



# Longmont Healing Arts Clinic

736 Kimbark Street, Suite A Longmont, CO 80501  
(720) 652-9972 www.longmonthealingarts.com

## HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask. Thank you.

**Please Note: We do not at this time accept credit cards. Cash or check only. Thank You!**

Name: _____	M	F
Street: _____	City: _____	State: _____ Zip: _____
Home Phone: _____	Cell: _____	Work: _____ E-mail: _____
Birthday: _____	Height: _____	Weight: _____
Occupation: _____	Social Security Number: _____	
Please circle:	Single	Married
	Life Partner	Divorced
	Widowed	Other
Name of Significant Other: _____	Names and age of Children: _____	
In Emergency Notify: _____	Relationship: _____	Phone: _____
Family Physician: _____	Address: _____	Phone: _____
How did you hear about the LHAC?		
<input type="checkbox"/> Referred by: _____	<input type="checkbox"/> Yellow Pages	
<input type="checkbox"/> Newspaper. Which one? _____	<input type="checkbox"/> Internet	
<input type="checkbox"/> Flyer. Where? _____	<input type="checkbox"/> Other: _____	
Which modalities of treatment are you interested in? <i>(Please circle all that apply.)</i>		
Naturopathic Medicine	Acupuncture	Herbal Medicine
Nutrition	Homeopathy	CranioSacral
Medical Intuition	Reiki	Theta Healing
DNA Reprogramming	Astrology	Tarot

### List Your Present Health Concerns in Order of Importance:

1. \_\_\_\_\_ Began: \_\_\_\_\_

What makes the condition better? \_\_\_\_\_

What makes the condition worse? \_\_\_\_\_

Other comments: \_\_\_\_\_
2. \_\_\_\_\_ Began: \_\_\_\_\_

What makes the condition better? \_\_\_\_\_

What makes the condition worse? \_\_\_\_\_

Other comments: \_\_\_\_\_
3. \_\_\_\_\_ Began: \_\_\_\_\_

What makes the condition better? \_\_\_\_\_

What makes the condition worse? \_\_\_\_\_

Other comments: \_\_\_\_\_

**Do you have any opinions or ideas regarding what has caused your concerns/conditions?**

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**List any chronic conditions, diseases or illnesses you have been previously diagnosed with:**

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**List other healthcare practitioners consulted for present concerns/complaints:**

<u>Name</u>	<u>When consulted</u>	<u>Diagnosis</u>	<u>Treatments</u>	<u>Outcome</u>
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**List any surgeries or hospitalizations:**

<u>Type</u>	<u>Date</u>	<u>Outcome</u>
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**List any accidents or falls and type of injury:**

<u>Type of accident/fall</u>	<u>Date</u>	<u>Injury</u>	<u>Treatment?</u>
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**List any childhood illness, age at which illness occurred and immunization history, if known:**

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**Did you have childhood allergies, asthma or skin conditions?** \_\_\_\_\_

**List medications you are currently taking with dosages, if known:**

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**List supplements, herbal medicine or homeopathic remedies you are currently taking with dosages, if known:**

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**List any known allergies or sensitivities (Medications/Environmental/Chemical/Food):**

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**FAMILY HISTORY:**

Are you adopted? **Yes No**

Please give information on biological family, if known:

Mother: Living\_\_\_\_\_ Deceased\_\_\_\_\_ Age\_\_\_\_\_
Reason for death, if deceased\_\_\_\_\_
Any pronounced illnesses:\_\_\_\_\_

Father: Living\_\_\_\_\_ Deceased\_\_\_\_\_ Age\_\_\_\_\_
Reason for death, if deceased\_\_\_\_\_
Any pronounced illnesses:\_\_\_\_\_

Mother's father: Living\_\_\_\_\_ Deceased\_\_\_\_\_ Age\_\_\_\_\_
Reason for death, if deceased\_\_\_\_\_
Any pronounced illnesses:\_\_\_\_\_

Mother's mother: Living\_\_\_\_\_ Deceased\_\_\_\_\_ Age\_\_\_\_\_
Reason for death, if deceased\_\_\_\_\_
Any pronounced illnesses:\_\_\_\_\_

