

**Center for Integrative Care
Patient Information**

Today's Date: _____

Name: _____ M ___ F ___ Age: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Alternate phone: _____

May we have permission to leave messages on your phone(s)? ___ Yes ___ No

Email: _____

May we have permission to contact you by email? ___ Yes ___ No

How did you hear about us:

___ physician ___ nurse ___ website ___ friend ___ Breast Health Navigator ___ self ___ 7 Levels ___ other: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

If anyone will be helping coordinate your care, please provide their name: _____

Service(s) requested: ___ Acupuncture ___ Massage/Reflexology ___ Wellness/Integrative Care Nurse Consult ___ Healing Touch/Reiki

If you are currently in active cancer treatment, would you be interested in financial assistance? ___ No ___ Yes

Oncologist(s): _____ Date of last visit: _____

How often do you see your oncologist: _____

Primary Care Physician: _____

Do you have concerns in any of the following areas? Please mark all that apply.

<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Incisions	<input type="checkbox"/> Recent history of blood clots	<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Low platelet count	<input type="checkbox"/> Pain or discomfort	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Depression
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Nausea	<input type="checkbox"/> Other mental health concerns
<input type="checkbox"/> Weight loss / gain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Neuropathy in hands or feet	<input type="checkbox"/> Sexuality
<input type="checkbox"/> Skin problems	<input type="checkbox"/> Low white blood count	<input type="checkbox"/> Medical devices	<input type="checkbox"/> Other:

When were you first diagnosed with cancer? _____

What type of cancer? _____

Where was/is it located? _____

Any recurrences/metastases? ___ No ___ Yes

Are you being treated now? ___ No ___ Yes

Surgery/Procedures:

Type _____ Date _____

Lymph Nodes removed: Number _____ Where _____

Reconstruction: Dates _____ Procedures _____

Side Effects: _____

Chemotherapy:

Chemo drugs: _____

Number of Treatments: _____ Beginning Date: _____ End: _____

Number of Treatments: _____ Beginning Date: _____ End: _____

Number of Treatments: _____ Beginning Date: _____ End: _____

Side effects: _____

Radiation:

Number of Treatments: _____ Beginning Date: _____ End: _____

Area of Treatment: _____ Nodes irradiated in the neck, armpit or groin? Yes No

Number of Treatments: _____ Beginning Date: _____ End: _____

Area of Treatment: _____ Nodes irradiated in the neck, armpit or groin? Yes No

Side effects: _____

Current Medications:

Drug Name	Purpose	Side Effects

Please inform us of any specific medical conditions:

Known allergies or sensitivities No Yes

Cardiovascular conditions No Yes

Arthritis No Yes

Liver or Kidney conditions No Yes

Respiratory or Lung conditions No Yes

Diabetes No Yes

Injuries (e.g. disc problems, fractures, etc) _____

Other surgeries _____

Major complaint(s): _____

Is there anything else about your past or current medical history you would like us to know about:

Do you have any barriers to learning: none Physical Emotional Language Desire/motivation
 Pain/discomfort Cognitive

I learn best by: Visual Reading Doing Listening All

Do you have any specific religious or cultural practices to consider: No Yes

Do you feel safe at home? Yes No

Signature _____

Thank you!

Revised 1/10

Center for Integrative Care
Consent to Services

Name: _____ Date: _____

I have requested and voluntarily consent to the services described below. Please initial all that apply.

- ___ Acupuncture
- ___ Healing Touch, Reiki
- ___ Integrative Health Nurse Consult
- ___ Massage Therapy/Manual Lymph Drainage/Reflexology

I have read and I understand the description of the services I have requested (the “Services”) and the description of risks and benefits as provided on this consent form.

I understand that the Services are intended to be complementary to medical treatment of my health condition. I understand the Services may not be effective and are not a substitute for medical examination, diagnosis or treatment of my health condition. I also understand that I am responsible for obtaining any follow-up care from my healthcare that is recommended as a result of the Service.

I understand that I can discontinue the Services at any time. If I wish to discontinue the Services, I will immediately notify the person who is providing the Services to me. I also will notify the person providing the Services of any pain or discomfort I feel while the Services are being provided.

I understand that I am responsible for the payment of the Services. Unless prior arrangements have been made, I am responsible for payment at the time the Services are provided.

I understand that sexual intimacy is never appropriate in this or any other professional relationship. I understand that I should report any concerns regarding sexual intimacy to the management of the Center for Integrative Care at 404.440.2469 or 720.854.7026 and to:

Director of the Division of Registration
Colorado Department of Regulatory Agencies:
Office of Acupuncturists Registration
1560 Broadway, Suite 1545
Denver, CO 80202
(303) 894-2464

I have had an opportunity to ask questions about the Services and the questions I have asked have been answered to my satisfaction. I believe that I have sufficient information to give informed consent to the Services.

I have read the above consent and understand and agree to what it says:

Patient Signature _____

The patient is unable to consent because _____
I, therefore consent for the patient:

Relative/Guardian/Representative _____ Relationship to patient _____

DESCRIPTION OF SERVICES AND RELATED RISKS AND BENEFITS

Please confirm that you have read and understand the following information by initialing the service(s) that you have requested.

