this consent at any time in writing.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

INFINITE WELLNESS

INTEGRATIVE THERAPUETIC MEDICINE

PATIENT HISTORY

Name: _____ Phone Home: _____ Work: _____
Cell Phone_____ Fax: _____Email Address: _____
Address: *(street)*_____ Age:_____ Ht:_____ Wt:_____ Sex:_____
(city) _____ Birth Date:_____ Marital status:_____ No. of children: ____
*(state)*_____*(zip)*_____Occupation: _____ Soc. Sec. No.:_____
Employer's Name and Address: _____
Primary Physician & Phone: _____Referred by:_____
In emergency, contact: _____ Emergency phone number: _____
Their address:_____ Relationship: _____
Insurance Company's Name and Address:_____
Check: ❑ Individual Policy ❑ Group Policy Insurance Policy Number: _____

PURPOSE FOR COMING: _____
_____
_____
_____

MAJOR COMPLAINT only: _____
_____
_____
_____
_____

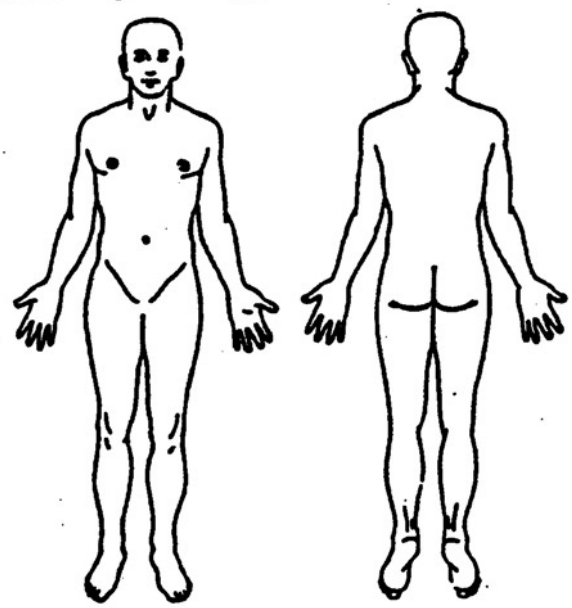
How did this condition develop? (What caused it? How did it start?)_____
_____
_____

When was the first time you were aware of this condition?_____
_____
_____

Have you ever had this condition or similar condition before? If yes, please explain:_____
_____
_____
_____

Have you ever received any treatment for this condition?
❑ Yes ❑ No If yes, where? _____
When? _____
By whom?_____
What was the diagnosis?_____
What were the results of treatment?_____
_____
_____

If you are in pain, please mark the exact location of your pain on the figure below. Describe the type, frequency, intensity and duration of your pain, as well as any activity which brings on or aggravates the pain. (i.e. abdominal sharp pain, every 30 seconds, for the last two hours when standing or sitting.)



Has the condition been getting ❑ better ❑ worse or ❑ staying the same?
Are you experiencing physical, mental, or emotional stress at ❑ home or ❑ at work ❑ other_____
How has this condition affected the following:
Your home life:_____
Your work experience: _____
Your social life:_____
Your ability to exercise: _____
Rest and sleep:_____
Other:_____
State injuries you have had, related or otherwise, to your condition:_____
_____

❑ Broken bones ❑ Concussion or Head Injury ❑ Dislocations ❑ Sprains ❑ Loss of Consciousness

Name: _____ Date: _____

PAST MEDICAL HISTORY

Birth: Anything significant about your birth?

Vaccination history: Any reaction that you remember?

Childhood illnesses: Any surgery or accidents? List in chronological order and indicate length of illness or injury.

Age 0-6:

Age 7-12:

Age 13-20:

Age 21-30:

Age 31-40:

Age 41 to present:

Family health history:

Name: _____ Date: _____

SYMPTOM REVIEW

Put ONE check by a symptom you sometimes experience; use TWO checks for those which often occur, and THREE checks for symptoms that are a major concern. In the space next to the symptom, comment on how long you have had the symptom, and how severe it is.

HEAD AND FACE
- ❑ Headaches
- ❑ Dizziness
- ❑ Memory loss
- ❑ Other

EYES
- ❑ Blurred vision
- ❑ Eyelid Problem
- ❑ Pain
- ❑ Other

EARS
- ❑ Poor hearing
- ❑ Earaches
- ❑ Discharges
- ❑ Ringing
- ❑ Other

NOSE
- ❑ Frequent colds
- ❑ Sinus trouble
- ❑ Bleeding
- ❑ Other

MOUTH
- ❑ Gum problems
- ❑ Teeth problems
- ❑ Tongue problems
- ❑ Lip problems
- ❑ Jaw problems
- ❑ Unusual tastes
- ❑ Other

