## Fractal Dragon Acupuncture & Oriental Medicine, LLC

Susan Gallagher, Dipl. OM | Licensed Acupuncturist | Certified Herbalist | Diplomate of Oriental Medicine
720-519-1548 (Office) | 720-261-1680 (Cell) | souljourneyhealth.com


# Patient Intake Form

**TODAY'S DATE:** _____

## Patient Information

**Name:** _____

**Home Phone:** _____ **Cell Phone:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**E-mail:** _____ **Is it alright to call or e-mail reminders?** Y / N

**Preferred Phone number or e-mail for reminders:** _____

**Birthdate:** _____

**Age:** _____ **Sex:** _____ **Height:** _____ **Weight:** _____

**Occupation:** _____

**Employer's Name:** _____

**Employer's Address:** _____

**Marital Status:** _____ **Number of Children:** _____

**Personal Physician:** _____ **Phone Number:** _____

**Date of Last Physical:** _____

**Emergency contact:** _____ **Phone #(s):** _____

**How did you hear about us?:** _____

**Have you tried acupuncture before?:** _____

## Responsible Party & Insurance

**Party Responsible for Payment (if other than above):** _____ **Birthdate:** _____

**Address:** _____ **Phone #(s):** _____

**Insurance Company (or provide card at visit) — Policy Holder:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Phone:** _____ **Relationship of Patient to Policy Holder:** _____

**Policy Number:** _____ **Group Number/Name:** _____

**Policy Holder's Employer:** _____

## Reason for Visit

**What is your reason for coming today?**

_____

**Please list your major health concerns:**

_____

**What are the major stressors in your life?**

_____

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## Informed Consent to Health Care by Traditional Oriental Medical Practitioner

I hereby request and consent to the performance of the following on me (or the patient named below, for whom I am legally responsible) by Susan Gallagher, Dipl. OM.: acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, and manual palpation on a variety of areas on my body; observation, range of motion evaluation, muscle, orthopedic, and neurological testing; modes of manual and physical therapy such as massage, manipulation of joints and/or viscera; heat and/or cold therapy; and electrical and or magnetic stimulation. The prescription of herbal medicines and dietary supplements, dietary recommendations, advice regarding exercise; and lifestyle counseling may also be included.

I have had the opportunity to discuss with Susan Gallagher, Dipl. OM questions I have regarding the nature and purpose of acupuncture and oriental medical procedures and potential risks of treatment. I understand that while acupuncture has helped millions of people, no guarantee of cure or improvement in my condition is given or implied. I do not expect Susan Gallagher, Dipl. OM to be able to anticipate and explain all risks and complications and during the course of treatment. I wish to rely on her judgment based on the facts known at this time.

I understand and am informed that there are some risks to treatment. I understand that, while unlikely, possible risks include but are not limited to: bleeding, bruising, inflammations, infections, burns, general aches, sprains, strains, dislocations, fractures, disc injuries, strokes, puncture of organs, pain or other strong sensations at the location where a needle is inserted or radiating from that location, nerve pain, aggravation of current symptoms, and appearance of new symptoms.

The herbs and supplements (which are from plant, animal, or mineral sources) that may be recommended are traditionally considered safe in oriental medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. Herbs may need to be prepared and herbal teas may be consumed according to instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify Susan Gallagher, Dipl. OM of any unanticipated or unpleasant effects associated with the consumption of herbs.

I understand that acupuncture and oriental medicine is not a substitute for Western medicine, and that certain health disorders may require a Western medical diagnosis and treatment. I am free to seek Western medical advice and treatment at any time, either in lieu of or concurrently with oriental medicine. I realize that I may withdraw from treatment at any time. I understand my patient records will be kept confidential and will not be released without my written consent.

I understand that in general the recommended treatment frequency is once a week and as my condition improves, treatment frequency is decreased. The number and frequency of treatments may vary greatly, depending on such factors as the patient's vitality, their health history, the type of condition, the length of time that the condition has existed, the patient's lifestyle, and many other factors. I understand it is not possible to initially determine how many treatments I may need. However during the course of treatment, my options with regard to treatment frequency and the number of treatments I may need will be discussed.

By signing below I agree to the above named procedures and have read and have had the opportunity to ask questions about the above consent. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. The following is to be completed by the patient or patient's representative, if necessary, that is, if the patient is a minor or physically or legally incapacitated.