Father's father: Living\_\_\_\_\_ Deceased\_\_\_\_\_ Age\_\_\_\_\_
Reason for death, if deceased\_\_\_\_\_
Any pronounced illnesses:\_\_\_\_\_

Father's mother: Living\_\_\_\_\_ Deceased\_\_\_\_\_ Age\_\_\_\_\_
Reason for death, if deceased\_\_\_\_\_
Any pronounced illnesses:\_\_\_\_\_

Siblings: Please list any significant illnesses

Aunts/Uncles: Please list any significant illnesses

**SLEEP HISTORY:**

Number of hours of sleep per night\_\_\_\_\_ Wake refreshed? **Y N** \_\_\_\_\_
Do you have difficulty falling to sleep? **Y N** If yes, why?\_\_\_\_\_ Do you have
difficulty staying asleep? **Y N** If yes, why?\_\_\_\_\_

Please describe your energy levels throughout the day (0 - extremely exhausted / 10 - ideal energy):
Awakening\_\_\_\_\_ Morning\_\_\_\_\_ Midmorning\_\_\_\_\_ Noon\_\_\_\_\_ Afternoon\_\_\_\_\_
Evening\_\_\_\_\_ Night\_\_\_\_\_ At bedtime\_\_\_\_\_

Do you have any of the following? (Please circle)
Nightmares Recurring dreams Sleep talking Sleep walking Grind teeth Leg restlessness or cramps
Do you have any more comments about your sleeping health?\_\_\_\_\_

**DIGESTIVE HISTORY:**

How many bowel movements do you have per day?\_\_\_\_\_ Any blood? **Y N** Any mucus? **Y N**
What are the consistency of your stools? Hard Firm Soft Runny
Are they well-formed? **Y N** Do you ever have tiny pellets? **Y N** Do your stools: float? sink? both?
When your digestive system is 'off' do you tend towards: constipation or loose stools/diarrhea?
Please circle if you are presently experiencing or have experienced in the past any of the following:
excessive gas bloating nausea vomiting jaundice hernias
abdominal pain – upper/lower/right-sided/left-sided pain during bowel movement
hemorrhoids heartburn belching acid reflux other?\_\_\_\_\_

**DIET HISTORY:**

Are you satisfied with your present diet? **Y N** Are you satisfied with your present weight? **Y N**

Does your weight fluctuate? **Y N** If yes, please describe \_\_\_\_\_

**TWENTY-FOUR HOUR DIET RECALL:**

Please write down what you have eaten in the last twenty-four hours, include all beverages and snacks. If it is presently the middle of the day, write down what you had for dinner, etc. the previous day.

Breakfast –

Lunch –

Dinner –

Snacks –

Is this a typical day? **Y N** If no, explain \_\_\_\_\_

Please circle appropriate answer and complete:

- Consume alcohol? **Y N** What/How often/Socially or alone \_\_\_\_\_
- Smoke? **Y N** For how long/How many per day \_\_\_\_\_
- Drink coffee? **Y N** How many cups per day or week \_\_\_\_\_
- Consume sugar? **Y N** In what form/How often/Craving \_\_\_\_\_
- Use saccharine or NutraSweet? **Y N** In what form/How often \_\_\_\_\_
- Eat fast food? **Y N** How often/Where \_\_\_\_\_
- Thirsty? **Y N** How often/For what/Temperature \_\_\_\_\_
- Drink soda pop? **Y N** How often/Which ones \_\_\_\_\_
- Drink water? **Y N** How many glasses per day/Sources \_\_\_\_\_
- Eat fried foods? **Y N** How often/What \_\_\_\_\_
- Eat margarine? **Y N** How much per day or week \_\_\_\_\_
- Eat red meat? **Y N** How often per day or week \_\_\_\_\_
- Eat poultry? **Y N** How often per day or week \_\_\_\_\_
- Eat fish? **Y N** How often per day or week \_\_\_\_\_
- Dietary restrictions? **Y N** What/How long \_\_\_\_\_
- Food cravings? **Y N** What/How often \_\_\_\_\_
- Food aversions? **Y N** What/How often \_\_\_\_\_
- Use aspirin? **Y N** Why/How often \_\_\_\_\_
- Use other pain medications? **Y N** Which ones/Why/How often \_\_\_\_\_
- Do you exercise? **Y N** What type(s)/How often \_\_\_\_\_
- What is your stress level? (0 – no stress / 10 – extreme stress) **0 1 2 3 4 5 6 7 8 9 10**
- What activities, if any, do you do for stress and anxiety? \_\_\_\_\_

