

TRADITIONAL CHINESE MEDICAL CLINIC, Inc.
700 West Mountain Avenue
Fort Collins, CO 80521
Phone: 970-416-0444 Fax: 970-416-0888



神道 神道
Shen Dao - "The Way of Spirit"

Olivario Pijoan
Licensed Acupuncturist (CO, NM)
Doctor of Oriental Medicine (NM)
Michael Johnston
Licensed Acupuncturist (CO, CA, NY)

Patient Information

Name: _____

Date: _____

Occupation: _____

Age: _____

How did you hear about this office? _____

Main problem you would like help with?

How long have you had this problem?

To what extent does this problem interfere with your daily activities?

Have you been given a diagnosis for this problem? If so, what?

What other treatments have you tried, and what has been your response?

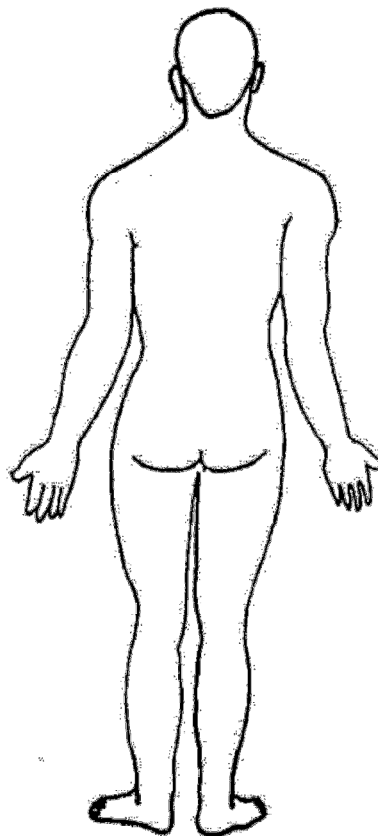
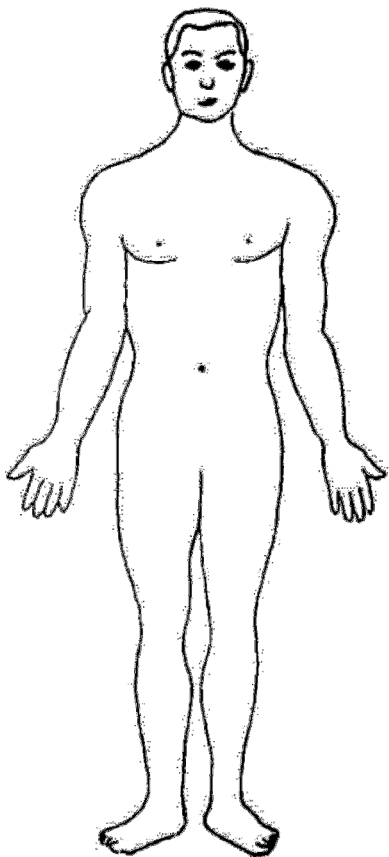
Medical History

Please indicate any of the following significant illnesses and the date of occurrence...

- | | | |
|---------------------------|-----------------------------|---------------------|
| _____ Cancer | _____ Diabetes | _____ Hepatitis |
| _____ Thyroid Disease | _____ Respiratory Allergies | _____ Seizures |
| _____ Food Allergies | _____ Venereal Disease | _____ Heart Disease |
| _____ High Blood Pressure | _____ Rheumatic Fever | _____ Other: _____ |
| _____ Alcohol Addiction | _____ Drug Addiction | _____ |

Musculo-Skeletal

Indicate areas where you experience pain...



The following best describes the nature of these pains on a scale of 1 to 10...

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Empty | <input type="checkbox"/> Worse when Humid |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Tight | <input type="checkbox"/> Worse when Dry |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Heavy | <input type="checkbox"/> Worse when Hot |
| <input type="checkbox"/> Distending | <input type="checkbox"/> Moving | <input type="checkbox"/> Worse when Cold |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Aggravated by Diet |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Worse in the Day | <input type="checkbox"/> Worse with Stress |
| <input type="checkbox"/> Cutting | <input type="checkbox"/> Worse at Night | |

When did you first experience discomfort or pain?

