RICHARD WOODWARD, L.AC., DIPL.AC.

THREE PILLARS ACUPUNCTURE
6857 S. HILL ST.
LITTLETON, CO 80120-3616

Disclosure Statement

The practice of acupuncture in the state of Colorado is regulated by the Department of Regulatory Agencies. Adjunctive therapies as defined by traditional oriental medical concepts and included under the auspices of acupuncture include tui na, Chinese herbal medicine, fire cupping, bleeding, moxibustion, acupressure, electroacupuncture, plum blossom, gua sha, intradermal needles, auricular acupuncture, ion cord and magnet therapy. As a practitioner of acupuncture and Traditional Chinese Medicine, I comply with the rules and regulations promulgated by the Department of Health and the Department of Regulatory Agencies with respect to C.R.S. 12-29-103. This clinic uses only individually packaged, sterilized, disposable needles, and adheres to the rules regarding the sanitation of acupuncture offices. As a prospective client, you are entitled to receive information about the methods of therapy, the technique used, and the duration of therapy if known. You are entitled to seek a second opinion from another health care provider or 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 Registration at the Department of Regulatory Agencies. Please direct correspondence to: The Director of the Division of Registrations, 1560 Broadway #1545, Denver, CO, 80202, or call 303-894-2464.

Fee Schedule*

• Initial Intake, Consultation & Treatment	$125 + cost of herbs
• Follow-up Consultation & Treatment	$75 + cost of herbs
• Out calls	$50 additional

Education

☯ Externship in Acupuncture & Moxibustion — 2006
- International Acupuncture Training Center, State Administration of TCM, Beijing, People's Republic of China

☯ Diploma, Traditional Chinese Medicine — 2001
- Colorado School of Traditional Chinese Medicine, Denver, Colorado
- 3 year, 1800 hour professional career program
- An additional 180 hours of direct clinical experience in the Denver community

Ψ Bachelor of Arts, Psychology — 1995
- University of Northern Colorado, Greeley, Colorado

Professional Memberships, Certifications, Etc.

- Acupuncture Association of Colorado, Former Board Member
- Council of Colleges of Acupuncture & Oriental Medicine, Clean Needle Technique Certification
- National Certification Commission for Acupuncture & Oriental Medicine, Diplomate in Acupuncture
- Colorado Department of Regulatory Agencies, Licensed Acupuncturist

note: None of the above licenses or certifications have ever been suspended or revoked at any time.

By signing below, I acknowledge that I have read and understand the information contained in this document.

Patient's Signature _____ Date: _____

* Fees reflect payment received on the same day services are rendered.

Notice of Privacy Practices

Roaring Fork Acupuncture & Massage, Inc., (RFAM, Inc.) dba Three Pillars Acupuncture will responsibly use your individually identifiable health information (referred to as "confidential information"). This includes information that is created or received by a health care provider, health plan, or your employer (in the case of Workman's Compensation). It also includes information related to your past, present and future physical and mental health, and payment for the provision of your health care.

RFAM, Inc., may use and/or disclose your confidential information without your authorization for the following purposes:

- Providing treatment, payment, or health care operations.
- Billing, and getting authorization for treatment from insurance companies and Workman's Compensation.
- Providing appointment reminders or information about treatment alternatives, other health related benefits, and services.
- RFAM, Inc., may also use/and or disclose your confidential information without your authorization as permitted or required by law, (i.e. to a public health authority or to the FDA, or for work related illness or injuries, or to the sponsor of a group's health plan, health insurance issuer, or HMO).

Your authorization is required for RFAM, Inc., to release your confidential information to other health care providers or have other individuals receive information about you. You may revoke that authorization in writing at any time.

You have the right to:

- Request an alternate address or method of contacting you.
- Inspect and copy your confidential information.
- Request restrictions on certain uses or disclosures; however, these restrictions are subject to agreement by RFAM, Inc.
- Receive an accounting of the disclosures RFAM, Inc., makes involving your confidential information.
- Amend your confidential information (in limited situations).

