WASHINGTON PARK
CHIROPRACTIC
heal thrive evolve

1313 S. Clarkson St. Unit 1, Denver, CO 80210 P: 303-744-7100 F: 303-744-7109 washparkchiro.com

Education and Experience
Cybil G. Kendrick, L. Ac, LMT

Certification of Massage Therapy (CMT) from Massage Therapy Institute of Colorado awarded January 1998. This program was a one year 1050 hour program with emphasis in sports massage, NMT and myofascial release. Another 150 hours of continuing education in orthopedic and sports massage from Boulder College of Massage Therapy. I worked at bodyworks spa for two years before working at a healing touch for 4 years with many local and professional athletes treating everything from pre and post event to pre and post surgery and everything in between.
Master of Acupuncture and Oriental Medicine degree (MSOM) from Southwest Acupuncture College awarded December 2005. This 3 year, 3000 hour program included 1000 hours of clinical practice. National Certification as a Diplomate of Acupuncture and Traditional Chinese Medicine (including Chinese Herbology) by the National Certification Commission of Acupuncture and Oriental Medicine (NCCAOM) awarded in January 2006. 130 hours of continuing education in Japanese Acupuncture completed June 2007. Certified in Sports Medicine Acupuncture ® in October of 2011. Trained in Kinesio Taping® (KT 1, KT2 & KT3) in 2012. Assistant to Matt Callison in the Sports Medicine Acupuncture® fundamental courses and certification program from 2012 to present.

No licenses, certificates or registrations have ever been revoked.

I comply with all rules and regulations promulgated by the Colorado Department of Public Health and Environment, including the proper cleaning and sterilization of needles used in the practice of Acupuncture and the sanitation of acupuncture offices. We only use single use, disposable, factory sanitized needles in this clinic.

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 2nd opinion from another health professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be immediately 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 the division of registrations, Colorado Department of Regulatory Agencies. If you have any questions, comments or complaints contact the Director of Registrations, Acupuncturists Licensure, 1560 Broadway, Suite 1350, Denver Co 80202. Telephone: (303) 894-7800

Fee Schedule

Initial 90 min consult and treatment	$130
Regular 1 hour appointment	$90
Massage & acupuncture (90 minutes)	$130
*Herbs for an additional fee**	

I have read and understand this form:

Signature: _____ Date: _____

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HIPAA Privacy Practices – Patient Reception Form

I have received or reviewed the privacy practice notice for Washington Park Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially initiated care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____
Patient/Guardian Signature Date

_____
Print Patient Name

Exception and Records Release

I allow the doctors and staff at Washington Park Chiropractic to discuss my treatment and diagnosis with the following doctors, health care professionals, coaches, lawyers, spouses, etc.

Name	Title
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Patient/Guardian Signature Date

_____
Print Patient Name

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HEALTH HISTORY QUESTIONNAIRE

Name: Date of Birth:

Address: City: State: Zip:

Gender: Age: Height: Weight:

Preferred Phone: Email Address:

Occupation: Marital Status:

Emergency Contact: Relationship: Phone:

Referred by:

Family Physician:

Insurance Carrier: Insurance ID#

Who may we thank for referring you to our office?

Have you tried acupuncture or Chinese herbal medicine before?

What are you coming in for today?

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?

How long has it been since you first noticed any symptoms?

Have you been given a diagnosis for the problem by your family physician?

If so, what is it?

What kinds of treatment or therapy have you tried?