If the pain is due to an injury, or you know the cause of the pain, please explain.

Is there anything that makes you feel better?

Surgery

Please list your past surgeries, and their dates...

Please check if you have experienced any of the following in the last 3 months...

General

- | | | |
|--|--|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Sudden Energy Drop |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Fevers | <input type="checkbox"/> Sweat Easily |
| <input type="checkbox"/> Easy to Bleed or Bruise | <input type="checkbox"/> Peculiar Tastes or Smells | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Strong Thirst | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Tremor | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Cravings | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Change in Appetite | <input type="checkbox"/> Puffiness or Swelling | <input type="checkbox"/> Other: _____ |

Skin and Hair

- | | | |
|--------------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Skin Ulcers | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Pimples | <input type="checkbox"/> Recent Moles |

Head, Eyes, Nose, and Throat

- | | | |
|--|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Glasses | <input type="checkbox"/> Poor Vision |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Gum Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Concussions | <input type="checkbox"/> Eye Strain |
| <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Poor Hearing |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Jaw Click |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Color Blindness |
| <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Spots in Front of Eyes | <input type="checkbox"/> Recurrent Sore Throat |
| <input type="checkbox"/> Lip or Tongue Sores | | |

Cardiovascular

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Swelling of Hands | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Swelling of Feet | <input type="checkbox"/> Fainting | <input type="checkbox"/> Light Headedness |

Respiratory

- | | | |
|---------------------------------|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Difficult Breathing |
| <input type="checkbox"/> Phlegm | <input type="checkbox"/> Coughing up Blood | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Painful Breathing | <input type="checkbox"/> Other: _____ |

Gastro-Intestinal

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Black Stools | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Chronic Laxative Use | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Intestinal Gas |
| <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Loss of Appetite |

Genito-Urinary

- | | | |
|---|---|---|
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Urgency to Urinate | <input type="checkbox"/> Unable to Hold Urine |
| <input type="checkbox"/> Decrease in Urine Flow | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Cloudy Urine | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Genital Sores | <input type="checkbox"/> Frequent Night Urination | |

Gynecology - Pregnancy

- | | | |
|--|--|---|
| <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Clots | <input type="checkbox"/> Premature Births |
| <input type="checkbox"/> Painful Periods | <input type="checkbox"/> PMS | <input type="checkbox"/> Miscarriages |
| <input type="checkbox"/> Heavy Flow | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Abortions |
| <input type="checkbox"/> Light Flow | <input type="checkbox"/> Yeast Infections | <input type="checkbox"/> Menopausal |
| <input type="checkbox"/> Spotting | <input type="checkbox"/> Vaginal Sores | <input type="checkbox"/> Postmenopausal |

Age at 1st Menses, _____. Date of last Menses, _____. Duration of Menses, _____ days.
 Number of days from 1st day of menses to 1st day of next menses, _____ days.
 Number of live births, _____, complications? _____
 Method of birth control used, _____

Neuro - Psychological

- | | | |
|---------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Numb Body Areas | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Twitches | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Bad Temper | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Tremors | <input type="checkbox"/> Other _____ |

Diet - Personal Habits

Which of the following best describes your diet?
 Total Vegetarian (eats no eggs, dairy, nor any meat of any kind)
 Lacto-ovo Vegetarian (eats vegetables and fruit plus eggs and dairy products)
 Semi-Vegetarian (eats vegetables and fruits plus eggs, dairy products, fish, and poultry)
 Omnivore (eats all foods)

Briefly describe a typical day's meals:
 Breakfast _____
 Lunch _____
 Dinner _____

Do you have any food allergies? If so, to what?

Do you diet or restrict your food intake? Explain.

Do you have a regular exercise program?

