Introduction and Policies

Welcome to the Verdure Health Traditions. I welcome the opportunity to work with you and am happy to answer any questions you may have. Oriental Medicine (OM) is a comprehensive system of health care with a continuous clinical tradition of more than 3000 years. It includes acupuncture and herbal treatment, Asian massage, dietary therapy, and lifestyle recommendations. Laser therapy is also offered and may be utilized in your health care plan. These therapies, combined with the technology of Western Medicine, provide you with an optimal system of health care that addresses not only disease, but health and well-being.

Oriental Medicine therapies are safe and often enjoyable. Most people feel a sense of relaxation and well-being both during and after the treatment. Due to the nature of OM questions, patients often experience a greater awareness of their bodies and able to help correct or prevent situations that create dysfunction or pain.

I received my Masters of Acupuncture degree from the Northwest Institute of Acupuncture and Oriental Medicine in 2002 and am currently licensed in Colorado. I am also nationally certified by the National Certification Commission for Acupuncture and Oriental Medicine, and the National American Detoxification Association. Please note that these licenses or designations have never been suspended or revoked.

Appointments and Fee Information

Please eat 1 to 2 hours prior to your appointment time and wear loose fitting clothing if possible. The initial visit will last approximately 90 minutes and costs $135. This will include a detailed conversation and physical exam based upon OM diagnostics, as well as an acupuncture treatment. Subsequent visits last approximately 60 minutes and cost $110. These include less detailed interviews and a full treatment. Herbs and supplements may be added and are additional. You are responsible for all fees at time of services rendered and the above cash discounts are provided to aid you in doing so. If the provider agrees towait for payment from an insurance company or otherwise, standard billing rates apply without the above discounts. Current billing rates are available upon request.

Superbills are available should you wish to submit the charges to your insurance company. In some cases, insurance may be billed directly, but please verify that your insurance plan covers acupuncture and how much deductible has been met. It may be less expensive to pay at time of service, rather than billing insurance (especially if your deductible has not been met). If your insurance company should deny coverage due to non-covered benefits, lack of referral, lack of proper reporting of incident/accident, or lack of individual coverage, then the responsible party will be billed for services rendered in full. I hereby assign to Verdure Health Traditions all benefits for medical expenses. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. Any account balance that are not paid by 30 days from the dates of service may be forwarded to our collection agency.

_____ (*please initial if you plan to use insurance benefits*)

On occasion, Verdure Health Traditions uses email and text messaging to correspond with patients. However, these forms of communication are not encrypted and could theoretically be read by an outside party with the technical

skills to intercept such messages. By signing this form, you consent that Jennifer Ulman, L.Ac. may correspond with you via email or text, despite potential risks.

Cancellation and Arriving Late

Treatment times are set aside for you. If you need to cancel or reschedule, please kindly give my office 24 hours notice. If you are unable to give sufficient notice, a $25 fee will be charged for the missed appointment. In addition, arriving more than 20 minutes late will result in cancellation of the appointment and a $25 fee.

Client Acknowledgement

I have read the preceding information and have been given the opportunity to ask questions clarifying the content. I understand that I am financially responsible for all charges and agree to pay for the services rendered. I authorize that payment(s) be made directly to Jennifer Ulman, L.Ac., LLC. I understand the contents of this disclosure and agree to abide by these policies.

The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies. Should you have questions, the director may be contacted at:

Director of Professions and Occupations Acupuncturist
1560 Broadway, Suite 1350
Denver, CO 80202
303.894.7800

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Jennifer Ulman, L.Ac. regarding the cure or improvement of my conditions. I hereby release Jennifer Ulman, L.Ac. 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 that if I have any questions about this information, I should ask Jennifer Ulman, L.Ac., and that I am entitled to receive information about the methods of therapy, techniques used, and duration of therapy, if known. I understand that I am free to obtain a second medical opinion from another health care professional, and may terminate therapy at any time.

Thank you for choosing me as part of your healthcare team, and I look forward to assisting you in achieving your wellness goals.

_____ _____

Client Signature (acknowledges 2 pages read) Date

_____

Authorized Person to Consent Signature

verdure
HEALTH TRADITIONS

Health History Questionnaire

Name: _____ **Birthday**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Cell Ph: _____ **Wk/Hm Ph**: _____ **E-mail**: _____

Employer: _____ **Occupation**: _____

Insurance Info _____ **Height**: _____ **Weight**: _____ **Sex**: M / F

Marital Status (circle one): Never Married / Married / Separated / Living with Partner / Divorced / Widowed

Family Physician: _____ **Referred By**: _____

Emergency Contact Name and Number: _____

Have you ever been treated by Acupuncture or Oriental Medicine before? _____

What is your main concern(s) that you would like help with? _____

_____

When did this begin? (Please be specific.) _____

_____

What do you think caused it? Is the cause still present? _____

_____

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

What kind of treatments have you tried? What were the results? _____

_____

To what extent does this condition interfere with your daily activities (eg. work, sleep, eating, sex) ? _____

_____

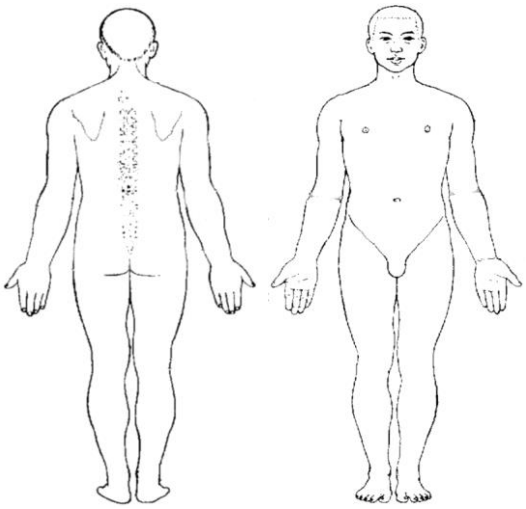
Please note the degree of severity of your problem now:

No problem Moderate Worst Imaginable

Please note the greatest degree of severity of your problem within the last week:

No problem Moderate Worst Imaginable

Please indicate painful or distressed areas on the diagrams to the right.