RFAM, Inc., will maintain the privacy of confidential information as required by law and by the notice currently in effect. RFAM, Inc., is also required by law to provide this notice of legal duties and privacy practices related to protected health information. This notice is effective April 14, 2003. RFAM, Inc., also reserves the right to make changes or revisions to the terms of this notice, and will make available at the office a new notice if any material changes are made.

If you believe that your rights have been violated, you may contact RFAM, Inc., or the director of the Colorado Department of Human Services. You will not be penalized for filing a complaint. You may send information to either party at the appropriate addresses listed below:

Roaring Fork Acupuncture & Massage, Inc.
6857 S. Hill St.
Littleton, CO 80120

Colorado Department of Human Services
1575 Sherman St.
Denver, CO 80203-1714

By signing below, I certify that I have read this notice and understand my rights in regards to the handling of my confidential information.

X_____ _____

Signature Date

Client Information

Please complete this form as thoroughly as possible. Some questions may seem unrelated to your condition, but the answers affect your diagnosis and treatment. All information is confidential.

First Name _____ Last Name _____ Date _____

Gender: ☐ M ☐ F Date of Birth _____ Age _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Place of Employment _____ Occupation _____

Insurance Coverage: ☐ Y ☐ N Carrier _____

How did you hear about us? (Please circle): Internet Website Fundraiser Radio

Friend or Family (Name) _____

Other _____

Major complaints, in order of importance to you:

#1 _____ Severe _____ Moderate _____ Slight _____

Describe your symptoms _____

When/how did this condition occur? _____

How does this condition impair your daily activities? _____

Treatments you have received for this condition? _____

Do you feel better since the onset of this condition? _____

#2 _____ Severe _____ Moderate _____ Slight _____

Describe your symptoms _____

When/how did this condition occur? _____

How does this condition impair your daily activities? _____

Treatments you have received for this condition? _____

Do you feel better since the onset of this condition? _____

#3 _____ Severe _____ Moderate _____ Slight _____

Describe your symptoms _____

When/how did this condition occur? _____

How does this condition impair your daily activities? _____

Treatments you have received for this condition? _____

Do you feel better since the onset of this condition? _____

Please rate your commitment to feeling better (On a scale of 1 to 10): _____

What are your goals for your acupuncture visits? _____

Have you had acupuncture treatments before? _____

Please list any concerns you may have regarding acupuncture and Chinese medicine: _____

_____

ACUPUNCTURE
MEDICAL CONDITIONS

Please list conditions and surgeries you have had, along with the year diagnosed:

Year	Condition/Surgery

Please list all prescription medications you take, including those you use occasionally and Inhalers, nose sprays, and eye drops:

Medication/Dose	Purpose	Length of Time	Last Dose

Please list all supplements you take including vitamins:

Medication/Dose	Purpose	Length of Time	Last Dose

Please list any allergies (seasonal, medications, environmental, food, etc.):

_____

_____

Please list any occupational concerns (stress, computer work, heavy lifting, etc):

_____

Please tell us about your exercise (regular, minimal, etc.):