Past Medical History (Please Include Dates):

❒ Allergies:
❒ Cancer
❒ Diabetes
❒ Hepatitis
❒ High Blood Pressure
❒ Heart Disease
❒ Seizures

❒ Rheumatic Fever
❒ Surgeries
❒ Venereal disease
❒ Thyroid Disease (describe)_____

❒ Birth Trauma (prolonged labor, forceps delivery, etc.)_____

❒ Other significant illness (describe)_____

❒ Accidents or significant trauma (describe)_____

❒ Notes:_____

Other Relevant Medical History:

FAMILY MEDICAL HISTORY

❒ Allergies	❒ Cancer	❒ Seizures	❒ Other:_____
❒ Diabetes	❒ Heart disease	❒ Stroke	_____
❒ Asthma	❒ High blood pressure		_____

OCCUPATION

Occupational stress factors: (physical, psychological,chemical:)

_____

LIFESTYLE

Do you follow a regular exercise program?_____If so, please describe: _____

_____

Please describe your average daily diet:_____

_____

Please check any of the following habits that apply. How much and how often do you use them?

▫ Cigarette smoking ▫ Coffee, tea or soda ▫ Alcoholic beverages

List medications taken within the last two months (vitamins, drugs, herbs, etc):

_____

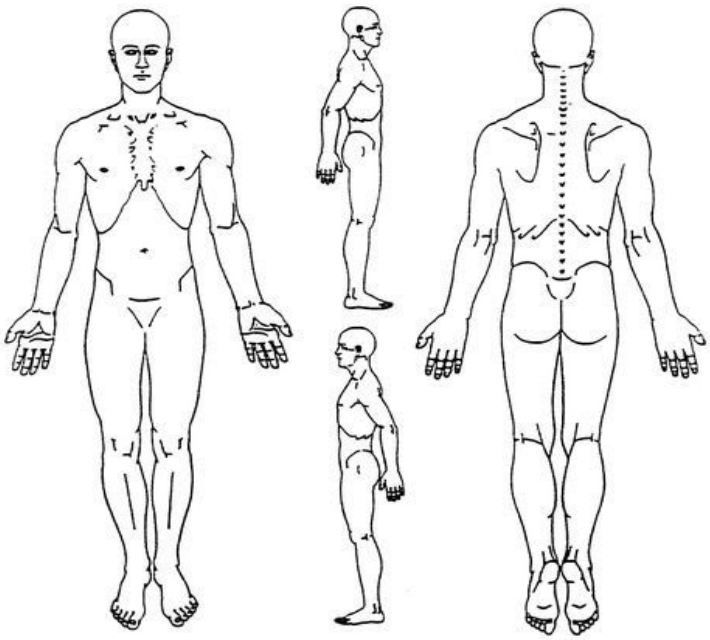
Please describe any use of drugs for non-medical purposes:

_____

Please mark any painful or distressed areas on the charts below:

PLEASE PUT A

Symbol	Reaction
PAIN ON PRESSURE	
X XX XXX	Little Moderate Strong
SWELLING	
^ ^^ ^^^	Slight Moderate Severe
TENSION/WEAKNESS	
≈ #	Weak Tense
SPONTANEOUS PAIN	
ŧ ŧŧ ŧŧŧ	Slight Moderate Severe
PULSING	
◯ ◯◯ ◯◯◯	Slight Moderate Strong
TEMPERATURE	
- +	Colder Hotter



List Any Notes Here:

Check next to any conditions you have experienced within the last three months. Indicate the length of time you have had this condition.

General
❒ Poor appetite
❒ Insomnia
❒ Disturbed sleep
❒ Localized weakness
❒ Cravings
❒ Strong thirst
❒ Weight gain
❒ Weight loss
❒ Changes in appetite
❒ Sweating easily
❒ Tremors
❒ Bleeding or bruising easily
❒ Night sweats
❒ Fever
❒ Chills
❒ Sudden energy drop (time of day?)
❒ Poor balance

Skin & Hair
❒ Rashes
❒ Ulcerations
❒ Hives
❒ Itching
❒ Eczema
❒ Pimples/Acne
❒ Dandruff
❒ Hair loss
❒ Recent moles
❒ Changes in texture of hair or skin
❒ Psoriasis

