

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. If I sincerely believe your condition will not respond satisfactorily, I will not accept your case. If you have any questions, please ask. If you have anything you wish to bring to my attention which is not asked on this form, please note it in the *Comments* section. Thank You.

---

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Height: \_\_\_ Weight: \_\_\_ Gender/Pronouns: \_\_\_\_\_

\_\_\_\_\_  
Employer: \_\_\_\_\_

\_\_\_\_\_  
Occupation: \_\_\_\_\_

Phone: \_\_\_\_\_ Hm/Wk/Cell Had Acupuncture previously? YES NO

Email: \_\_\_\_\_ Like to receive occasional emails? YES NO

Spouse's Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Physician: \_\_\_\_\_ Referred to this office by: \_\_\_\_\_

*In Emergency, Notify:* \_\_\_\_\_ *Relationship:* \_\_\_\_\_ *Phone:* \_\_\_\_\_

---

Main problem you would like help with: \_\_\_\_\_

When did the problem begin (be specific): \_\_\_\_\_

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)?

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

What kind of treatments have you tried or are using? \_\_\_\_\_

**Past Medical History** – please note dates: Hypo/Hyper/Hashimoto's Thyroid: \_\_\_\_\_

Cancer: \_\_\_\_\_ Chemo/Radiation: (dates) \_\_\_\_\_

HIV/AIDS: \_\_\_\_\_ Lyme/Parasites: \_\_\_\_\_ Autoimmune Dx: \_\_\_\_\_

STDs: \_\_\_\_\_ High Blood Pressure: \_\_\_\_\_ Long Covid: \_\_\_\_\_

Hepatitis: \_\_\_\_\_ Heart Disease: \_\_\_\_\_ Diabetes: Type I / Type II \_\_\_\_\_

Mono/EBV/CFS: \_\_\_\_\_ Kidney/Gallstones: \_\_\_\_\_ Chx Pox/Shingles: \_\_\_\_\_

Surgeries (types & dates): \_\_\_\_\_

Significant Traumas: \_\_\_\_\_

Significant Dental Work: \_\_\_\_\_

Scars & Locations: \_\_\_\_\_

Allergies (drugs, chemicals, foods, etc.) \_\_\_\_\_

Occupational Stress (chemical, physical, psychological) \_\_\_\_\_

Birth History (prolonged labor, forceps, premature, etc.) \_\_\_\_\_

**FAMILY Medical History**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cancer _____              | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Asthma _____             |
| <input type="checkbox"/> Diabetes _____            | <input type="checkbox"/> Stroke _____        | <input type="checkbox"/> Allergies _____          |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Seizures _____      | <input type="checkbox"/> Depression/Anxiety _____ |
| <input type="checkbox"/> Thyroid _____             | <input type="checkbox"/> Other _____         |   |

**Medications/Supplements**

What medications and/or supplements are you currently taking? \_\_\_\_\_

Have you had any courses of antibiotics recently?  Many  A few  1 or 2  None Why? \_\_\_\_\_

**Habits**

Do you have a regular exercise program? Please describe: \_\_\_\_\_

Are you or have you been on a restricted diet? What kind and why? \_\_\_\_\_

Please indicate usage per day or per week:

Cigarettes _____ per Day/Week/Month	Tea _____ per Day/Week/Month
Alcohol _____ per Day/Week/Month	Soft Drinks _____ per Day/Week/Month
Drugs _____ per Day/Week/Month	Sugar _____ per Day/Week/Month
Coffee _____ per Day/Week/Month	Water _____ per Day/Week/Month

Please describe your average daily diet:

Morning: \_\_\_\_\_

Afternoon: \_\_\_\_\_

Evening: \_\_\_\_\_

**Do you suffer from any of the following?**

Check all that apply, and for each note if it is current or past.