_____

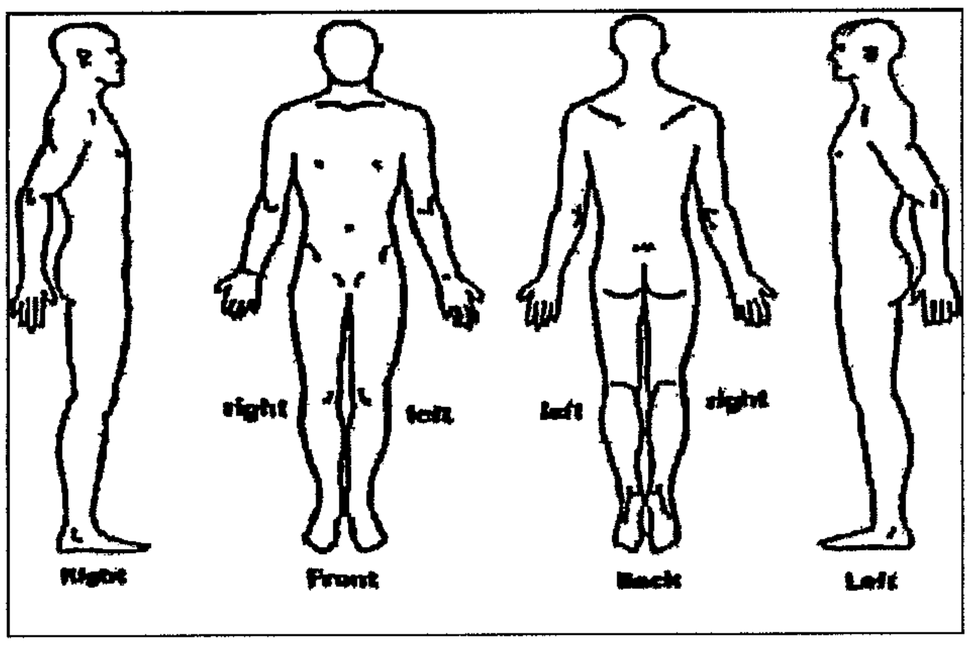
Musculoskeletal (Please list areas where you have problems, if any):

Muscle Cramps? _____ Muscle Pain? _____

Joint Swelling? _____ Tendonitis? _____

Arthritis? _____ Bursitis? _____

Please label (A,B,C,D) problem areas on diagram, then answer the questions about each area:



A: Sharp _____ Burning _____ Aching _____
Fixed _____ Other _____

B: Sharp _____ Burning _____ Aching _____
Fixed _____ Other _____

C: Sharp _____ Burning _____ Aching _____
Fixed _____ Other _____

D: Sharp _____ Burning _____ Aching _____
Fixed _____ Other _____

Symptom Index

Note: For each symptom you currently have, rate its severity on a scale from 1 – 5 (1 being the least severity and 5 being the worst severity) Leave blank if Not Applicable

_____ Irritability / Anger
_____ Depression / Stress
_____ Headache / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Blurred Vision
_____ Dizziness
_____ Gall Stones
_____ Feeling of Lump in the Throat
_____ Clenching of Teeth at Night
_____ Muscle Cramping/Twitching
_____ Tension
_____ Joints/Neck/Shoulder Pain/Tight
_____ Poor Circulation
_____ Soft / Brittle Nails
_____ Emotional Eater

_____ Urinary/ Problems
_____ Bladder Infection
_____ Lack of Bladder Control
_____ Weakness / Pain in Lower Back
_____ Decreased Bone Density
_____ Feel Cold Easily
_____ Low Sex Drive
_____ Excess Sexual Desire
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities
_____ Crave / Avoid Salty Foods
_____ Fear
_____ Hot Flush / Night Sweating

_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life

_____ Dry Cough
_____ Cough with Sputum
_____ Nasal Discharge
_____ Post-Nasal Drip
_____ Sinus Infections/Congestion
_____ Itchy, Red or Painful Throat
_____ Dry Mouth / Throat / Nose
_____ Skin Rashes / Hives
_____ Snoring
_____ Gr[a] f / Sadness
_____ Shortness of Breath
_____ Allergies / Asthma
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever Comes & Goes
_____ Smoke Cigarettes

_____ Heaviness in the body
_____ Fatigue / Worse after eating
_____ Hard to get up in the am
_____ Edema (Swelling)
_____ Muscles feel tired often
_____ Easily Bruising or Bleeding
_____ Bad Breath
_____ Decreased / Increased Appetite
_____ Craves Sweets
_____ Hypoglycemia
_____ Difficulty Digesting Oily Foods
_____ Nausea / Vomiting
_____ Gas / Belching
_____ Insulin Sensitivity
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over-Thinking
_____ Tendency to Gain Weight
_____ Brain Fog

