

## New Client Intake Form & Information Sheet

### Welcome to Apothecary Tinctura!

We are a retail medicinal herb store specializing in natural remedies and health solutions for women. We have a small but busy 'clinic'/healing center/spa where we offer private consultation and treatments by skilled practitioners in a safe, nurturing environment. We specialize in women's health care integrating herbal medicine, aromatherapy, dietary counseling and Maya Uterine Massage into comprehensive holistic treatment plans.

Our mission is to provide an environment that allows healing to naturally happen...where all aspects of who we are and what our lives are about are welcome. Our goal is to provide you with the information and educational avenues needed to support self-healing and integration of herbal medicines, natural remedies and elements of self-care and beauty into your life. Whether you are here for a nurturing massage or have come seeking support for more serious health challenges, we welcome you.

### How to Find Us

We are located on the corner of 6<sup>th</sup> Avenue & Fillmore St. just north of Cherry Creek  
address: 2900 East 6<sup>th</sup> Ave, Denver 80206 tel: 303.399.1175

### Cancellation / Re-Scheduling Policy

In order to best serve our clients and respect our clinic practitioners:

- We ask for a credit card number to reserve all clinic appointments
- We require at least 24 hours notice to cancel or reschedule an appointment
- We will not charge your credit card unless you miss your appointment or cancel/change your appointment with less than 24 hours notice
- A \$45 cancellation/rescheduling fee will be charged if less than 24 hours notice is given

I have read and understand the cancellation/re-scheduling policy

Client signature \_\_\_\_\_ date \_\_\_\_\_

**scheduled date and time of first visit** \_\_\_\_\_

We look forward to seeing you soon! Please bring your completed intake form with you to your first appointment.

**New Patient Initial Intake Form**  
ALL INFORMATION WILL REMAIN CONFIDENTIAL

Name \_\_\_\_\_ Date \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_\_\_ SSN (opt.) \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_ Age \_\_\_\_ Sex M / F

Height \_\_\_\_\_ Weight \_\_\_\_\_ Marital Status \_\_\_\_\_ Occupation \_\_\_\_\_

Referred By \_\_\_\_\_

Office Use Only:	Referral Credit ____
DOB ____	Contact List ____

Reason for Today's Visit \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CONTACT**

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Preferred Contact Number (Circle One) HOME / CELL / WORK

Is it okay to leave you messages at this number? YES or NO

Email Address \_\_\_\_\_

Would you like to receive future news or promotional information? YES or NO

Emergency Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE**

PCP Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Health Insurance Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Group Number \_\_\_\_\_ Policy Number \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Please include any and all history of disease, mental/emotional/physical disorders, cause of death, and age at death (if applicable)

Mother: \_\_\_\_\_  
 \_\_\_\_\_  
 Father: \_\_\_\_\_  
 \_\_\_\_\_  
 Sister(s): \_\_\_\_\_  
 \_\_\_\_\_  
 Brother(s): \_\_\_\_\_  
 \_\_\_\_\_  
 M. Grandmother: \_\_\_\_\_  
 \_\_\_\_\_  
 M. Grandfather: \_\_\_\_\_  
 \_\_\_\_\_  
 P. Grandmother: \_\_\_\_\_  
 \_\_\_\_\_  
 P. Grandfather: \_\_\_\_\_  
 \_\_\_\_\_  
 Other: \_\_\_\_\_  
 \_\_\_\_\_

**PERSONAL MEDICAL HISTORY**

**Check any illness or condition you have or had in the past:**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> AIDs/HIV       | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Measles            | <input type="checkbox"/> Scarlet Fever    |
| <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Meningitis         | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mental disorder    | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Antibiotic use | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Typhoid fever    |
| <input type="checkbox"/> Bleed easily   | <input type="checkbox"/> High fevers         | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Vascular disease |
| <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Polio              | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Diabetes       |  | <input type="checkbox"/> Rheumatic Fever    |   |

**Current Medications and Dosage:**

- \_\_\_\_\_ for the treatment of \_\_\_\_\_
- \_\_\_\_\_ for the treatment of \_\_\_\_\_
- \_\_\_\_\_ for the treatment of \_\_\_\_\_
- \_\_\_\_\_ for the treatment of \_\_\_\_\_

**Vitamins / Supplements:**

\_\_\_\_\_  
 \_\_\_\_\_

**Diagnosed Diseases / Disorders / Surgeries:**

\_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_\_

**Labs or Diagnostic Tests (relevant to current conditions):**

Date	Test/Exam	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____

**SYSTEMS REVIEW**

Please fill this out carefully, even if some of the symptoms don't seem at all connected to your current issue! Place **one check** next to a symptom you have experienced, **two checks** next to a frequently occurring symptom, and **three checks** next to a symptom that is particularly distressing to you.