_____ _____

*Print Name of Patient* *Print name of patient's representative (if applicable)*

_____ _____

*Signature of Patient* *Signature of patient's representative (if applicable)/relationship*

_____

*Today's Date*

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## Disclosure Statement

This disclosure statement is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Statute Title 12, Article 29.5. Every effort to comply with these rules and regulations, as well as those set forth by the Department of Health, is made by this clinic, including proper cleaning and sterilization of equipment and the office. Only single use, sterile, disposable needles are used.

The Department of Regulatory Agencies (DORA) regulates the practice of acupuncture. Any complaints should be directed to the Director of the Division of Registrations in the Department of Regulatory Agencies: 1560 Broadway, Suite 1340, Denver, CO 80202-5140. Telephone (303) 894-7851.

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. Your relationship with this office is strictly confidential. No license, certificate, or registration has been suspended or revoked. 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.

My training and experience include the recommendation and application of adjunctive therapies and herbs consistent with traditional Oriental medical concepts. Your therapy may include recommendations for adjunctive therapies or herbs.

## Education

- Masters of Science in Oriental Medicine, Southwest Acupuncture College, Boulder, CO, 2002 – 3-year program.
- Masters in Business Administration, University of Colorado, Denver, CO, 1993 – 3-year program.
- Bachelor of Science, Forest Science, Pennsylvania State University, 1979, attended 1973–74, 1976–79.

### Current Professional Memberships

- Acupuncture Association of Colorado

### Certifications, Licenses, and Registrations

- Clean Needle Technique Certificate, 2000
- Master of Science, Oriental Medicine, 2002
- Licensed Acupuncturist, State of Colorado, since 2002
- Certified Herbalist, since 2002
- Diplomate Oriental Medicine, since 2005

## Fee Schedule Updated - 3/24/2026

| | Insurance | Self Pay |
|---|---|---|
| **Initial Evaluation** | By insurance contract | **$70** |
| **Standard Treatment** | By insurance contract | **$55** |

Insurance reimbursement is usually sometimes lower than the standard cash rate. Cash rates reflect the true cost of care, including practitioner time, needles, supplies, overhead, charting, staff support, and adjunct therapies such as cupping, far infrared heat and TCM massage. Insurance, however, dictates what it believes a service should be worth.

**Cancellation Policy:** I ask that you make every effort to notify the office as far in advance as possible, if you are unable to keep an appointment. I ask for 24 hours advance notice for cancellation. A fee of $55 will be assessed for excessive cancellations.

*I have carefully read and understand the above, and agree to the terms of this Client Disclosure Form.*

_____ _____

*Patient's Initials* *Date*

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## Financial Agreement

Patients must select a payment plan. If he/she chooses to switch from a Self-Pay Plan to the Billing Plan, it is understood that our office will not produce claims retroactively. Instead, we will bill claims according to the appropriate fee schedule from that date forward. Please refer to the disclosure form for the fee schedule and payment policy.

If you have any questions, please ask for clarification.

**By signing below, I agree to the following Financial Plan:**

_____ Self-Pay Plan _____ Billing Plan

I, _____, have read and understand the above statements, including those on the Disclosure form, regarding fee schedules and financial agreement. By signing below, I agree to accept these policies.

_____ _____
*Patient Signature (or Guardian if a Minor)* *Date*

If you are in one of the offices of Fractal Dragon Acupuncture, LLC, it is at your own risk. While we are making efforts to sanitize the facility and complete other precautions, we cannot guarantee the prevention of disease transmission. You agree to waive legal liability or recourse by entering and using these facilities and services and indemnify Fractal Dragon Acupuncture, LLC, it's facilities, owners and any businesses within or associated with Fractal Dragon Acupuncture, LLC and any guests, or patrons of these facilities, and businesses.

