Ancient Art Health Center
Your Path to Extraordinary Health

2516 W. Main Street
Littleton CO 80120
303 797-6656
AncientArtHealing.com

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. . Thank you.

Name:_____Nickname:_____Sex: M/ F

Street:_____City/State:_____ Zip:_____

Birthdate:_____Birthplace:_____ Height:_____Weight:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Email Address:_____Please Contact me at: ☐ Home ☐ Cell ☐ Work

May we add your email address to the Historic Downtown Littleton Merchants enewsletter subscriber list? Y/N

Occupation:_____Marital Status: S M D W

In Case of Emergency, contact:_____Phone:_____

Referred By:_____Family Physician:_____

Main Problem(s) you would like to address:_____-

_____

To what extent does this problem affect your daily activities (work, sleep,eating,etc.)?_____

How long have you had symptoms?_____

Have you been diagnosed by your family physician?_____

If so, what was the diagnosis?_____

What kinds of treatments have you tried?_____

Past/Present Medical History S=Self M=Mother F=Father

S M F	S M F	S M F	S M F
☐☐☐Alcoholism	☐☐☐Depression	☐☐☐HIV/AIDS	☐☐☐Prostate Problems
☐☐☐Allergies	☐☐☐Diabetes	☐☐☐Indigestion	☐☐☐Reproductive Issues
☐☐☐Anemia	☐☐☐Drug Dependency	☐☐☐Kidney Disorder	☐☐☐Rheumatism
☐☐☐Arthritis	☐☐☐Emphysema	☐☐☐Liver Disease	☐☐☐Scoliosis
☐☐☐Asthma	☐☐☐Eating Disorders	☐☐☐Lung disease	☐☐☐Serious Injury
☐☐☐Back Pain	☐☐☐Epilepsy	☐☐☐Menstrual Cramps	☐☐☐Sinus Trouble
☐☐☐Bladder Trouble	☐☐☐Fibromyalgia	☐☐☐Multiple Sclerosis	☐☐☐Stroke
☐☐☐Bowel Control Loss	☐☐☐Gout	☐☐☐Muscular Dystrophy	☐☐☐Thyroid Problems
☐☐☐Blood Pressure	☐☐☐Headaches	☐☐☐Neck Pain	☐☐☐Tuberculosis
☐☐☐Bronchitis	☐☐☐Heart Trouble	☐☐☐Nervousness	☐☐☐Tumors
☐☐☐Cancer	☐☐☐Hepatitis	☐☐☐Numbness	☐☐☐Ulcers
☐☐☐Chest Pain	☐☐☐Hernia	☐☐☐Osteoporosis	☐☐☐Vaginal Infections
☐☐☐Cholesterol	☐☐☐Herniated Disc	☐☐☐Parkinson's Disease	☐☐☐Venereal Disease
☐☐☐Constipation	☐☐☐Herpes	☐☐☐Poor Circulation	☐☐☐Mononucleosis

Birth History (prolonged labor, forceps delivery, etc.):_____

Other relevant medical history:_____

_____

Occupational Stress Factors (physical, psychological, chemical):_____

_____

Lifestyle History

Do you follow a regular exercise program?_____ If so, please describe:_____

_____

Please describe your average daily diet:_____

_____

Please check any of the following habits that apply. Indicate how much and how often you consume them:

☐ Cigarette smoking:_____ ☐ Coffee, tea or cola:_____ ☐ Alcoholic beverages:_____

How much time do you have for yourself to relax and what do you do to relax, ie.hobbies, yoga, meditation,etc?_____

How many hours a night do you sleep?____Is your sleep restful?_____If not, please explain_____

Medications taken within the last two months (vitamins, drugs, herbs, etc.):_____

_____

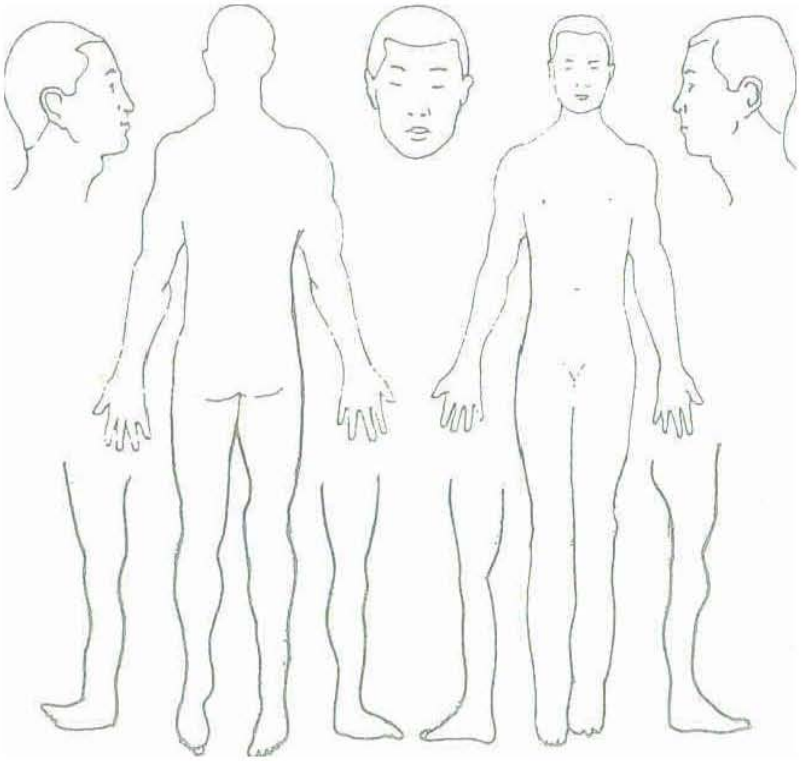
Please describe any use of drugs for non-medical purposes:_____