THROAT
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Other

RESPIRATION
- ❑ Difficulty inhaling
- ❑ Difficulty exhaling
- ❑ Pain
- ❑ Cough
- ❑ Phlegm
- ❑ Other

HEART AND THORAX
- ❑ Palpitations
- ❑ High blood pressure
- ❑ Tightness in chest
- ❑ Low blood pressure
- ❑ Difficulty lying flat
- ❑ Other

CIRCULATION
- ❑ Bruise easily
- ❑ Bleed easily
- ❑ Cold limbs
- ❑ Other

GASTROINTESTINAL
- ❑ Excess thirst
- ❑ Never thirsty
- ❑ Excess appetite
- ❑ Digestive pain
- ❑ Nausea
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Colon problems
- ❑ Other

URINATION
- ❑ Frequent
- ❑ Difficulty
- ❑ Painful
- ❑ Nighttime
- ❑ Bleeding
- ❑ Other

SKIN
- ❑ Rashes
- ❑ Dryness
- ❑ Moles or lumps that change
- ❑ Excess sweat
- ❑ Night sweat
- ❑ Rarely sweat
- ❑ Other

NEUROLOGICAL
- ❑ Nervousness
- ❑ Tremors
- ❑ Convulsions
- ❑ Numb or tingling limbs
- ❑ Poor coordination
- ❑ Nerve pain or neuralgia
- ❑ Other

SLEEP
- ❑ Insomnia
- ❑ Drowsiness
- ❑ Excess Dreams
- ❑ Other

ENERGY LEVELS
- ❑ Low
- ❑ High
- ❑ Other

PAIN (Please describe below)

_____
_____
_____
_____

OTHER COMMENTS

_____
_____
_____
_____
_____
_____
_____

CURRENT AND FORMER CONDITIONS

Name: _____ **Date:** _____

Underline current conditions. Put a check mark in the box for former conditions.
State duration, frequency, intensity and pain in the space beside current symptoms.

GENERAL SYMPTOMS
- ❑ Tremors
- ❑ Headache
- ❑ Fever
- ❑ Sweats
- ❑ Fainting
- ❑ Dizziness
- ❑ Convulsions
- ❑ Loss of sleep
- ❑ Fatigue
- ❑ Nervousness
- ❑ Depression
- ❑ Loss of weight
- ❑ Forgetfulness
- ❑ Numbness or pain in arms, hands, elbows, shoulders, hips, legs, knees, or feet
- ❑ Confusion
- ❑ Auto Immune Deficiency
- ❑ Paralysis

EYES, EARS, NOSE AND THROAT
- ❑ Failing vision
- ❑ Near sighted
- ❑ Eye pain
- ❑ Eye strain
- ❑ Cross eyed
- ❑ Eye inflammation
- ❑ Glaucoma
- ❑ Deafness
- ❑ Earache
- ❑ Loss of hearing
- ❑ Ear discharge
- ❑ Ear noises
- ❑ Nose bleeds
- ❑ Nasal obstruction
- ❑ Nasal drainage
- ❑ Loss of smell
- ❑ Sinus infection
- ❑ Hay fever
- ❑ Allergies
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Difficult swallowing
- ❑ Loss of taste
- ❑ Change in tastes
- ❑ Dental decay
- ❑ Gum troubles
- ❑ Tonsillitis
- ❑ Asthma
- ❑ Frequent colds
- ❑ Enlarged thyroid
- ❑ Enlarged glands

SKIN
- ❑ Skin eruptions
- ❑ Clammy skin
- ❑ Dryness
- ❑ Bruises easily
- ❑ Boils
- ❑ Rashes
- ❑ Sensitive skin
- ❑ Hives or allergy

RESPIRATORY
- ❑ Chronic cough
- ❑ Spitting up phlegm
- ❑ Spitting up blood
- ❑ Chest pain
- ❑ Difficult breathing
- ❑ Wheezing

CARDIOVASCULAR
- ❑ Rapid beating heart
- ❑ Slow beating heart
- ❑ Irregular beating heart
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pain over heart
- ❑ Previous heart stroke
- ❑ Hardening of arteries
- ❑ Swelling of ankles
- ❑ Poor circulation
- ❑ Paralytic stroke
- ❑ Varicose veins

MUSCLE AND JOINT
- ❑ Stiff neck
- ❑ Pain between shoulders
- ❑ Backache
- ❑ Painful tail bone
- ❑ Foot trouble
- ❑ Hernia
- ❑ Spinal curvature
- ❑ Faulty posture
- ❑ Swollen joints
- ❑ Stiff joints
- ❑ Painful joints
- ❑ Arthritis
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Sciatica