Past Medical History (please indicate by date):

Cancer: _____ Pacemaker: _____ High Blood Pressure: _____
Diabetes: _____ Rheumatic Fever: _____ Stroke: _____
Hepatitis: _____ Heart Disease: _____ STD: _____
Other Conditions: _____

Surgeries (type and date): _____
_____

Significant Trauma (auto accidents, falls, etc.): _____
_____
_____

Significant Dental Work (type and date): _____
_____

Additional Medications / Herbs / Supplements you are currently taking: _____
_____
_____

Occupational Stress (physical, chemical, psychological, etc.): _____
_____

Do you exercise regularly? Y / N Please describe: _____
_____

Last Physical Date: _____ Doctor: _____ Results: _____

Habits Please indicate below: None, Light, Moderate, or Heavy. Please add comments where significant.

	Excessive	Moderate	Minimal	None	
Alcohol:	☐	☐	☐	☐	
Coffee / Tea:	☐	☐	☐	☐	
Tobacco:	☐	☐	☐	☐	
Exercise:	☐	☐	☐	☐	
Sleep:	☐	☐	☐	☐	
Appetite:	☐	☐	☐	☐	
Energy Level:	☐	☐	☐	☐	
Medication:	☐	☐	☐	☐	
Vitamins:	☐	☐	☐	☐	
Food Intake:	☐	☐	☐	☐	
Drugs:	☐	☐	☐	☐	
Salt Intake:	☐	☐	☐	☐	
Stress Level:	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	

Diet Please give a general description of the food you eat during a "typical" day.

Morning: .....

Afternoon: .....

Evening: .....

Between meals: .....

Are you now, or have you ever been, on a restricted diet? Please describe the diet and give the start/stop dates:

_____

_____

What allergies do you have? What reactions do you have to these chemicals, foods, drugs, animals, etc?

_____

_____

Family Medical History

☐ High Blood Pressure	☐ Alcoholism	☐ Cancer: _____	☐ Allergies: _____
☐ Heart Disease	☐ Seizures	_____	_____
☐ Arteriosclerosis	☐ Asthma	_____	_____
☐ Stroke	☐ Diabetes		

General

- ☐ Chills
- ☐ Fevers
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold / hot)
- ☐ Thirst, no desire to drink
- ☐ Fatigue
- ☐ Sudden energy drop
  *Time of day:*_____
- ☐ Edema
  *Where:*_____
- ☐ Poor sleeping
- ☐ Tremors
- ☐ Poor balance
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight change
  Gain / Loss _____

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Oozing skin lesion
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Dandruff

Other hair or skin problems

_____

_____

Head, Eyes, Ears Nose, and Throat

- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches
- ☐ Facial pain
- ☐ Glasses
- ☐ Poor vision
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Color blindness
- ☐ Blind field
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cataracts
- ☐ Eye Dryness
- ☐ Excessive tearing
- ☐ Discharge from eyes
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Discharge from ear
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Nasal drainage
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Concussions
- ☐ Recurrent sore throats
- ☐ Hoarseness
- ☐ Sores on lips/tongue

Other head / neck problems

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty in breathing

Other heart/blood vessel problems: _____

Respiratory

- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Difficulty in breathing when lying down
- ☐ Phlegm *Color?*_____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis

*Other lung problems:*_____

_____

Gastrointestinal

- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Belching
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic laxative use
- ☐ Blood in stools
- ☐ Black stools
- ☐ Abdominal pain/cramps
- ☐ Gas
- ☐ Rectal pain
- ☐ Hemorrhoids

*Other stomach or intestinal problems:*_____

_____

Genito-Urinary

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Kidney stones
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Sores on genitals

Do you wake to urinate?

☐ Yes ☐ No

How often? _____

What color is your urine?

_____

*Other genital or urinary system problems?*_____

_____

Pregnancy and Gynecology

of pregnancies: _____
# of births: _____
premature births: _____
of miscarriages: _____
# of abortions: _____
Age at first menses: _____
Length of full cycle: _____
Length of menses: _____
Last menses start date: _____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Vaginal discharge:
- ☐ Menopause:
  Age: _____
  *Year:*_____
- ☐ Postcoital bleeding
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Nipple discharge

Do you practice birth control?

☐ Yes ☐ No

What type and for how long?

_____

Musculoskeletal

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

Other pain? _____

_____

Neuropsychological

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Weakness
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Violence potential
- ☐ Vertigo
- ☐ Lack of coordination
- ☐ Bad temper
- ☐ Depression
- ☐ Easily stressed
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Substance abuse

Have you ever been treated for emotional problems?

☐ Yes ☐ No

* Please check any symptoms you have had in the past 3 months