Do you smoke, and if so, how much? _____
 Do you drink alcoholic beverages, and if so, how much per week? _____
 Do you drink caffeinated beverages, and if so, how much per week? _____
 Please list any medications, vitamins, or supplements that you are taking. _____

Do you use any recreational drugs, if so, please give details. _____

Traditional Chinese Medical Clinic, Inc.
700 West Mountain Ave.
Fort Collins, CO 80521
(970) 416-0444 - FAX (970) 416-0888
Federal ID # 84-1516199

神道

Shen Dao - "The Way of Spirit"

Olivario Pijoan
License # 482(CO), 348(NM)

Michael Johnston
License # 1105(CO), 9474(CA), 1574 (NY)

Patient Information

Name:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	DOB:	Age:
SSN:	Best Contact Phone #	Secondary Phone #	
Street Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
E-mail:	Marital Status: S <input type="checkbox"/> , M <input type="checkbox"/> , D <input type="checkbox"/> , W <input type="checkbox"/>		

Person Responsible for Payment if Minor:	Phone:
Address:	City: State: Zip:

Person to Contact in an emergency:	Relationship to Patient:
Day Phone:	Evening Phone:
Address:	City: State: Zip:

Employer:	Supervisor:
Address:	City: State: Zip:
Phone:	Other Contact Information:

PLEASE DO NOT WEAR PERFUME OR COLOGNE TO APPOINTMENTS

Agreement of Financial Responsibility

I, _____ the undersigned, agree to payment as services are rendered unless prior agreement has been made in writing by the Traditional Chinese Medical Clinic, Inc. (TCM Clinic).

Patient billing will incur an 18% annual percentage rate of interest (1.5% per month) from the date of original service. Patient/Responsible Party will be liable for reasonable expenses incurred by the TCM Clinic in enforcing the terms of this agreement including all costs of collection and attorney fees. This agreement shall be interpreted and enforced in accordance with the laws of the State of Colorado. The TCM Clinic has the right to waive without prejudice all fees at its sole discretion.

Concerning Insurance claims: I, the undersigned, assume full financial responsibility for any fees I, or parties I am responsible for, have incurred at the TCM Clinic that are not paid by medical insurance or any other second party, as per this agreement.

I, the undersigned, understand that there will be a \$50.00 charge for missed appointments or cancellations without 24 hours advance notice. There will also be a \$25.00 fee charged for any returned checks.

I hereby agree to the above statement of financial responsibility to the TCM Clinic:

Patient/Responsible Party Signature: _____

Date: _____

*Thank You For Filling Out This Form.
All Information Is Strictly Confidential.*

Traditional Chinese Medical Clinic, Inc.
700 West Mountain Ave.
Fort Collins, CO 80521
(970) 416-0444 - FAX (970) 416-0888
Federal ID # 84-1516199



Shen Dao - "The Way of Spirit"

Olivario Pijoan
License # 482(CO), 348(NM)

~
Michael Johnston
License # 1105(CO), 9474(CA), 1574 (NY)

HIPPA – Notice of Privacy Practices

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

No medical information with any third parties will be discussed, unless written consent/authorization has been obtained from you. (This includes by telephone, fax, letter, e-mail, or in person.) This consent form gives us permission to do so.

Ways in which this information might be used:

Treatment - Such as when our providers discuss your care or provide information to another health care provider for the continuation or supplementation of your care.

Insurance - If your insurance company requests copies of your records.

Family - Such as sharing information with members of your family that you choose.

I authorize the following individuals(s) to receive my medical information:

_____, _____
Full name Relationship to patient

_____, _____
Full name Relationship to patient

_____, _____
Full name Relationship to patient

_____, _____
Full name Relationship to patient

You may request a copy of your this authorization. You may revoke authorization at any time in writing. You may refuse to sign this authorization. You have the right to request access to your protected health information that may be used or disclosed.

Patient name (Please Print) _____

Signature of Patient (or legal guardian) _____ date _____

Signature of Covered Dependent if 18 or over _____ date _____

* * * * *

If you do not want your records disclosed to anyone, draw a line through the above authorization section and sign below so as to acknowledge having seen this form.