**General**

- Recurrent Infections
- Night Sweats
- Sweat easily
- Bleed or bruise easily
- Strong thirst (prefer hot or cold?)
- Thirst with no desire to drink
- Fatigue
- Sudden energy drops  
Time of day \_\_\_\_\_
- Poor Sleep
- Tremors
- Poor Balance
- Edema
- Underweight
- Overweight

- Oozing
- Pimples
- Dry skin / scalp
- Recent moles
- Changes in hair/skin
- Other \_\_\_\_\_

**Head/Eyes/Ears/Nose/Throat**

- Headaches  
Where \_\_\_\_\_  
When \_\_\_\_\_
- Migraines
- Dizziness
- Discharge from ear
- Poor hearing
- Ringing in ears
- Blurry vision
- Night blindness
- Color blindness
- Spots in front of eyes

- Eye Pain
- Excessive Tearing
- Squint
- Glasses
- Sore eyes
- Facial Pain
- Nose bleeds
- Nasal discharge
- Blocked nose
- Snoring
- Grinding teeth
- Teeth problems
- Recurrent sore throat
- Hoarseness
- Tonsillitis
- Swollen glands
- Sores on lips/mouth
- Other \_\_\_\_\_

**Skin**

- Rashes
- Itching
- Eczema

**Cardiovascular**

- Pacemaker
- High Blood Pressure
- Low Blood Pressure
- Chest discomfort/pain
- Heart Palpitations
- Cold hands or feet
- Swelling of hands or feet
- Blood Clots
- Spider veins
- Fainting
- Other \_\_\_\_\_

**Respiratory**

- Difficulty breathing
- Pain with breathing
- Shallow breathing
- Shortness of breath
- Production of phlegm  
Color \_\_\_\_\_
- Recurrent cough
- Bronchitis
- Pneumonia
- Asthma/Wheezing
- Tonsils Removed
- Other \_\_\_\_\_

**Digestion**

- Bad breath
- Change in appetite
- Nausea
- Vomiting
- Heartburn
- Indigestion
- Belching
- Abdominal pain or cramps
- Weight gain
- Weight loss
- Loose stools / Diarrhea
- Strong smelling stools
- Bloody stools
- Pale stools
- Green stools
- Black stools
- Constipation
- Alternating Constipation/Diarrhea
- Pain with passing stools
- Gas
- Rectal pain
- Hemorrhoids
- Anorexia nervosa
- Bulimia
- Other \_\_\_\_\_

**Genito-urinary**

- Pain on urination
- Urgency with urination
- Frequent urination
- Blood in urine
- Decrease in urinary flow
- Unable to hold urine
- Incontinence at night
- Dribbling urination
- Kidney stones
- Prostate problems
- Impotency
- Changes in sexual drive
- Rashes
- Do you wake at night to urinate?  
How many times? \_\_\_\_\_
- Other \_\_\_\_\_

**Gynecological**

- # of pregnancies \_\_\_\_\_
- # births \_\_\_\_\_
- # premature births \_\_\_\_\_
- # abortions \_\_\_\_\_
- Age of 1<sup>st</sup> menses \_\_\_\_\_
- # days between menses \_\_\_\_\_
- Duration of menses \_\_\_\_\_
- 1<sup>st</sup> day of last menses \_\_\_\_\_
- Age of menopause \_\_\_\_\_
- Other \_\_\_\_\_
- Date of last PAP \_\_\_\_\_

 **PMS**

- Irregular periods
- Painful periods
- Light periods
- Heavy periods
- Clots
- Fibroids
- Endometriosis
- Infertility
- Vaginal discharge
- Vaginal sores
- Postcoital bleeding
- Breast lumps
- Nipple discharge
- Other \_\_\_\_\_

Do you practice birth control?

- yes  no

What type and for how long?

\_\_\_\_\_

**Are you pregnant now?**

- yes
- no
- don't know/maybe

**Musculoskeletal**

- Neck ache/pain
- Back ache/pain
- Knee ache/pain
- Shoulder pain
- Elbow/Forearm pain
- Hand/Wrist pain
- Foot/Ankle pain
- Joint/Bone problems
- Torn tissues
- Prostheses
- Muscle pain/weakness
- Hernia
- Other \_\_\_\_\_

**Neurological**

- Seizures
- Nerve damage
- Paralysis \_\_\_\_\_
- Stroke \_\_\_\_\_
- Sleep disorder
- Concussion \_\_\_\_\_
- Vertigo
- Lack of coordination
- Loss of balance
- Poor memory
- Difficulty in concentrating

**Behavioral**

- Vacant
- Moody
- Easily susceptible to stress
- Aggressive/Bad temper
- Lose control of emotions
- Anxiety
- Panic Attacks
- Depression
- Fear
- Substance abuse
- Other \_\_\_\_\_

Have you ever been treated for emotional problems?