Head, Eyes, Ears, Nose, Throat
❒ Dizziness
❒ Concussions
❒ Migraines
❒ Glasses
❒ Poor vision
❒ Spots in front of eyes
❒ Eye pain
❒ Night blindness
❒ Color blindness
❒ Cataracts
❒ Blurry vision
❒ Ear aches
❒ Ringing in ears
❒ Poor hearing
❒ Eye strain
❒ Recurrent sore throats
❒ Nose bleeds
❒ Grinding teeth
❒ Sores on lips or tongue
❒ Facial pain
❒ Teeth problems
❒ Headaches (where/when)
❒ Jaw clicks

Cardiovascular
❒ Dizziness
❒ High blood pressure
❒ Low blood pressure
❒ Swelling of feet
❒ Swelling of hands
❒ Fainting
❒ Blood clots
❒ Chest pain
❒ Irregular heartbeat
❒ Difficulty in breathing
❒ Phlebitis

Respiratory
❒ Cough
❒ Coughing up blood
❒ Asthma
❒ Bronchitis
❒ Pain with deep inhalation
❒ Excessive phlegm (color?)
❒ Pneumonia
❒ Difficulty breathing when lying down

GENERAL

Other unusual or abnormal conditions you have noticed in your general sense of health:

SKIN & HAIR

Any other skin problems:

HEAD, EYES, EARS, NOSE, THROAT

Any other head or neck problems:

CARDIOVASCULAR

Any other or heart or blood vessel problems:

RESPIRATORY

Any other lung problems:

Gastrointestinal
❒ Nausea
❒ Vomiting
❒ Diarrhea
❒ Constipation
❒ Gas
❒ Belching
❒ Black stools
❒ Blood in stools
❒ Indigestion
❒ Bad breath
❒ Rectal pain
❒ Hemorrhoids
❒ Abdominal pain or cramps
❒ Chronic laxative use

Genitourinary
❒ Pain with urination
❒ Unable to hold urine
❒ Prostate problems
❒ Urgent or frequent urination
❒ Blood in urine
❒ Decrease in flow
❒ Impotence
❒ Kidney stones
❒ Sores on genitals

REPRODUCTIVE & GYNECOLOGIC
❒ Premenstrual changes
❒ Heavy menstrual flow
❒ Premature births
❒ Menstrual clots
❒ Light menstrual flow
❒ Miscarriages
❒ Painful menses
❒ Irregular menses
❒ Abortions
❒ Unusual menses
❒ Other problems

NEURO-PSYCHOLOGICAL
❒ Seizures
❒ Anxiety
❒ Loss of Balance
❒ Areas of numbness
❒ Lack of coordination
❒ Poor Memory
❒ Depression
❒ Dizziness
❒ Epilepsy
❒ Concussion
❒ Bad Temper
❒ Easily susceptible to stress

Musculoskeletal
❒ Neck pain
❒ Back pain
❒ Hand/wrist pains
❒ Muscle pains
❒ Knee Pain
❒ Muscle weakness
❒ Shoulder pains
❒ Foot/ankle pains

GASTROINTESTINAL

Any other problems with the stomach or intestines?

GENITOURINARY

Do you wake up at night to urinate?_____If so, how often?_____

Any particular color to your urine? _____

Any other genital or urinary problems?_____

REPRODUCTIVE AND GYNECOLOGIC

Age at first menses_____Age at menopause_____Number of pregnancies _____

Time between cycles_____Duration of bleeding_____First day of last menses_____

Do you practice birth control?_____If so, what type?_____For how long?_____

Any other gynecologic problems:

MUSCULOSKELETAL

Any other joint or bone problems:

NEUROPSYCHOLOGICAL

Have you ever been treated for mental health episodes?_____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological diagnoses/suspicions?_____

COMMENTS

Please list any other problems you would like to discuss _____

_____

_____

_____

Cybil Kendrick L.Ac., LMT
Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at the Chinese Medical Clinic. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Chinese Medical Clinic as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Address:_____

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

SIGN BELOW *ONLY* IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

*X*_____ *X*_____

Patient's Signature Date Explained by me and signed in my presence Date