Listening Heart Medicines

Acupuncture, Herbs, Massage

David W. Armstrong, M.Ac., L.Ac., L.M.T.
Licensed Acupuncturist
P.O. Box 6072
Colorado Springs, CO 80934
(719) 684-3909

Client Medical History

Name:_____Date:_____

Address:_____

City:_____State:_____Zip:_____ Email:_____

Phones:home:(_____)_____work:(_____)_____

Date of Birth:_____ Male:__ Female:__ Height:_____ Weight:_____

Occupation:_____ Referred by:_____

In case of emergency, notify: Name:_____Relation:_____

Phone number:(_____)_____

Main concern for treatment:_____

Date of original symptoms:_____Describe symptoms, changes and/or progression

of symptoms:_____

_____

_____

Do you have a diagnosis: yes____no____if yes what is your diagnosis_____

_____

Current medications:_____

Medications taken in the last 6 months not mentioned above:_____

_____

Vitamins, minerals, herbs, etc._____

_____

Family medical history:diabetes___which relative_____

high blood pressure:__which relative_____

heart disease___which relative_____

cancer___which relative_____

Any other diseases in family history not mentioned above:_____

_____

Daily diet: Breakfast:_____Lunch_____

Evening meal:_____Snacks:_____

Coffee____# cups per day, Soft drinks____# per day, Alcohol____# per day____week___month

Glasses of water each day____Do you smoke cigarettes____# per day____ week____per month

Do have a strong desire for any certain kind of food or taste_____

Does your body temperature tend to run: warm__hot__cool__cold__

Digestion: Belching___Gas___Bloating___

Number of bowel movements per day___Are your stools well formed and consistent_____

Comments about digestion:_____

Urination: Number of times per day___Burining urination__Kidney stones_____

Do you have urgency to urinate____Do you have to get up in the middle of the night to urinate___

# of times_____comments_____

Respiratory: cough___productive____ color and consistency of mucus_____

Comments_____

Allergies (drug, food, plants, chemicals):_____

_____

Females: are you pregnant? Yes____No___number of pregnancies____ number of births:_____

Date most recent menstruation began_____length of entire cycle____ # of days of bleeding___

Color and consistency of menstrual blood:light___medium___dark___thin___thick___clots_____

Do your moods or feelings change a great deal before__,during__,or just after___menstruation

Do you take birth control pills?_____

Please list any premenstrual symptoms:_____

All Clients:

Surgeries and dates:_____

_____

Traumas (auto collisions, falls, etc.):_____

_____

Sleep: difficulty going to sleep___ wake up in the middle of the night_____

Excessive dreaming____nightmares_____

Headaches: yes___no___frequency_____which part of your head_____

Energy level: high____medium____low____

Exercise: what kind and how often_____

Describe your current emotional state of being: (glad, sad, angry, irritable, afraid, etc.)

_____

_____

Describe the pain and location of pain in your body:_____

_____

List any other information you would like to say:_____

_____

_____

Payment Policy Agreement

I_____, understand that I am responsible for payment of services rendered at the time of treatment unless prior arrangements have been made for a different payment agreement. I also understand and agree to a charge of the regular treatment fee for cancellation of an appointment less than 24 hours in advance of the scheduled treatment time, unless a valid reason is cause for cancellation. This is a charge that is due at the time of the missed appointment and is to be paid by the patient at the earliest date possible following the missed appointment, as insurance companies do not pay for missed appointments. Late policy: the period of time scheduled for your treatment is allotted for you, and will begin and end as scheduled. In event you arrive late, the period of time stills ends at the same time it was scheduled to end, and you are still responsible for payment of the entire scheduled time. If our schedules permit extension beyond the scheduled period of time, the extended time period is charged at the same hourly rate with a 15 minute minimum.

Signature of person being treated or Guardian_____, Date:_____.

Colorado Mandatory Disclosure Statement

David W. Armstrong, M.Ac.,L.Ac.,
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Education and Experience

David W. Armstrong, M.Ac., L.Ac., has been board certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in acupuncture since March of 1997 and in Chinese Herbology since March of 2001. David graduated from the School of Complementary Medicine in Oviedo, Florida in January of 1997 with certifications in Acupuncture and Chinese Herbology. This course work lasted 29 months and included 1273 hours of didactic training and 891 hours of clinical training. David did post graduate work at the Northwest Institute of Acupuncture and Oriental Medicine in Seattle Washington and received his Master's degree in Acupuncture and a certification in Chinese Herbology in June of 1999 and February 2001 respectively. This course work included an additional 859 didactic hours and an additional 562 clinical hours of training. David's training included Clean Needle Technique. David studied Shiatsu massage and Chinese medicine theory at the Massage therapy Institute of Colorado in 1993 and he has been active in studying and applying Chinese medicine for the past ten years.

David's training also included adjunctive therapies such as moxibustion, tui na, external applications of herbs and liniments, application of heat therapies, cupping, auriculotherapy, electro acupuncture, dietary and lifestyle recommendations.

David has been licensed for Acupuncture and licensed for Massage in Florida and is licensed for Acupuncture and for Massage in Washington. None of these licenses have ever been suspended or revoked.

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

Fee Schedule: $120.00 per hour + costs of herbs, cost per hour is reduced for payment on date of treatment and for advanced payment.

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 1340 Denver, Colorado 80202. Telephone (303) 894-7800

I have read and understand this document,

Signature of patient or Guardian_____, Date:_____.