GENITOURINARY
- ❑ Frequent urination
- ❑ Scanty urine
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Pus in urine
- ❑ Kidney infection or stones
- ❑ Bed wetting
- ❑ Inability to control urine
- ❑ Prostrate trouble
- ❑ Bladder trouble
- ❑ Foul smelling urine
- ❑ Discolored urine

GASTROINTESTINAL
- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Belching or gas
- ❑ Nausea
- ❑ Gas
- ❑ Vomiting
- ❑ Vomiting of blood
- ❑ Pain over stomach
- ❑ Distention of abdomen
- ❑ Constipation
- ❑ Diarrhea
- ❑ Black stool
- ❑ Blood in stool
- ❑ Colon trouble
- ❑ Hemorrhoids (Piles)
- ❑ Intestinal worms
- ❑ Liver trouble
- ❑ Gall bladder trouble
- ❑ Jaundice
- ❑ Colitis
- ❑ Weight trouble

FEMALE
- ❑ Painful menstrual periods
- ❑ Excessive flow
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Cramps or backache
- ❑ Previous miscarriage
- ❑ Vaginal discharge
- ❑ Vaginal pain
- ❑ Congested breast
- ❑ Breast pain
- ❑ Lumps in breast
- ❑ Menopausal symptoms
- ❑ Abnormal bleeding
- ❑ Reduced sexual energy
- ❑ Pregnancy
- ❑ Pregnancy complications

MALE
- ❑ Pain associated with genitals
- ❑ Reduced sexual energies
- ❑ Premature ejaculation
- ❑ Seminal emission
- ❑ Impotence
- ❑ Discharges

Name: _____ Date: _____

FEMALES ONLY

Are you or might you be pregnant? ❑ Yes ❑ No ❑ Maybe If yes, what month? _____
What method of birth control do you use?_____
Are you experiencing reduced sexual energies? ❑ Yes ❑ No Other difficulties? ❑ Yes ❑ No
Explain:_____
Do you have regular PAP tests? ❑ Yes ❑ No How regular? _____

PLEASE CHECK OR EXPLAIN IF APPLICABLE:

Menstrual Cycle
Age started: _____ Age stopped: _____

- ❑ Irregular _____
- ❑ Painful _____
- ❑ Excess blood _____
- ❑ Lack of blood _____
- ❑ Dark _____
- ❑ Light _____
- ❑ Heavy clotting _____
- ❑ Water retention _____
- ❑ Painful breast _____

Vaginal Discharge:

- ❑ Liquid _____
- ❑ Yellow _____
- ❑ Thick _____
- ❑ Bad odor _____
- ❑ White _____
- ❑ Other _____

Gynecological History or Operations:

- ❑ Ovaries _____
- ❑ Uterus _____
- ❑ Tubes _____
- ❑ Vagina _____
- ❑ Breast _____
- ❑ Other _____

Pregnancy:
Total Number: _____
Number of children: _____
Number of abortions: _____
Number of miscarriages: _____
Complications: _____

MALES ONLY

PLEASE CHECK OR EXPLAIN IF APPLICABLE:

- ❑ Reduced sexual energies: _____
- ❑ Premature ejaculation: _____
- ❑ Seminal emission: _____
- ❑ Impotence: _____
- ❑ Discharges: _____
- ❑ Pain associated with genitals:_____
- ❑ Other: _____

HABITS, DIET, MEDICINES, ALLERGIES

Name:_____ **Date** _____

LAST PHYSICAL: Date_____ Practitioner:_____ Results:_____

HABITS: Indicate below: Heavy, Moderate, Light, or None If significant, comment.

Heavy	Moderate	Light	None	
❑	❑	❑	❑	Alcohol:
❑	❑	❑	❑	Coffee:
❑	❑	❑	❑	Tea:
❑	❑	❑	❑	Tobacco:
❑	❑	❑	❑	Exercise:
❑	❑	❑	❑	Sleep:
❑	❑	❑	❑	Appetite:
❑	❑	❑	❑	Energy:
❑	❑	❑	❑	Medication:
❑	❑	❑	❑	Vitamins:
❑	❑	❑	❑	Diet:
❑	❑	❑	❑	Teeth problems:
❑	❑	❑	❑	Drugs:
❑	❑	❑	❑	Salt:
❑	❑	❑	❑	Other:
❑	❑	❑	❑	Stress: _____ (Chemical, physical, psychological)

AVERAGE DAILY DIET

Morning:

Afternoon:

Evening:

Between Meals:

Are you now on (or have you undertaken) a restricted diet? Please describe and indicate when.

_____

_____

MEDICINES taken within the last two months (include vitamins, over-the counter drugs, herbs)

_____

_____

ALLERGIES: (Drugs, chemicals, foods. Type of reaction.)

_____

_____

WELCOME TO INFINITE WELLNESS