- yes  no

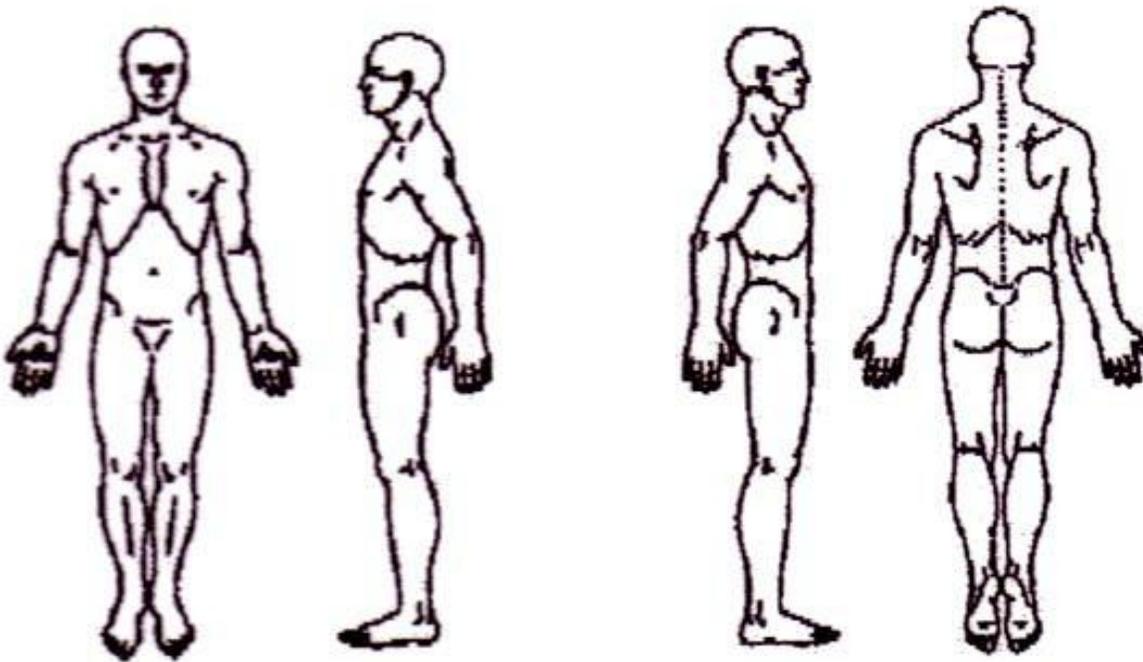
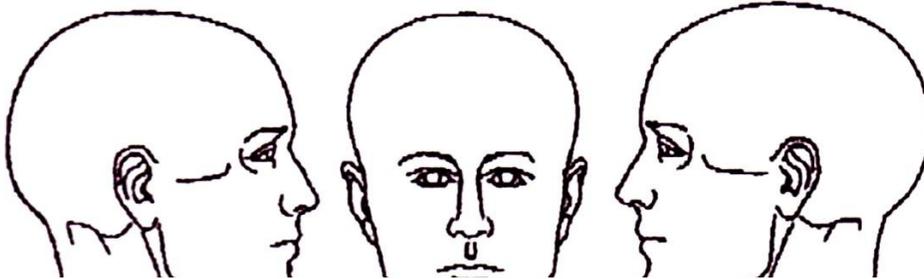
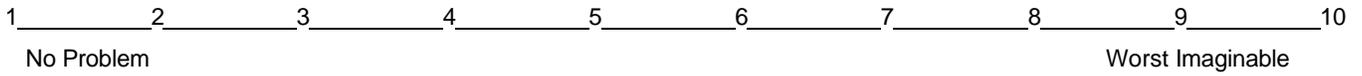
Have you ever considered or attempted suicide?