Please circle any of the following feelings you have experienced in the last few months.

Abused	Paranoid	Unable to grieve	Panic
Criticized	Overwhelmed	Apprehensive	Intolerant
Overworked	Muddled	Agitated	Uncertainty
Paralyzed	Persecuted	Uneasy	Aggravated
Depressed	Guilty	Distress	Annoyed
Rejected	Easily irritated	Fearful	Angry
Despair	Anxious	Impatient	Outraged
Helpless	Sad	Intimidated	Nervous
Hopeless	Grieving	Restless	Worried

Please mark the square that best describes the level of stress for the below listings.

My family stress is: ☐None ☐Minimal ☐Moderate ☐Severe
My relationship stress is: ☐None ☐Minimal ☐Moderate ☐Severe
My work stress is: ☐None ☐Minimal ☐Moderate ☐Severe
My financial stress is: ☐None ☐Minimal ☐Moderate ☐Severe
My health stress is: ☐None ☐Minimal ☐Moderate ☐Severe
Other stress is: ☐None ☐Minimal ☐Moderate ☐Severe_____



On the above diagram please indicate any pain, swelling, or tension

Please put a check next to the conditions you have experienced within the last three months. Indicate the length of time you have had this condition.

General

- ☐ Poor appetite:_____
- ☐ Insomnia:_____
- ☐ Disturbed Sleep:_____
- ☐ Localized weakness:_____
- ☐ Cravings:_____
- ☐ Strong Thirst:_____
- ☐ Weight Gain:_____
- ☐ Weight Loss:_____
- ☐ Changes in Appetite:_____
- ☐ Sweating Easily:_____
- ☐ Tremors:_____
- ☐ Bleeding or bruising easily:_____
- ☐ Night Sweats:_____
- ☐ Fever:_____
- ☐ Chills:_____
- ☐ Sudden energy drop (time of day)_____
- ☐ Poor balance:_____
- ☐ Other unusual or abnormal conditions you have noticed in your general sense of health?_____

_____

Skin and Hair

- ☐ Rashes:_____
- ☐ Ulcerations:_____
- ☐ Hives:_____
- ☐ Itching:_____
- ☐ Eczema:_____
- ☐ Pimples:_____
- ☐ Dandruff:_____
- ☐ Hair loss:_____
- ☐ Recent moles:_____
- ☐ Changes in hair or skin texture:_____
- ☐ Other hair or skin problems:_____

Head, Eyes, Ears, Nose, Throat

- ☐ Dizziness:_____
- ☐ Concussions:_____
- ☐ Migraines:_____
- ☐ Spots in front of eyes:_____
- ☐ Glasses:_____
- ☐ Eye Pain:_____
- ☐ Poor vision:_____
- ☐ Night blindness:_____
- ☐ Color blindness:_____
- ☐ Cataracts:_____
- ☐ Blurry Vision:_____
- ☐ Earaches:_____
- ☐ Ringing in ears:_____
- ☐ Poor hearing:_____
- ☐ Eyestrain:_____
- ☐ Sinus problems:_____
- ☐ Nose bleeds:_____
- ☐ Recurrent sore throat:_____
- ☐ Grinding teeth:_____
- ☐ Facial pain:_____
- ☐ Sores on lips or tongue:_____
- ☐ Teeth problems:_____
- ☐ Jaw clicks:_____
- ☐ Headaches (where? when?):_____
- ☐ Other head or neck problems:_____

Cardiovascular

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

Respiratory

- ☐ Cough:_____ ☐ Asthma:_____ ☐ Coughing up blood:_____
- ☐ Bronchitis:_____ ☐ Pneumonia:_____ ☐ Pain with deep inhalation:_____
- ☐ Difficulty breathing when lying down:_____ ☐ Production of phlegm (color):_____
- ☐ Other lung problems:_____

Gastrointestinal

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

Genito-Urinary

- ☐ Pain or urination:_____ ☐ Frequent urination:_____ ☐ Blood in urine:_____
- ☐ Urgency to urinate:_____ ☐ Kidney stones:_____ ☐ Unable to hold urine:_____
- ☐ Decrease in flow:_____ ☐ Impotence:_____ ☐ Sores on genitals:_____