Have there ever been any life experiences/situations which did, or continue to, affect you deeply?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Instructions: Circle the letter which best describes your symptoms. If you have never experienced the symptom, leave blank. If you have any questions, please ask.**

**Y = Currently having symptom P = Past experience of symptom R = Reoccurring symptom (comes and goes)**

**Head/Neurological**

- |                               |   |   |   |
|-------------------------------|---|---|---|
| 1. Head feels heavy           | Y | P | R |
| 2. Light headedness/fainting  | Y | P | R |
| 3. Dizziness/Loss of balance  | Y | P | R |
| 4. Ringing in ears            | Y | P | R |
| 5. Trembling in hands or feet | Y | P | R |
| 6. Double vision              | Y | P | R |
| 7. Headaches                  | Y | P | R |
| 8. Night Blindness            | Y | P | R |
| 9. Eye pain/itching           | Y | P | R |
| 10. Eye dryness               | Y | P | R |
| 11. Floating 'dots' in vision | Y | P | R |
| 12. Halos or lights in eyes   | Y | P | R |
| 13. Blurry vision             | Y | P | R |
| 14. Glaucoma                  | Y | P | R |
| 15. Cataracts                 | Y | P | R |
| 16. Light sensitivity         | Y | P | R |
| 17. Swollen eyes              | Y | P | R |
| 18. Circles under eyes        | Y | P | R |
| 19. Poor concentration        | Y | P | R |
| 20. Poor memory               | Y | P | R |
| 21. Slurred speech            | Y | P | R |
| 22. Jaw pain                  | Y | P | R |

**Respiratory**

- |                           |   |   |   |
|---------------------------|---|---|---|
| 1. Difficulty breathing   | Y | P | R |
| 2. Chronic cough          | Y | P | R |
| 3. Coughing phlegm/blood  | Y | P | R |
| 4. Shortness of breath    | Y | P | R |
| 5. Painful breathing      | Y | P | R |
| 6. Asthma                 | Y | P | R |
| 7. Allergies              | Y | P | R |
| 8. Bronchitis             | Y | P | R |
| 9. Pneumonia              | Y | P | R |
| 10. Tuberculosis          | Y | P | R |
| 11. Frequent chest colds  | Y | P | R |
| 12. Exposure to chemicals | Y | P | R |

**Genito-Urinary**

- |  |   |   |   |
|--|---|---|---|
| 1. Frequent urination                          | Y | P | R |
| 2. Wake to urinate                             | Y | P | R |
| 3. Pain on urination                           | Y | P | R |
| 4. Brown, black or bloody urine                | Y | P | R |
| 5. Bladder infections                          | Y | P | R |
| 6. Constant urge to urinate                    | Y | P | R |
| 7. Unable to urinate                           | Y | P | R |
| 8. Bed wetting                                 | Y | P | R |
| 9. Urination on laughing/<br>sneezing/coughing | Y | P | R |
| 10. Kidney infections/stones                   | Y | P | R |

**Sinus/Ear/Nose/Throat**

- |   |   |   |   |
|---|---|---|---|
| 1. Frequent colds                       | Y | P | R |
| 2. Sore throats                         | Y | P | R |
| 3. Sore or bleeding gums                | Y | P | R |
| 4. Nose pain                            | Y | P | R |
| 5. Nose bleeding                        | Y | P | R |
| 6. Nose discharge                       | Y | P | R |
| 7. Frequent blowing nose                | Y | P | R |
| 8. Difficulty breathing<br>through nose | Y | P | R |
| 9. Earaches                             | Y | P | R |
| 10. Canker sores                        | Y | P | R |
| 11. Fever Blisters                      | Y | P | R |
| 12. Dental problems                     | Y | P | R |
| 13. Difficulty swallowing               | Y | P | R |
| 14. Hayfever/Allergies                  | Y | P | R |
| 15. Post nasal drip                     | Y | P | R |
| 16. Loss of taste                       | Y | P | R |