Head and Face

Headaches  
Dizziness  
Memory Loss  
Other

Eyes

Blurry Vision  
Eyelid Twitch  
Floaters  
Pain  
Other

Nose

Frequent Colds  
Sinus Issues  
Bleeding  
Other

Mouth

Dental Problems  
Gum Problems  
Teeth Grinding/TMJ  
Unusual Tastes  
Other

Throat

Sore Throat  
Hoarseness  
Lump in Throat  
Dryness  
Other

Respiration

Difficulty Inhaling  
Difficulty Exhaling  
Pain  
Cough  
Congestion  
Shortness of Breath  
Other

Heart and Chest

High Blood Pressure  
Low Blood Pressure  
Chest Pain  
Chest Tightness  
Difficulty Lying Down  
Pace Maker  
Other

Circulation

Easy Bruising  
Easy Bleeding  
Cold Hands or Feet  
Cold Limbs  
Raynaud's Syndrome  
Other

Gastrointestinal

Always Thirsty  
Never Thirsty  
Excessive Appetite  
Gas/Bloating  
Abdominal Pain  
Nausea  
Diarrhea/Loose Stools  
Constipation  
Rectal Bleeding  
Colon Problems  
Other

Urination

Frequent  
Difficult  
Painful  
Nocturnal  
Bleeding  
Other

Energy Level

Low  
High

Skin

Acne  
Dryness  
Moles that Change  
Lumps  
Excessive Sweating  
Night Sweats  
Rarely Sweat  
Other

Neurological

Tremors  
Numbness or Tingling  
Nerve Pain  
Other

Sleep

Insomnia  
Drowsiness  
Excessive Dreaming  
Restless  
Other

Emotions

Depression  
Anxiety  
Sadness  
Anger/Irritability  
Worry  
Other

Pain – Please Describe

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Food Allergies - List

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**WOMEN ONLY**

Are you, or could you be pregnant? \_\_\_\_\_ If so, how far along? \_\_\_\_\_ weeks

Number of Pregnancies \_\_\_\_\_ Births \_\_\_\_\_ Abortions \_\_\_\_\_ Miscarriages \_\_\_\_\_

What form of birth control do you use? \_\_\_\_\_

Age of first menses \_\_\_\_\_ Age of menopause, if applicable \_\_\_\_\_

Have you ever had any gynecological surgeries or any abnormal findings on any tests?

Are your periods irregular, uncomfortable or painful? \_\_\_\_\_

Are you experiencing any low or high sexual desires? \_\_\_\_\_

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**MEN ONLY**

Do you experience any of the following:

Reduced Libido \_\_\_\_\_ Excessive Libido \_\_\_\_\_ Impotence \_\_\_\_\_

Urinary Frequency \_\_\_\_\_ Premature Ejaculation \_\_\_\_\_ Discharge \_\_\_\_\_

Genital/ Testicular pain \_\_\_\_\_

Any other concerns? \_\_\_\_\_

*I authorize treatment by the practitioners at Eastern Roots Medicine. All information that I have provided above is correct and complete to the best of my knowledge. I understand that I am responsible for payment of all fees to Eastern Roots Medicine on the day of services rendered unless other arrangements are made in advance.*

\_\_\_\_\_  
Patient's or Guardian's signature

\_\_\_\_\_  
Date

**CONSENT TO TREATMENT**

I, \_\_\_\_\_, do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at the Eastern Roots Medicine

Clinic. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important part of your healthcare.

**Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat physical and energetic imbalance or disease, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

**Direct Moxibustion:** I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

**Chinese Herbs:** I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Eastern Roots Medicine Clinic as soon as possible.*

**Acupressure/Tui-Na/Shiatsu Massage and Cupping:** I understand that I may also be given acupressure/tui-na/shiatsu massage or cupping as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

**Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City, State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION  
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

I understand that as part of my healthcare, this clinic originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

**I understand that this information serves as:**

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

**I understand that I have the right:**

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

\_\_\_\_\_

**Optional: Please list any individuals you would like to allow access to your records upon request (ie: Other healthcare providers, spouse, etc):**

\_\_\_\_\_  
\_\_\_\_\_

**Patient:**

X \_\_\_\_\_

**Patient Signature**

**Date**

**Witness**

**Signature**

**or Legal Representative**

Office Use Only:

detpeccA 1 \_\_\_\_\_

1 Denied

Signature

Title

Date

**COLORADO MANDATORY DISCLOSURE STATEMENT**

Education & Experience

Emily Jo Kehnast earned her Masters of Science in Oriental Medicine degree from the Southwest Acupuncture College in Boulder, CO on August 21, 2010. This four-year program consists of 3,045 hours of education including over 1,000 hours of clinical practice. She is certified as a Diplomate in Acupuncture and Traditional Chinese Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). This includes certification in Clean Needle Technique and Chinese Herbology. She has studied and practiced in many specialty clinics including Oncology, OB/GYN, AIDs, and Pediatrics. Emily’s training includes adjunctive therapies such as moxibustion, tui na, shiatsu, acupressure, cupping, gua sha, auriculotherapy, qi gong, and dietary & lifestyle recommendations.

Emily is a member of the Acupuncture Association of Colorado and the American Association of Oriental Medicine. She is a registered and licensed acupuncturist in Colorado since November 2010. None of her licenses, certificates, or registrations have ever been suspended or revoked.

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

Fee Schedule

Intake Consultation and Treatment	\$100
Follow-up Treatment	\$75
Herbal Consultation only	\$45
Herbal Prescription	VARIES

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 Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

I have read and understand this document.

\_\_\_\_\_  
Patient’s or Guardian’s Signature

\_\_\_\_\_  
Date

**CANCELLATION POLICY**

We require a minimum of 24 hours notice to cancel an appointment. If you are unable to contact us in time we will charge 50% of the cost of the scheduled appointment to your account. We understand that life can be distracting and complicated sometimes, so we will waive this fee the first time. If it happens again, we must enforce the policy since it affects the clinic on many different levels. Thank you for your understanding and respect of this policy.

I, \_\_\_\_\_, agree to the cancellation policy explained above.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date