Wyler Family Acupuncture
Family-friendly acupuncture & herbs

Jennifer Wyler, LAc., Dipl. OM
Confidential HEALTH HISTORY

First Name (child) _____ Last Name _____
First Name (parent)_____ Last Name_____
Address _____ City, State, Zip _____
Home Phone _____ Cell Phone _____
Email _____ Age (child) _____
Emergency Contact_____ Phone _____
Referred by_____ How did you hear about us?_____

Reasons for your visit at this time?

How long has your child had these symptom? _____
Current energy level from 1-10 (1=no energy, 10=a lot of energy) _____ Stable or Fluctuates?
Sleep: Hours/night: _____ Time to bed: _____ Time to wake: _____ Trouble falling asleep:_____
Does your child feel rested in the morning? _____

What does your child eat and drink on a typical day?
Breakfast:_____
Lunch_____
Dinner_____
Snacks: _____
Beverages:_____
Anything your child does not eat _____
Food sensitivities?_____

Stools: Constipation: _____ Diarrhea or loose: _____ Alternating: _____
Frequency of bowel movements _____ per day _____per week

Please check YES if you currently or regularly experience these symptoms:

	Yes
Tantrums?	☐
Easily irritated, angered, or frustrated?	☐
Does your child sigh a lot?	☐
Cold hands and feet?	☐
Abdominal bloating or gas after eating?	☐
Tendency for loose stools?	☐
Frequent worrying?	☐
Eczema?	☐
Stomachaches?	☐
Bruise easily?	☐
Chronic sniffles or coughing?	☐
Finicky eating?	☐

Delayed growth (teeth, hair, size, weight)? ☐
Often fearful? ☐
Bed-wetting? ☐
Asthma or breathing difficulties? ☐
Gets sick easily and often? ☐
Born premature? ☐

Chronic or troublesome insomnia? ☐
trouble falling asleep?_____waking in the night?_____what time?_____
Nightmares? ☐
Does your child have a tendency toward anxiety or panic attacks? ☐
Hyperactivity? ☐
Colic? ☐

Excessively dry skin? ☐
Excessively thirsty? ☐

Allergies to
Environment? _____
Foods? _____
Medications? _____
Animals? _____

Please **CIRCLE** any conditions / illnesses your child has had or currently has:

Asthma Autoimmune illness If so, what type? _____ Diabetes
Chronic Earaches Chronic Strep throat Mono Chicken Pox Other?_____

List any surgeries, hospitalizations, serious illnesses not covered above:

List any supplements/vitamins your child is on:

Any specific stress or trauma your child has either witnessed or personally experienced?

Comments, as well as anything else you would like us to know:

Disclosure Statement

This disclosure statement is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Statute Title 12 Article 29.5. All rules and regulations set forth by the Department of Health are strictly adhered to, including proper cleaning, sterilization, and sanitation of equipment and office. The practice of acupuncture is regulated by the Department of Regulatory Agencies. Inquiries should be made to: Director of Registrations, Acupuncturists Licensure, 1560 Broadway, Suite 1350, Denver, CO 80202, (303)894-7800. Patients are entitled to receive information about the methods of therapy, techniques used, and the duration of therapy, if known. Patients may seek a second opinion and 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.

Clinic Fee Schedule (due at time of service)

Initial Adult Acupuncture Consultation and treatment: $100 Followup: $75
Initial pediatric consultation and treatment: $75 Followup: $55

We ask patients to give us 24 hours notice in advance of an appointment if it is necessary to cancel/reschedule. All appointments that are canceled/rescheduled with less than 24 hours notice, as well as appointments missed without notice, will be charged $50.00 for that appointment.
Insurance: We do not bill insurance. Upon request, we will provide you with a receipt for your insurance company.

Practitioner Education, Certification, and Experience

Jennifer Wyler, Dipl. O.M., L.Ac., Master of Science, Southwest Acupuncture College in Boulder, CO, 2009. NCCAOM Diplomate in Oriental Medicine issued 2009. Colorado Licensed Acupuncturist # 1583.

Informed Consent

I hereby request and consent to the performance of acupuncture procedures by Jennifer Wyler, LAc. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including discomfort, pain, dizziness, bruising, or numbness at site of procedure. Unusual and rare risks of acupuncture include nerve damage, organ puncture including lung puncture, infection, and spontaneous miscarriage. Other side effects and risks may occur. If I suspect that I am pregnant, I will immediately inform the acupuncturist.

I have discussed the nature and purpose of my treatment with the acupuncturist named above. I understand that there are no guarantees regarding cure or improvement of my condition. I understand that there may be limitations to the care provided and that in my best interest I may be referred to another acupuncture practitioner or other healthcare provider who may be more qualified to treat me outside of these facilities. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications, and I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist judges to be in my best interests based upon the facts then known. I understand that I have the choice to accept or reject treatment at any time.

I have read or have had read to me the above consent. By signing below I agree to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition(s) for which I seek treatment.

_____	_____	_____
Signature of Patient/Person authorized to consent	PRINT YOUR NAME	DATE