**Skin**

- |                                |   |   |   |
|--------------------------------|---|---|---|
| 1. Rashes                      | Y | P | R |
| 2. Hives                       | Y | P | R |
| 3. Dryness                     | Y | P | R |
| 4. Itching                     | Y | P | R |
| 5. Bruise easily               | Y | P | R |
| 6. Loss of hair                | Y | P | R |
| 7. Ulcerations/Sores           | Y | P | R |
| 8. Growths                     | Y | P | R |
| 9. Acne                        | Y | P | R |
| 10. Shingles                   | Y | P | R |
| 11. Thick skin or finger nails | Y | P | R |
| 12. Swollen or puffy skin      | Y | P | R |

**Cardio-Vascular**

- |                                  |   |   |   |
|----------------------------------|---|---|---|
| 1. High blood pressure           | Y | P | R |
| 2. Low blood pressure            | Y | P | R |
| 3. Rapid beating heart           | Y | P | R |
| 4. Slow beating heart            | Y | P | R |
| 5. Chest pain                    | Y | P | R |
| 6. Hardening of the arteries     | Y | P | R |
| 7. Poor circulation              | Y | P | R |
| 8. Varicose veins                | Y | P | R |
| 9. Stroke                        | Y | P | R |
| 10. Heart attack                 | Y | P | R |
| 11. Pain in left arm             | Y | P | R |
| 12. Poor wound healing           | Y | P | R |
| 13. Dry cracked hands/feet/nails | Y | P | R |

**Emotional**

- |   |   |   |   |
|---|---|---|---|
| 1. Depression                           | Y | P | R |
| 2. Nervousness/Anxiety                  | Y | P | R |
| 3. Stress                               | Y | P | R |
| 4. Mood swings                          | Y | P | R |
| 5. History of emotional trauma or abuse | Y | P | R |
| 6. Eating disorders                     | Y | P | R |
| 7. Suicidal thoughts                    | Y | P | R |
| 8. Attempted suicide                    |   | P |   |

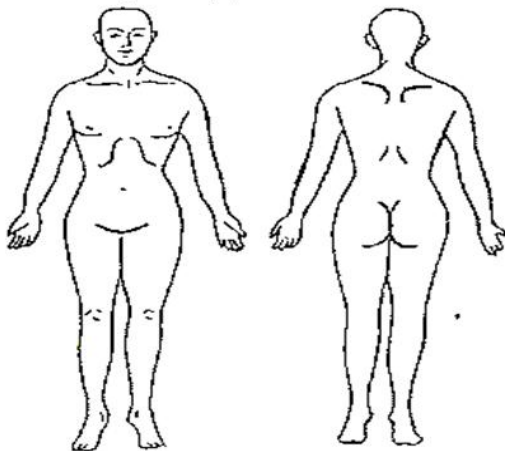
**Endocrine**

- |                               |   |   |   |
|-------------------------------|---|---|---|
| 1. Cold hands and feet        | Y | P | R |
| 2. Excessive hunger           | Y | P | R |
| 3. Excessive thirst           | Y | P | R |
| 4. Excessive sweating         | Y | P | R |
| 5. Night sweats               | Y | P | R |
| 6. Poor appetite              | Y | P | R |
| 7. Chronic fatigue            | Y | P | R |
| 8. Recurrent fevers           | Y | P | R |
| 9. Always feeling cold/chills | Y | P | R |
| 10. Heat intolerance          | Y | P | R |
| 11. Cold intolerance          | Y | P | R |
| 12. Loss of weight            | Y | P | R |
| 13. Weight gain               | Y | P | R |

