Kalin Davidov, L. Ac. , M.S.TCM

PATIENT INFORMATION

Patient Name _____ Male ____ Female ____

Date of Birth ____/____/_____ SSN_____ Height _____ Weight _____

Marital Status _____
Phone (cell) _____

Address_____
City _____ State _____ Zip _____

E-mail _____ Phone (home) _____
Occupation_____ Phone (work) _____

Family Physician _____ Phone _____
Referred by _____ Phone _____

Emergency Contact

Name _____
Relationship _____
Phone _____

Chief Complaint How long you've had the condition.

Other Complaints How long you've had the conditions.

What kinds of treatments have you received?
List any Hospitalizations & Surgeries **Date** **Place**

_____
_____
_____

List medications being taken (including dose)

_____
_____
_____

Signature _____ **Date** _____

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Patient Health History

Name: _____ Date: ____/____/_____

Please check if you have had in the past three months:

General

[ ] Anemia
[ ] Fatigue
[ ] Fever
[ ] Weight Loss
[ ] Sweats
[ ] Chills
[ ] Drug Addiction
[ ] Poor Appetite
[ ] Localized Weakness
[ ] Bleed or Bruise Easily
[ ] Peculiar Tastes or Smells
[ ] Strong Thirst (hot or cold drinks)
[ ] Sudden Energy Drop
[ ] Poor Sleep Habits
[ ] Tremors
[ ] Poor Balance
[ ] Cravings
[ ] Weight Gain
[ ] Alcoholism
[ ] Tetanus Shot
[ ] Frequent cold/flu

Skin and Hair

[ ] Rashes
[ ] Itching
[ ] Dandruff
[ ] Change in hair/skin texture
[ ] Ulcerations
[ ] Eczema
[ ] Open sore
[ ] Acne
[ ] Corns
[ ] Warts
[ ] Psoriasis
[ ] Recent moles
[ ] Loss of Hair
[ ] Hives
[ ] Nail Problems
[ ] Dry skin

Head, Eyes, Ears, Nose and Throat

[ ] Dizziness/Vertigo
[ ] Poor Vision
[ ] Cataracts
[ ] Ringing in ears
[ ] Sinus Problems
[ ] Grinding Teeth
[ ] Nasal Congestion
[ ] Headaches
[ ] Concussions
[ ] Eye Strain
[ ] Night Blindness
[ ] Blurry Vision
[ ] Poor Hearing
[ ] Nose Bleeds
[ ] Hoarseness
[ ] Migraines
[ ] Eye Pain
[ ] Color Blindness
[ ] Earaches
[ ] Spots in front of eyes
[ ] Recurrent Sore Throats
[ ] Facial Pain

Cardiovascular

[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Palpitations
[ ] Irregular Heartbeat
[ ] Mitral Stenosis
[ ] Mitral Prolapse
[ ] Myocarditis
[ ] Pneumatic Heart Disease
[ ] Chest Pain
[ ] Varicose Veins
[ ] Swelling of Hands/Feet
[ ] Fainting
[ ] Coronary Heart Disease
[ ] Difficulty in Breathing
[ ] Hardening of Arteries
[ ] Phlebitis
[ ] Blood Clots
[ ] Cold hands/feet

Respiratory

[ ] Cough
[ ] Bronchitis
[ ] Difficulty breathing lying down
[ ] Emphysema
[ ] Coughing Blood
[ ] Pneumonia
[ ] Asthma
[ ] Pain w/ deep breath
[ ] Production of Phlegm
[ ] Pleurisy

Gastrointestinal

[ ] Nausea
[ ] Vomiting
[ ] Bad Breath
[ ] Abdominal Pain or Cramps
[ ] Indigestion
[ ] Ulcer
[ ] Constipation
[ ] Gas
[ ] Blood in Stools
[ ] Rectal Pain
[ ] Chronic Laxative Use
[ ] Colitis
[ ] Diarrhea
[ ] Belching
[ ] Black Stools
[ ] Hemorrhoids
[ ] Acid Reflux

Genitourinary

[ ] Bed Wetting
[ ] Kidney Infections / Stones
[ ] Genital Herpes
[ ] Cystitis [ ] Incontinence
[ ] Blood in Urine
[ ] Painful Urination
[ ] Venereal Disease
[ ] Frequent Urination
[ ] Bladder Infections
[ ] Prostate Problems

Pregnancy and Gynecology

[ ] Number of Pregnancies
[ ] Number of Abortions
[ ] Number of Births
[ ] Number of Miscarriages
[ ] Use of Birth Control
[ ] Clots
[ ] Hot Flash/Night Sweats
[ ] Age at 1st Menstruation
____ Time between Menstruation
____ Duration of Menstruation
____ First Date of Last Menstruation
[ ] Irregular Periods
[ ] Endometriosis
[ ] Frequent changes in emotion
[ ] Unusual Character (heavy/light)
[ ] Vaginal Sores
[ ] Vaginal Discharge
[ ] Breast Lumps
[ ] Painful Periods/Cramps
[ ] Uterine Fibroids
[ ] Osteoporosis