Print Name

Signature

Date

COLORADO MANDATORY DISCLOSURE STATEMENT

TRADITIONAL CHINESE MEDICAL CLINIC, Inc.

700 West Mountain Avenue
Fort Collins, CO 80521

Phone: 970-416-0444
Fax: 970-416-0888



Olivario Pijoan
Licensed Acupuncturist (CO, NM)
Doctor of Oriental Medicine (NM)

Michael Johnston
Licensed Acupuncturist (CO, CA, NY)

Education and Experience

Olivario Pijoan (Oliver) L.Ac. (Colorado – license # 482); D.O.M., L.Ac. (New Mexico – license # 348)

Oliver graduated from Dr. Jay Victor Scherer's Academy of Natural Healing in 1980 after which time he worked as a body therapist and teacher for over 10 years. He then attended the International Institute of Chinese Medicine (IICM) and graduated valedictorian of his class in 1994, being awarded the degree of *Master of Acupuncture and Oriental Medicine*. He was certified as a Diplomat in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in 1994. He passed his State Board Exams that same year and was licensed as a *Doctor of Oriental Medicine* (D.O.M.) by the state of New Mexico. He opened a clinic in Rio Rancho, New Mexico where he practiced for 5 years. He also became a faculty member of IICM, where he taught classes in Traditional Chinese Medicine for 5 years. Oliver moved to Fort Collins, Colorado in 1999, at which time he opened his current clinic, the Traditional Chinese Medical Clinic, where he now practices acupuncture and Chinese herbology. He is an active member of both the New Mexico and Colorado State Associations of Acupuncture and Oriental Medicine and the American Association of Oriental Medicine (AAOM).

Oliver has and continues to maintain all licensing, registrations and memberships current and in good standing by the NCCAOM, the State of Colorado and the State of New Mexico. None of these licenses, certificates or memberships have ever been suspended or revoked.

Michael Johnston L.Ac. (Colorado – license # 1105, California license # 9474, New York license # 1574)

Michael Johnston graduated from the International Institute of Chinese Medicine in Santa Fe, NM in 2000. He was awarded the Zheng Scholarship for academic excellence and was chosen as liaison for a group of exchange students that went to China. After graduation he opened his practice in New York City. During this time he traveled frequently to China to continue his studies. In 2003 Michael created a program for foreign students at the WanXian ChongQing University of Traditional Chinese Medicine. He relocated to California in 2003 and became licensed there the same year. In San Diego he opened Infinity Acupuncture. Michael moved to Fort Collins in 2005 where he currently practices. Michael is nationally certified by the NCCAOM (2000), California Board Certified (2003) and is licensed in Colorado, California and New York. He is a member of AAOM, AOMA and CSOMA.

Michael has and continues to maintain all licensing, registrations and memberships current and in good standing by the NCCAOM, and the states of Colorado, New York and California. None of these licenses, certificates or memberships have ever been suspended or revoked.

(Continued on next page...)

Note

Both Oliver Pijoan's and Michael Johnston's training includes Acupuncture, Chinese Herbology and related modalities such as moxibustion, tuina, electro-neuro stimulation, acupressure, cupping, guasha, auriculotherapy, infrared heat therapy, injection therapy and dietary and lifestyle recommendations.

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. All acupuncture needles are of the factory-sterilized disposable type, never used more than once, and then disposed of in approved sharps containers that are picked up by an approved hazardous waste service.

Fee Schedule

New patient Consultation with Acupuncture	\$103.00
Established patient Consultation with Acupuncture	\$79.00
New patient Herbal Consultation	\$79.00
Established patient Herbal Consultation	\$61.00
Limited Patient Herbal Consultation	\$22.00

Herbs and adjunctive therapies are an addition charge
(Prices subject to change without notice)
(We give senior discounts and student discounts)

Patient's Rights

- ☉ The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of the 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 Regulations 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 Acupuncturist's Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-2440.

I have read and understand both sides of this document.

Patient's or Guardian's Signature

Date

神道