**Musculo-Skeletal**

- |                                |   |   |   |
|--------------------------------|---|---|---|
| 1. Leg cramp on walking        | Y | P | R |
| 2. Weakness in arms/legs       | Y | P | R |
| 3. Numbness/Tingling           | Y | P | R |
| 4. Joint pain or stiffness     | Y | P | R |
| 5. Morning pain or stiffness   | Y | P | R |
| 6. Gout                        | Y | P | R |
| 7. Sciatica                    | Y | P | R |
| 8. Swelling of hands/feet      | Y | P | R |
| 9. Difficulty standing/sitting | Y | P | R |
| 10. Pain bending forward/back  | Y | P | R |
| 11. Posture problems           | Y | P | R |
| 12. Tremors                    | Y | P | R |
| 13. Sprained ankles            | Y | P | R |
| 14. Broken bones               | Y | P | R |

Indicate on diagram any problem areas:



**Female Only**

- |  |       |     |     |
|--|-------|-----|-----|
| 1. Age menses began                            | _____ |     |     |
| 2. Number of days of menstrual flow            | _____ |     |     |
| 3. Length of cycle (i.e. 28 days)              | _____ |     |     |
| 4. Are cycles regular?                         | Yes   | No  |     |
| 5. Date of last PAP?                           | _____ |     |     |
| 6. Date of last menstrual period?              | _____ |     |     |
| 7. Number of pregnancies                       | _____ |     |     |
| 8. Number of live births                       | _____ |     |     |
| 9. Number of miscarriages                      | _____ |     |     |
| 10. Number of abortions                        | _____ |     |     |
| 11. Are you sexually active?                   | Yes   | No  |     |
| 12. Birth control?                             | Yes   | No  |     |
| 13. What type?                                 | _____ |     |     |
| 14. Do you self examine your breasts?          | Yes   | No  |     |
| 15. Is it possible that you could be pregnant? | Yes   | No  |     |
| 16. Sexual drive/libido                        | High  | Med | Low |
| 17. Pain during intercourse                    | Y     | P   | R   |
| 18. Sexual difficulties                        | Y     | P   | R   |
| 19. Menstrual cramps                           | Y     | P   | R   |
| 20. Bleeding between periods                   | Y     | P   | R   |
| 21. Excessive bleeding                         | Y     | P   | R   |
| 22. Scanty bleeding                            | Y     | P   | R   |
| 23. Clots                                      | Y     | P   | R   |
| 24. Premenstrual Syndrome                      | Y     | P   | R   |
| 25. Vaginal discharge/itching                  | Y     | P   | R   |
| 26. Vaginal dryness                            | Y     | P   | R   |
| 27. Difficulty conceiving                      | Y     | P   | R   |
| 28. Menopausal symptoms                        | Y     | P   | R   |
| 29. Hysterectomy                               | Y     | P   | R   |
| 30. Sexually transmitted disease               | Y     | P   | R   |
| 31. Abnormal PAP                               | Y     | P   | R   |

**Male Only**

- |   |       |     |     |
|---|-------|-----|-----|
| 1. Are you sexually active?                   | Yes   | No  |     |
| 2. Birth control?                             | Yes   | No  |     |
| 3. What type?                                 | _____ |     |     |
| 4. Sexual drive/libido                        | High  | Med | Low |
| 5. Erectile difficulty                        | Y     | P   | R   |
| 6. Sexual difficulties                        | Y     | P   | R   |
| 7. Penile pain                                | Y     | P   | R   |
| 8. Penile discharge                           | Y     | P   | R   |
| 9. Testicular pain                            | Y     | P   | R   |
| 10. Testicular masses                         | Y     | P   | R   |
| 11. Hernia                                    | Y     | P   | R   |
| 12. Genital sores                             | Y     | P   | R   |
| 13. Difficulty starting or stopping urination | Y     | P   | R   |
| 14. Enlarged prostate                         | Y     | P   | R   |
| 15. Sexually transmitted disease              | Y     | P   | R   |



# Longmont Healing Arts Clinic

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## **MANDATORY DISCLOSURE FORM**

Please read the following disclosure form required by the State of Colorado Department of Regulatory Agencies and sign on the line provided at the bottom of the 2<sup>nd</sup> page.