_____ Cold Entire Body
_____ Cold Extremities
_____ Hot All Day
_____ Hot Only in Afternoons
_____ Hot Only at Night
_____ Normal Body Temp

ENERGY LEVEL: (Please circle)

Low 1 2 3 4 5 6 7 8 9 10 High

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a **"C"** under the appropriate person's column. **"P"** should be used to indicate a past problem. Leave blank those that do not apply.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
AIDS/HIV											
Alcohol											
Anxiety											
Arthritis											
Asthma /Hay Fever/Allergy											
Back trouble											
Bursitis											
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Tobacco											
Weight Problem											
Other Emotional Problems: _____											
Other: _____											

If any of the above family members are deceased, please list their age at time of death and cause:

_____

_____

ACUPUNCTURE
PERSONAL INFORMATION

For Women Only

Have you had a hysterectomy? ☐Yes ☐No

Ovaries removed? ☐Yes ☐No
Post-menopausal bleeding? ☐Yes ☐No
Could you be pregnant at this time? ☐Yes ☐No

Number of: Pregnancies _____ Births _____
Miscarriages _____ Abortions _____
When did your last period end? _____

Number of days in your monthly cycle? _____

Number of days bleeding lasts? _____

Describe menstrual flow:
☐ Heavy ☐ Moderate ☐ Light ☐ None

Color of menstrual flow:
☐ Dark ☐ Bright Red ☐ Slightly Reddish

Birth Control:
☐ None ☐ Birth Control Pills ☐ IUD
☐ Spermicides ☐ Barriers ☐ Other _____

Do you suffer from:
Cramping? ☐Yes ☐No
☐ Before period ☐ During period ☐ After period
☐ Mild ☐ Moderate ☐ Severe

Clotting? ☐Yes ☐No
☐ Bright in color ☐ Dark in color

Do you suffer from any of the following:
☐ Bleeding between periods ☐ Infertility
☐ Pelvic Inflammatory Disease ☐ Ovarian cysts
☐ Endometriosis ☐ Hot Flashes ☐ Mastitis
☐ Breast Cysts ☐ Yeast Infections/Vaginitis
☐ Other _____

Premenstrual Syndrome
☐ Fluid Retention ☐ Fluctuating Emotions
☐ Cravings ☐ Irritability ☐ Depression
☐ Tenderness in Breasts ☐ Fatigue

For Men Only

☐ Impotence ☐ Testicular Pain/Lump
☐ Weak Erection ☐ Discharge from Penis
☐ Infertility ☐ Prostate Problems
☐ Premature Ejaculation ☐ Low Sex Drive

For Women and Men
Diet Information

Please describe your appetite:
☐ Strong ☐ Normal ☐ Poor
Do you hunger quickly? ☐ Yes ☐ No
Please describe your diet (low-fat, low-carb, vegetarian, etc.): _____

_____

Please list what you ate yesterday:
Breakfast _____
Lunch _____
Dinner _____
Snacks _____
How much water do you drink per day?

_____
Other fluids? _____
Please describe your thirst:
Strong Normal Poor

If you eat any of the following, please check and list how much per week:
☐ Candy _____
☐ Cookies/Baked goods _____
☐ Chocolate _____
☐ White flour bread _____
☐ Soda - Regular/Diet _____
☐ Milk _____
☐ Cheese _____
☐ Yogurt _____
☐ Eggs _____
☐ Ice-cream _____
☐ Pasta _____
☐ Coffee _____
☐ Alcohol _____
☐ Fast Food _____
☐ Protein _____
☐ Dark Green Vegetables _____
☐ Fruit _____
☐ Other _____

ACID-ALKALINE QUESTIONNAIRE

SECTION A - HISTORY

Circle the number score for each yes answer.