- yes  no

Please note the severity of your PAIN or concern right now:



Please note the greatest degree of severity of this problem within the last week:



**Additional  
Comments:** \_\_\_\_\_

*Email:* At times, The Krasovec Clinic uses email to correspond with patients as a convenience. However, these emails are not encrypted and could theoretically be read by an outside party with the technical skills to intercept such correspondences. By initialing this, you consent to allow Kellie Krasovec and associates to correspond with you via email despite these potential risks. **Initial:** \_\_\_\_\_

## **Informed Consent for Acupuncture & Chinese Medicine Treatment**

I, the undersigned, hereby request and consent to the performance of acupuncture procedures including, but not limited to, moxibustion, cupping (dry and/or wet), plum blossom, gua sha, electroacupuncture, Tuina (Chinese massage), and Chinese herbal supplements, on me or the patient for whom I am legally responsible, by my acupuncture practitioner. I recognize the potential risk and benefit of this procedure as described below:

**Potential Risk:**

Discomfort, pain, infection, weakness, fainting, nausea, temporary discoloration or bruising at site of procedure, occasional aggravation of symptoms existing prior to the treatment.

**Potential Benefits:**

Drugless relief of presenting symptoms and improved balance of the body's circulations, which may lead to prevention or elimination of the presenting problems and strengthen the constitution.

***I agree to inform acupuncturist if I become pregnant or if I am potentially pregnant.***

I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my presenting condition and for any future conditions for which I seek treatment.

I hereby release associates of Kellie Krasovec from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

COLORADO MANDATORY DISCLOSURE STATEMENT

**Kellie Krasovec, Dipl.Ac., L.Ac.**

97 Main Street, W - 202

Riverwalk

Edwards, CO 81632

970.926.6588

INITIAL INTAKE AND TREATMENT:	\$268 - \$300
FOLLOW-UP TREATMENT:	\$200 - \$230
AESTHETIC ACUPUNCTURE:	\$300 per treatment (includes Celluma)
CELLUMA LIGHT THERAPY:	\$30 per 30 minute treatment
HERBAL FORMULAS:	at or below retail

Kellie Krasovec is certified as a Diplomate in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine. She earned her Master of Science in Oriental Medicine in 2005 from Southwest Acupuncture College located in Santa Fe, New Mexico. This four-year program includes 1873 actual classroom hours and 1030 clinical hours. The degree includes training in acupuncture, auriculotherapy, moxibustion, cupping, tuina, Chinese herbology, electrical stimulation and nutritional therapy.

Kellie Krasovec earned three advanced certificates during additional studies in Beijing, China, in 2004 and 2005. Two of these were awarded by the Beijing International Acupuncture Training Centre for programs in Acupuncture and Moxibustion as well as Chinese Herbal Medicine. A third was awarded by Guang An Men Hospital for in-hospital training in Traditional Chinese Medicine. She is also certified as a Facial Rejuvenation and Microneedling practitioner.

Kellie Krasovec is a member of the American Acupuncture Council and is licensed acupuncturist by the state of Colorado.

This practitioner complies with all the rules and regulations promulgated by the Colorado Department of Public Health and Environment, including those related to the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. *Only single-use, disposable, factory-sterilized needles are used.*

As a patient you are entitled to receive information about the methods of therapy, techniques used and duration of such therapy, if known.

As a patient you are entitled to seek a second opinion from another health care professional and may terminate therapy at any time.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies at the following address:

Director, Division of Registrations  
Acupuncturists Licensure  
1560 Broadway, Suite 1350  
Denver, CO 80202  
303.894.7800

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

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

\_\_\_\_\_  
Date

## Financial Policy

- Payment is due at time of service, unless otherwise arranged prior to treatment.
- Ask about 10 appointment packages, to save approximately 10%
- Failure to give *24-business hour notice* for cancellation of any appointment will result in \$200 cancellation fee.
- Failure to notify office and failure to meet appointment without any notice will result in a \$200 missed appointment fee.

Any patient wishing to have insurance cover all or a portion of their treatment should contact their insurance provider to learn the coverage boundaries of their policies with respect to Acupuncture. In recent years, pain and conditions related to pain are most often covered.

- I am able to provide my patients with a Superbill upon request.
- A Superbill is an invoice for your visit that uses standardized codes for all of the treatments performed. This process requires the patient to pay the full cost of the treatment out-of-pocket at the time of the visit. The Superbill can thereafter be submitted to your insurance carrier for full or partial reimbursement depending on your policy.
- Patients wishing to make use of this service should check with their insurance carriers to be sure that Superbills are accepted.
- We are unable to change standardized codes on invoices, if insurance does not approve.

## Payment Agreement

*(please check and sign)*

- I understand the above terms and agree to keep my account current by paying with cash, check or a credit card at each visit.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name