Thank You.

- **Education**

	<b>Date</b>	<b>Degree</b>
University of Colorado, Boulder, CO	'84-'89	BA
Bastyr University, Seattle, WA	'94-'99	ND, MSA
Brenneke School of Massage, Seattle, WA	'95	LMT
Upledger Institute, Cranio-Sacral	'99	Certified
National College of Naturopathic Medicine	'00	Residency
The Mystery School, Louisville, CO	'02-'05	Certified
-Medical Intuition, Reiki, Theta		
  
- **Memberships**
  - AANP – *American Association of Naturopathic Physicians* since 1994
  - CANP – *Colorado Association of Naturopathic Physicians* since 2001
  - NCCAOM – *National Certification Commission for Acupuncture and Oriental Medicine*, awarded Diplomate in Acupuncture in 1999.
  - AAC – *Acupuncture Association of Colorado* since 2002
  - IONS – *Institute of Noetic Sciences* since 1986
  
- **Work Experience**
  - Bastyr University Natural Health Clinic, Seattle, Washington '95 - '99
  - North Hawaii Community Hospital, Waimea, the Big Island, Hawaii '99 - '01
  - Ho'o Lokahi Integrated Healthcare Center, Kailua-Kona, the Big Island, Hawaii '99 – '01
  - Longmont Healing Arts Clinic, Longmont, Colorado '02 - present
  
- **Licenses**
  - Department of Health, State of Hawaii
    - Licensed Naturopathic Physician
    - Licensed Acupuncturist
  - Department of Health, State of Washington
    - Licensed Naturopathic Physician #1079
    - Licensed Acupuncturist
  - Department of Regulatory Agencies, State of Colorado
    - Licensed Acupuncturist #785

None of the above licenses have ever been suspended or revoked.
  
- Dr. Blunt complies with all rules and regulations promulgated by the Department of Health with respect to this article, including those related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices.
  
- The practice of acupuncture in the state of Colorado is licensed by the Department of Regulatory agencies:
  - Division of Registrations
  - 1560 Broadway, Suite 1545 Denver, CO 80202 (303) 894-2464

- The patient may seek a second opinion from another health care 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 patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- Dr. Blunt has training in Naturopathic Medicine, Acupuncture, Western and Chinese botanical medicine, homeopathy, cranio-sacral therapy, physical medicine (which includes bodywork and hydrotherapy), nutritional therapy, auricular therapy (ear acupuncture) and electroacupuncture (the use of a small TENS device in conjunction with acupuncture.) Dr. Blunt also has training in medical intuition, Reiki, Theta Healing and DNA Reprogramming.
- *24 Hour Cancellation Policy:* If you cancel less than 24 hours before scheduled appointment, you will be charged \$50 for your missed appointment.
- *Phone Consultation Policy:* Established patients may call Dr. Blunt at any time with questions or concerns. The first five minutes are free of charge. After that, you will be charged \$1.00 per minute.
- *Treatment Package Policy:* You may purchase treatment packages at a discounted rate. You may discontinue treatment at anytime and receive a full refund minus the cost of treatments rendered at the regular rate.

- **Fee Schedule:**

<u>Description</u>	<u>Duration</u>	<u>Fee (Children)</u>
• First office visit	1-2 hours	\$125 (\$95)
• Follow-up visit	1 hour	\$75 (\$60)
• 2 treatments per week	2 X 1 hour	\$130 (\$80)
• 3 treatments per week	3 X 1 hour	\$150 (\$120)
• Brief visit	½ hour	\$40 (\$35)
• Series of 5 treatments		\$325 (\$250)
• Series of 10 treatments		\$600 (\$450)
• Cosmetic Acupuncture	1 ½ hours	\$95
• Cosmetic Package	10 treatments	\$800

\_\_\_\_\_  
**Patient's signature**

\_\_\_\_\_  
**Date**

THANK YOU!! I look forward to working with you, Dr. B.

*Longmont Healing Arts Clinic*

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