1. Have you taken tetracyclines (Sumycin, Panmycin Minocin, Vibramycin, etc.) or other antibiotics for one month or longer? **35**
2. Have you ever taken other "broad spectrum" antibiotics for urinary, respiratory. or other infections for two months or longer, or in shorter courses, four or more times in a one-year period? **35**
3. Have you ever taken a "broad spectrum" antibiotic? **6**
4. Have you ever been bothered by persistent prostatitis, vaginitis, or other reproductive organ problems? **25**
5. Have you been pregnant two or more times? **5**
   Pregnant one time? **3**
6. Have you taken birth control pills for more than two years? **15**
   For six months to two years? **8**
7. Have you taken Prednisone, Decadron, or other cortisone-type drugs for more than two weeks? **15**
   For two weeks or less? **6**
8. Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke moderate to severe symptoms? **20**
   Mild symptoms? **5**
9. Are symptoms worse on damp, muggy days, or in moldy places? **20**
10. Have you had severe or persistent athlete's foot, ring worm, jock itch, or chronic fungus infections of the skin or nails? **20**
    Mild to moderate? **10**
11. Do you crave sugar? **10**
12. Do you crave breads? **10**
13. Do you crave alcoholic beverages? **10**
14. Does tobacco smoke really bother you? **10**

SECTION A TOTAL _____

SECTION B - MAJOR SYMPTOMS

Enter the appropriate score for each symptom below.
If a symptom is *occasional* or *mild*, score **3 points**.
If a symptom is *frequent* or *moderately severe*, score **6 points**.
If a symptom is *severe* or *disabling*, score **9 points**.

1. Fatigue or lethargy _____
2. Feeling of being "drained" _____
3. Poor memory _____
4. Feeling "spacey" or "unreal" _____
5. Depression _____
6. Numbness, burning, or tingling _____
7. Muscle aches _____
8. Muscle weakness or paralysis _____
9. Joint pain _____
10. Abdominal pain _____
11. Constipation _____
12. Diarrhea _____
13. Bloating _____
14. Troublesome vaginal discharge _____
15. Persistent vaginal burning or itching _____
16. Prostatitis _____
17. Impotence _____
18. Loss of sexual drive _____
19. Endometriosis _____
20. Cramps or other menstrual irregularities _____
21. Premenstrual tension _____
22. Spots in front of eyes _____
23. Erratic vision _____

SECTION B TOTAL _____

SECTION C – OTHER SYSTEMS

Enter the appropriate score for each symptom below.
If a symptom is *occasional* or *mild*, score **1 points**.
If a symptom is *frequent* or *moderately severe*, score **2 points**.
If a symptom is *severe* or *disabling*, score **3 points**.

1. Drowsiness _____
2. Irritability or jitteriness _____
3. No coordination _____
4. Inability to concentrate _____
5. Frequent mood swings _____
6. Headaches _____
7. Dizziness/loss of balance _____
8. Pressure above ears, head tingling _____
9. Itching _____
10. Rashes _____
11. Heartburn _____
12. Indigestion _____
13. Belching and intestinal gas _____
14. Mucus in stools _____
15. Hemorrhoids _____
16. Dry mouth _____
17. Rash or blisters in mouth _____
18. Bad breath _____
19. Joint swelling or arthritis _____
20. Nasal congestion or discharge _____
21. Postnasal drip _____
22. Nasal itching _____
23. Sore or dry throat _____
24. Cough _____
25. Pain or tightness in chest _____
26. Wheezing or shortness of breath _____
27. Urgency or urinary frequency _____
28. Burning on urination _____
29. Failing vision _____
30. Burning or tearing of eyes _____
31. Recurrent infections or fluid in cars _____
32. Ear pain or deafness _____

SECTION C TOTAL _____

GRAND TOTAL SCORE _____

Your Grand Total Score will help determine if your health problems are yeast-connected

Yeast-connected health problems are:	**Women**	**Men**
Almost certainly present with scores over	180	140
Probably present with scores over	120	90
Possibly present with scores over	60	40

Women with scores less than 60 and men with scores less than 40 are less apt to have yeast-connected health problems.