Musculoskeletal

[ ] Neck Pain
[ ] Back Pain
[ ] Hand/Wrist Pain
[ ] Muscle Pains
[ ] Muscle Weakness
[ ] Shoulder Pain
[ ] Knee Pain
[ ] Foot/Ankle Pain
[ ] Hip Pain

Neuropsychological

[ ] Seizures
[ ] Areas of Numbness
[ ] Concussion
[ ] Bad Temper
[ ] Difficulty Concentrating
[ ] Dizziness
[ ] Lack of Coordination
[ ] Depression
[ ] Easily susceptible to stress
[ ] Loss of Balance
[ ] Poor Memory
[ ] Anxiety
[ ] ADD

Infection

[ ] Measles
[ ] Rheumatic Fever
[ ] Malaria
[ ] Small Pox
[ ] Mumps
[ ] Tuberculosis
[ ] Chicken Pox
[ ] Whopping Cough
[ ] Typhoid Fever
[ ] Scarlet Fever

Are you allergic to any of the following?

( ) Medicine
( ) Food
( ) Herbs
( ) Others

Do you have or are you any of the following?

( ) Pacemaker
( ) Electric Implants
( ) Metal Implants
( ) Severe Bleeding Disorders
( ) Pregnant
( ) HIV Positive
( ) Hepatitis A/B/C

Do you consume:

Coffee: [ ] moderate [ ] medium [ ] heavy
Alcohol: [ ] moderate [ ] medium [ ] heavy
Tea: [ ] moderate [ ] medium [ ] heavy
Tobacco: [ ] moderate [ ] medium [ ] heavy

Family History (please include the relation)

[ ] Migraines _____
[ ] Heart Disease _____
[ ] Allergies _____
[ ] Asthma _____
[ ] Arthritis _____
[ ] Diabetes _____
[ ] Glaucoma _____
[ ] Stroke _____
[ ] High Blood Press _____
[ ] Mental Illness _____
[ ] Gall Stones _____
[ ] Cancer _____
[ ] Thyroid Disease _____
[ ] Epilepsy _____

Signature _____ **Date** _____

Kalin Davidov

Acupuncture Consent to Treatment

I hereby request and consent to the performance of Acupuncture treatments and other Oriental Medicine procedures on me (or on the patient named below, for which I am legally responsible) by the licensed Acupuncturist named below.

I understand that methods or treatments may include, but are not limited to, Acupuncture, moxabustion, cupping, bleeding, electrical stimulation, Tui Na Massage, Gua Sha, Plum Blossom, Chinese or Western Herbal Medicine, nutritional counseling and/or supplementation.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain and to treat certain diseases of dysfunction of the body. I have been informed that Acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances of spontaneous miscarriage and pnuemothorax. There may be some bruising after cupping. I do not expect the Acupuncturist to be able to anticipate all risks and complications. I wish to rely on the Acupuncturist to exercise correct judgment during the course of the procedure which the Acupuncturist feels at the time, based on the facts then known, and is in my best interests._____**initials**

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the Acupuncturist immediately._____**initials**

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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.

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss any emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above.

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation._____**initials**

I agree to pay all charges incurred for services rendered, over and above insurance coverage.

By signing below, I agree to the above-named procedures. 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:

Patient's name

Patient's signature

Date signed **Date of Birth**

Are you pregnant?

Kalin Davidov, L.Ac, D.OM.

Name of Licensed Acupuncturist

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.

Name of Patient

Patient's Representative

Relationship of Authority of Patient

Witness

COLORADO MANDATORY DISCLOSURE STATEMENT

Kalin Davidov,
Center for Neuromuscular Massage Therapy
3955 E. Exposition Ave. #320
303-777-1151

Education and Experience
Kalin Davidov earned his Master of Science in Traditional Chinese Medicine from the Colorado School of Traditional Chinese Medicine in April 2015. This three-year program consists of 2,850 hours of education including over 700 hours of clinical practice. Kalin's training includes adjunct therapies such as Acupuncture, Moxibustion, Chinese massage, Cupping, Plum Blossom, Auriculotherapy, and dietary and lifestyle recommendations.

Kalin is certified as a Diplomate in Acupuncture and Traditional Chinese Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in April 2015. This includes certification in Clean Needle Technique and Chinese Herbology. He is a licensed acupuncturist in Colorado. None of these licenses, certificates, or registrations has 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	$110 + cost of herbs
Follow-up Treatment	$75 + cost of herbs
Herbal Consultation only	$40

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if know.
- 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*

24 HOUR CANCELLATION POLICY

Center for Neuromuscular Massage Therapy, Inc has a 24-hour cancellation policy. This means as a patient or client, you need to notify the clinic twenty-four hours in advance if you are unable to keep your scheduled appointment.

Your therapist sets aside time for you, and does not get paid if you do not either keep your appointment, cancel, or pay the late cancellation fee.

We certainly understand that situations can arise over which you have no control. However, if appointments are missed without notice, more than once, you will be charged a cancellation fee of $35. **YOUR INSURANCE COMPANY WILL NOT PAY THIS FEE.** It will be your responsibility, and billed directly to you.

Thank you for your consideration of our time, and of other clients who would benefit from that time.

Signed_____ Date_____