Extraordinary Chinese Medicine, LLC
Thomas Richardson, MAcOM, Dipl. OM

New Patient Intake Form

This information is confidential Date: _____

Name: _____ Age: _____ Sex: M / F
Address:_____ Birth Date: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell: _____
E-Mail: _____
Occupation: _____
Physician: _____ Physician Phone #: _____
Referred by: _____

Have you ever had acupuncture? Yes / No

Reason for today's visit:_____
_____

What other treatments have you tried? _____
_____

Medications you are currently taking:	For what conditions:
_____	_____
_____	_____
_____	_____
_____	_____

Supplements and herbs you are currently taking:
_____
_____

Medical History (Check all that apply)

___Aids/HIV	___Alcoholism/Substance Abuse	___Colitis
___Bleeding/Clotting disorder	___Irritable Bowel Syndrome	___Epilepsy
___High Blood Pressure	___Kidney Disease	___Migraines
___Thyroid Disorder	___Tuberculosis	___Allergies
___Hepatitis A / B / C	___Diabetes	___Jaundice
___Asthma	___Birth Trauma	___Seizures
___Cancer	___Herpes	___Pacemaker
___Emphysema	___Lyme Disease	___Heart Disease

Allergies: Are you sensitive or allergic to any foods or drugs? Yes / No
Which?_____

Are you currently taking or have you taken recently:
Coumadin, Warfarin, or any blood thinner? Yes / No
Lithium, Zoloft, Prozac, or any anti-depressant/anti-anxiety medication? Yes / No
Sleeping pills? Yes / No

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Please describe your typical diet, including any snacks and beverages:

Do you tend to feel hot or cold during the day or at night? If one or the other, is it your whole body or just the extremities?

Surgeries you have had:

On average, how many hours of sleep do you get each night? _____
How would you describe the quality of your sleep? _____

Any Food Allergies? _____

General Wellness Information (optional):

Please describe your goals in working together:_____

Do you have any consistent self-care, meditation, or spiritual practices? If so, please describe:

Please describe a typical day:

How would you describe your general emotional and psychological states? Are there any dominant emotions or patterns that you are aware of?

In general, how are your relationships (work, family, friends, romantic, etc)?
Any particular issues, concerns, or patterns?

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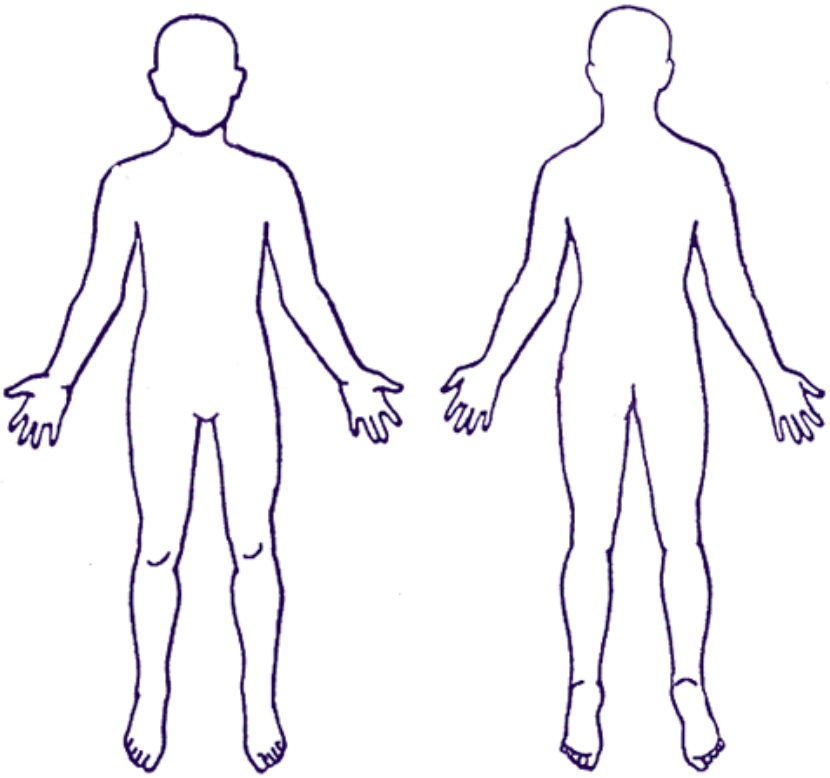
Mark with an (X) over any areas where you are feeling discomfort or pain.



If pain, please describe: Sharp Dull Stabbing Other:_____

What makes the pain better? (circle all that apply)
heat cold movement massage rest

Do you have any additional health conditions or concerns?_____
_____
_____
_____
_____
_____

Print Name _____

Patient Signature _____

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New Patient Information

Here are some general guidelines regarding your appointment:

1. Please eat a moderate amount of food 1 to 1½ hours before your appointment.
2. Please dress comfortably or wear loose clothing so that your arms and legs may be accessible. If we need to have access to your back or other areas that require the removal of clothes, we will drape you appropriately with a sheet.
3. Whenever possible, please arrange your schedule so you do not have to rush to or away from the clinic.
4. Please tell us if you are uncomfortable with physical touch or with discussing certain activities or parts of the body.
5. Feel free to ask any questions that may arise during your treatment. It is important that you feel informed and understand your own health!