ACUPUNCTURE

I understand that acupuncture is performed by the insertion of sterilized, disposable needles through the skin or by application of heat to the skin or by both, at certain points on or near the surface of the body. I understand that certain adverse side effects may result from acupuncture treatment including but not limited to local bruising, bleeding, fainting, nausea, temporary pain or discomfort, and the possible aggravation of symptoms existing prior to the acupuncture treatment. In some cases, more serious side effects may occur. I understand that acupuncture has not been established by adequate scientific studies as an effective treatment method and is not a substitute for medical treatment of my health care condition. I understand that acupuncture may not achieve the desired purposes. I further understand that I should see a medical specialist for diagnosis and treatment of my health conditions.

HEALING TOUCH, REIKI

I understand that during touch therapy, I may be gently touched in various places on MY fully clothed body. At other times, the practitioner may be working within one or two inches of my body but will not touch me. The purposes of touch therapy include the promotion of relaxation, reduction of pain and anxiety and facilitation of the body's nature restorative processes. I understand that touch therapy is not a substitute for medical treatment, is not guaranteed to be effective, and may not achieve the desired purpose. I understand that I should see a medical specialist for diagnosis and treatment of my health concerns.

INTEGRATIVE HEALTH NURSE CONSULTATION

I understand that the purpose of the integrative care nurse consultation is to provide information about complementary approaches to conventional medical care and may include lifestyle recommendations and interventions to promote relaxation. I understand that the recommendations and interventions discussed in this consultation are not a substitute for medical treatment, are not guaranteed to be effective, and may not achieve the desired purpose. I understand that I should see a medical specialist for diagnosis and treatment of my medical conditions.

MASSAGE THERAPY/MANUAL LYMPH DRAINAGE/REFLEXOLOGY

I understand that therapeutic massage involves the manipulation of the soft tissue structures of the body to prevent and alleviate pain, discomfort, muscle spasm, and stress; and, to promote health and wellness. The American Massage Therapy Association (AMTA) defines massage as, "a manual soft tissue manipulation that includes holding, causing movement, and/or applying pressure to the body."

I understand that certain adverse side effects may result from massage therapy including but not limited to local bruising, muscle soreness, temporary pain or discomfort, and the possible aggravation of symptoms existing prior to the massage therapy treatment. In some cases, more serious side effects may occur. I understand that massage therapy is not a substitute for medical treatment of my health care condition. I understand that I should see a medical specialist for diagnosis and treatment of my health concerns.

Revised 1/10



**Disclosure Statement
Acupuncture Treatment**

Colorado law requires that all acupuncturists provide the following information to patients at the first visit:

Acupuncturist Information

Acupuncturists in the Center for Integrative Care are employees of Boulder Community Hospital. Information regarding individual licensure and educational background is on file in the Human Resources Department.

Disclosure Statement

Patients are entitled to receive information about the methods of therapy, the techniques used and the duration of therapy if known.

The Center for Integrative Care at Boulder Community Hospital adheres to all rules and regulations pertaining to acupuncture as specified by the Colorado Department of Health, including the proper cleaning and sterilization of equipment. Sterile, disposable needles are used for all acupuncture treatments.

Patients may seek a second opinion from another health care professional or may terminate therapy at any time.

Sexual intimacy is never appropriate in a professional relationship and any questions or complaints about inappropriate behavior should be reported to the management of the Center for Integrative Care at 303.440.2469 or 720.854.7026 and to:

Director of the Division of Registration in the Department of Regulatory Agencies:
Office of Acupuncturists Registration
1560 Broadway, Suite 1545
Denver, CO 80202 303.894.2464

Payment, Fee Schedule and Patient Responsibility

You are responsible for payment at the time service is rendered. If you need to cancel your appointment please give 24 hours notice. If you cancel without giving 24 hours notice, except in emergency situations or extreme weather, you will be charged a \$25.00 cancellation fee.

I have read and agree to the above conditions prior to treatment.

_____ Date _____
Patient or Guardian Signature

Print Name

Relationship to Patient

CENTER FOR INTEGRATIVE CARE
PATIENT SERVICE AGREEMENT

Patient Name: _____

1. Cancellation Policy – We request a minimum of 24 hours notice if you are unable to attend a scheduled appointment. Late notice or no shows will be charged a \$25.00 fee, payable at the next visit. Exceptions will be made for illness, emergencies, and bad weather.

Please call 720.854.7292 to cancel an appointment.

2. Three missed sessions due to no shows or late cancellations may result in a termination of therapy.

3. Our standard treatment is a 50-minute hour. Appointments are scheduled on the hour and half-hour only.

4. We request that you notify the person providing the service of any health condition that might affect the safety or effectiveness of the service including but not limited to:

- Fever equal to or greater than 100.5°
- Unrelenting cough
- Ongoing infectious disease process
- An INR count of greater than 3 when on anticoagulants
- Extreme weakness

5. In order to protect your well being, we will not provide services if you have any of the following conditions:

- Absolute neutrophil count of 500 or less
- A platelet count of 25,000 or less

By signing below I confirm that I have read and understood the above policies.

Signature: _____ Date: _____

Please keep this information for future reference.