Do you wake up at night to urinate?_____ If so, how often?_____

Any particular color to your urine?_____

- ☐ Other problems with your genital or urinary functions:_____

Reproductive and Gynecologic

- ☐ (heavy/light) menses:_____ ☐ Menstrual clots:_____ ☐ Painful menses:_____
- ☐ Changes in body/psyche prior to menstruation:_____
- ☐ Irregular menses:_____ ☐ Menopause (age?):_____
- ☐ Other gynecological problems:_____

Age at first menses:_____ Length of time between menses:_____ Duration:_____

First day of last menses:_____ Number of pregnancies:_____ Premature births:_____

Miscarriages:_____ Abortions:_____ Number of births:_____

Do you use birth control?_____ If so, what type?_____ For how long?_____

Musculoskeletal

- ☐ Neck pain:_____ ☐ Muscle pains:_____ ☐ Knee pain:_____
- ☐ Back pain:_____ ☐ Muscle weakness:_____ ☐ Foot/ankle pain:_____
- ☐ Hand/wrist pain:_____ ☐ Shoulder pain:_____ ☐ Hip pain:_____
- ☐ Other joint or bone problems:_____

Neuropsychological

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

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Verification of Receipt of Notice of Privacy Practices

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, via the website, www.ancientarthealing.com, or hard copy kept on file at the offices at 2516 W. Main St., Littleton, CO, 80120, which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Relationship of Personal Representative Date_____

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Colorado law requires all acupuncturists provide the following information to clients at the first visit.

DISCLOSURE STATEMENT

Clients are entitled to receive information about the methods of therapy, the techniques used and the duration of therapy, if known.

All rules and regulations specified by the Colorado Department of Health are strictly adhered to in this clinic, including the proper cleaning and sterilization of equipment. As well, we follow clean needle technique, using sterilized, disposable, one-time use needles only. Training and experience has also been received in the recommendation and application of adjunctive therapies and herbs as defined by traditional oriental medicine concepts.

Clients may seek a second opinion from another health care professional, or may terminate treatment at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Regulatory Agencies. Acupuncture is regulated by the Department of Regulatory Agencies. Any complaints should be directed to:

Department of Regulatory Agencies
1560 Broadway, Suite 1545
Denver, CO 80202
(303) 894-2464

Payment, Fee Schedule and Client Responsibility:

Unless prior arrangements have been made, clients are responsible for payment at the time service is rendered. If you need to cancel, please provide 24 hours notice. Except in an emergency situation, patient's are responsible for the appointment fee if cancellation is less than a 24-hour notice.

Initial Evaluation $110
Follow-up Treatments $75

Finally, in our view, the client-practitioner relationship is one of a team. We are working together to promote a healing experience for you. Suggestions given regarding lifestyle and diet are intended to support this process in between treatments and in some cases can be an integral and as important piece to promote healing as the needles inserted or the supplements prescribed. I look forward to working with you. Thank you for choosing Ancient Art Healing Center.

I have read and agree to the above conditions prior to treatment.

Name:_____Date:_____

Ruth A.Graham MA, LAc

Education

* Colorado School of Traditional Medicine, Denver, CO
  3 year – 1800-hour program in traditional Chinese Medicine (acupuncture and herbology)
  500 hours of clinical training
  Dipolomate of Acupuncture and Chinese Herbology, 1997
* University of Denver, Denver, CO
  Masters of Arts, Speech/ Language Pathology, 1981
* Oklahoma Christian University, Oklahoma City, OK
  Bachelors of Arts, Speech/Language Pathology, 1979

Certifications

* NCCAOM Certified Council of Colleges of Acupuncture
* Council of Colleges of Acupuncture and Oriental Medicine
  Certificate in Clean Needle Technique, 1997
* NAET Advanced Certification

Registrations and Memberships

* Colorado Acupuncture Association
  Professional Membership 1998 – present
* Historic Downtown Littleton Merchants Board Member 1999 - 2007
* Colorado of Regulatory Agencies
  Licensed Acupuncturist June 1998 – present

Mark Costello, MA, LAc

Education

*Oregon College of Oriental Medicine
Masters of Acupuncture degree includes supervised hours of internship with over 400 patient contacts

Certification

*National Board certified in acupuncture and Chinese herbology by the National Commission for the Certification of Acupuncturists.

License and Membership

*Licensed in Acupuncture by the State of Colorado

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Client Cancellation Policies

Please read the following carefully and sign below

- ❑ I understand that there is a 24-hour cancellation policy and that if I fail to notify Ancient Art Healing Center, I will be charged a **Full appointment fee.**

- ❑ I understand that being 15 minutes late to a session is considered a "no-show" and I will be charged for the full amount of my session.

I understand these policies and I will adhere to them.

_____ _____

signature date