Cancellation Policy: Cancellation must be done via phone and at least twenty-four (24) hours prior to your appointment time, or you will be charged for the appointment.

Payment for Services Rendered

Payment is due at the time of service & may be paid in cash, check or credit card.

Health Care Information Authorization

Protecting your privacy and healthcare information is fundamental in the course of our relationship. The independent practitioners and any staff member of Extraordinary Chinese Medicine, LLC may need to use your name, address and phone number to contact you with appointment reminders, to follow-up after an appointment, to provide information about your treatment alternatives, or other health-related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering device or with whoever answers the phone. By signing this form, you are giving us authorization to contact you via phone, mail, and e-mail. Please let us know in person if you would like to change your preferences.

Further, in order to provide you with quality care and to comply with certain legal requirements, we create a record of the care and services you receive at this clinic. We are committed to protecting, securing and keeping confidential your personal and medical information unless we have your written consent for its disclosure. There are instances, however, in which your personal health information may be disclosed without your expressed written consent according to the Health Insurance Portability & Accountability Act (HIPAA); these include 1) at your verbal request, 2) for default of payment, 3) as required by an agency of the government.

_____
Patient's name (please print)

_____ _____
Patient's signature Date signed

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Informed Consent to Acupuncture and Oriental Medicine

I hereby request and consent to the performance of acupuncture, and other procedures within the scope of the practice of Oriental Medicine, on me (or the patient named below for whom I am legally responsible) by Thomas Richardson, LAc, MAcOM, Dipl. OM (NCCAOM).

I understand that methods of treatment may include, but are not limited to: acupuncture; moxibustion; cupping; gua sha (scraping therapy); needle retention; tuina and shiatsu (Chinese and Japanese forms of bodywork); electrical, laser, and/or magnetic stimulation; micropuncture (mild bleeding therapy); diagnostic palpation on various areas of my body; herbal medicine; qigong and meditation guidance; and nutritional and/or lifestyle counseling.

I understand and am informed that in the practice of Oriental Medicine, as in the practice of allopathic medicine, there are some side effects and/or risks of treatment; I understand that although these are unlikely to occur, they are possible. Some of these effects include, but are not limited to: bleeding; bruising, numbness, tingling, pain or other strong sensation at the location where a needle is inserted or radiating from that location; aggravation of current symptoms; appearance of new symptoms; general aches or dizziness. Bruising is a common side effect of gua sha and cupping. Burns and/or scarring are a potential risk of moxibustion and cupping. Unusual risks of acupuncture include infection or nerve pain, although the acupuncturist uses sterile, single-use, disposable needles and maintains a clean and safe environment. Highly unusual risks include organ puncture, including pneumothorax (punctured lung), and spontaneous miscarriage. I understand that some methods may be inappropriate during pregnancy and will immediately notify the acupuncturist(s) if I know or suspect that I am pregnant. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, at any time before or during the diagnosis or treatment.

The Chinese and Western herbs (which are derived from plant, animal and mineral sources) that are recommended are traditionally considered safe in the practice of herbal medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, diarrhea, headache, rashes and tingling of the tongue; some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin. I understand that some herbs may be inappropriate during pregnancy and will immediately notify the acupuncturist(s) if I know or suspect that I am pregnant. Further, I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption or application of any Chinese herbs.

I do not expect the acupuncturist(s) to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist(s) to exercise such judgment based on the known facts, during the course of my treatment, to be in my best interest. I understand that results are not guaranteed.

By signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the benefits and risks of acupuncture treatments and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from this clinic.

_____
Patient's name (please print)

_____ _____
Patient's signature Date signed
or signature of Patient's Representative/Legal Guardian

_____ _____
Representative/Legal Guardian, if applicable (please print) Relationship or authority

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Colorado Mandatory Disclosure Statement

Education and Experience

Thomas Richardson earned his Masters of Acupuncture and Oriental Medicine degree from the Academy of Oriental Medicine at Austin (AOMA). This program, which Thomas completed in five calendar years, consisted of over 2850 hours of education, including 1250 hours of clinical experience. He is certified as a Diplomate in Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), which includes certification in Clean Needle Technique and Chinese Herbology. Additionally, Thomas earned a Master of Theological Studies from Harvard Divinity School, where his research focused on the intersection of medicine and religion, as well as trauma, storytelling, and healing.

In addition to acupuncture, Thomas's training includes adjunctive therapies such as moxibustion, shiatsu, medical qigong, meditation, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations.

Thomas Richardson is a licensed acupuncturist in Colorado. His license has never been suspended or revoked.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper use and disposal of needles and the sanitation of acupuncture clinics. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule

Initial Consultation and Treatment	$125
Follow-up Acupuncture Session	$108

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional, or 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.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Director of the Division of Registrations, Acupuncturist Licensure, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-7800.

I have read and understand this document.

_____ _____

Patient / Guardian's Signature Date