_____ _____
*Patient Signature (or Guardian)* *Date*

_____ _____
*I have been offered and/or read HIPPA policies* *Date*

*(Attached at the end of this document or a separate client form on website.)*

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**Your Name:** _____ **Today's Date:** _____

## Personal Health History:

If you have had any of the following symptoms, check a box specifying whether it was in the past or if it is a current concern. Also, circle one of the numbers that appears to right of the symptom, indicating how much of a concern this symptom is to your health -- circle 0 for no impact, 4 for severe impact.

| Past | Now | Symptom | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Abdominal/Stomach Pain | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Always Hungry | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Black Stools | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Constipation (less 1/day) | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Diarrhea | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Heartburn | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Indigestion | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Gas | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Lack of Appetite | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Nausea | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Overweight | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Unusually Thirsty | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Vomiting | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Weight Changes | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Bleeding Easily | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Bleeding Gums | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Bruising Easily | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Chest Pain or Pressure | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Dizzy Spells or Blackouts | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Irregular Heart Beat | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Poor Circulation | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Pounding Heart Beat | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Racing Heart Beat | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Chest Colds | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Chronic Cough | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Congested Nose | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Coughing up Blood | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Smoking | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Sneezing | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Wheezing | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Chills | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Excessive Sweating | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Fever | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Lack of Perspiration | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Night Sweats | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Fatigue | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Frequent/Extended Hoarseness | 0 | 1 | 2 | 3 | 4 |

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| Past | Now | Symptom | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Pain -- Other Locations | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Tendency to be too Cold | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Tendency to be too Hot | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Earaches | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Hearing Loss/Difficulties | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Nose Bleeds | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Sinus Problems | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Sore Throats | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Sounds/Ringing in Ears | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Swollen Glands | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Eye Problems | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Corrective Lenses/Glasses | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Unusual Taste in Mouth | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Dry Skin | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Itching or Burning Skin | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Skin Rash | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Bloody Urination | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Burning Urination | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Difficult Urination | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Frequent Urination | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Loss of Bladder Control | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Painful Urination | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Urination at Night | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Convulsions | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Depression | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Frequent / Severe Headache | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Difficulty Getting to Sleep | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Difficulty Staying Asleep | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Leg Cramps | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Nervousness | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Shaking or Trembling | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Stuttering or Stammering | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Back Trouble / Pain | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Pain / Swelling -- Any Joint | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Painful Feet | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Painful Muscles | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Stiff or Painful Neck | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Swelling in Feet or Legs | 0 | 1 | 2 | 3 | 4 |
| ☐ | ☐ | Other Symptoms | 0 | 1 | 2 | 3 | 4 |

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**Your Name:** _____ **Today's Date:** _____

## Personal Health History (continued):

**Please check if you have had any of the following diagnoses:**

- ☐ AIDs/HIV Positive
- ☐ Allergies
- ☐ Anemia
- ☐ Antibiotic Use
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusions
- ☐ Bone Disease
- ☐ Bronchitis
- ☐ Bursitis
- ☐ Cancer or Tumor
- ☐ Chickenpox
- ☐ Colon / Bowel Disease
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Drug / Alcohol Addiction
- ☐ Drug Sensitivity/ Reaction
- ☐ Emotional/Mental Problems
- ☐ Emphysema
- ☐ Gall Stones
- ☐ Gallbladder Problems
- ☐ German Measles
- ☐ Heart Trouble
- ☐ Heart Murmur
- ☐ Hemorrhoids
- ☐ Hepatitis / Jaundice
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives
- ☐ Kidney Stones
- ☐ Kidney or Bladder Infection
- ☐ Liver Disease
- ☐ Elevated Liver Enzymes
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Malaria
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pancreatitis
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Smallpox
- ☐ Spinal Meningitis
- ☐ Stomach or Duodenal Ulcer
- ☐ Tendonitis
- ☐ Tuberculosis
- ☐ Thyroid/ Goiter Trouble
- ☐ Typhoid
- ☐ Venereal Disease
- ☐ Varicose Veins
- ☐ Vaccinations
- ☐ Whooping Cough
- ☐ Other Illnesses (list):

**Please list surgeries and hospitalizations and Doctor's name (if you remember):** _____

_____

**What kinds of foods do you eat, or are there any kinds of food that you do not eat?** _____

_____

**List current medicines and supplements/herbs (or attach list):** _____

_____

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## Family History

Parents' Age and Health or if deceased, Parents Age at Death and Cause of Death:

---

Number of Siblings, Age, Health Status or Cause of Death if Deceased:

---

Number of Children, Age, Health Status or Cause of Death if Deceased:

---

**Check if you have family history of any of these:**

- ☐ AIDs/HIV Positive
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Mental Illness
- ☐ Problems with Alcohol
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other potentially-inherited disease

## You did it!

Thank you for completing this form and for your patience.
The information you've shared helps us create a more personalized and supportive healing experience for you.