

**Dr. Mark Kelley ND, LAc**  
**Naturopathic Doctor & Acupuncturist**  
**209 E. Swallow Rd.**  
**Fort Collins, CO 80525**  
**office (970) 223-7425 fax (866) 225-2126**  
**[www.thehealthyplace.com](http://www.thehealthyplace.com)**

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Dr. Kelley received his pre-medical training with a BA in Psychology from Ohio University. Dr. Kelley then completed his Doctorate of Naturopathic Medicine from Southwest College of Naturopathic Medicine in Tempe, AZ in 2000. This school is an accredited four-year medical program, (4500 hours), specializing in natural therapeutics including basic sciences and clinical training. Dr. Kelley then went on to complete a Masters Degree in Oriental Medicine (2001) from Southwest Acupuncture College, (2643 hours), in Boulder, CO. After passing the naturopathic licensing board exams, Dr. Kelley obtained a license as a Naturopathic Physician in the state of Montana (2001), Arizona (2000) (ret.) and Vermont (2000). Dr. Kelley is also a licensed acupuncturist in Colorado (2004) and Montana (2001). Dr. Kelley is certified through the National Certification Commission for Acupuncture and Oriental Medicine as a Diplomate in Acupuncture from 8/31/01 to 8/31/09. Dr. Kelley has never had a registration, certificate or license suspended or revoked. Dr. Kelley is continually expanding his education with seminars and workshops several times a year, completing much more than the required continuing education hours. Dr. Kelley is a member of the Colorado Association of Naturopathic Physicians, the American Association of Naturopathic Physicians, and the American College for Advancement in Medicine. The practice of Naturopathy includes: western diagnostics/labs, botanical medicine, homeopathy, lifestyle counseling, nutrition and physical medicine. The scope of Chinese Medicine includes: acupuncture, needling and injections, Chinese herbs, (bulk teas, fluid extracts and patent formulas), moxibustion, and gua sha. Dr. Kelley may utilize one or a combination of the above listed therapies in working with clients and has trained extensively in combining therapies to meet the health needs of the client. This office complies with all rules and regulations promulgated by the Colorado Department of Public Health and Environment, including those related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices. This office uses one-time use disposable needles only. Sexual intimacy is never appropriate in a professional relationship and should be reported to the agency listed below.

The Colorado Department of Regulatory Agencies regulates acupuncture at:  
Director of Registrations Acupuncturist Licensure  
1560 Broadway, Suite 1545  
Denver, CO 80202 Phone: (303) 894-2464

As a client you are entitled to receive information about the methods of therapy, the treatment modalities used, and the duration of therapy if known. As a patient you may seek a second opinion from another health care professional, or may terminate therapy at any time. All clients are asked to pay in full at the time of the visit. All expenses for supplements, herbs, and homeopathic medicines are in addition to the cost of the treatment. I take great care, and am able with my education, to discern quality and potency. I use physician-only lines of supplements that are what they say they are, and that are designed to be very potent and therefore only used by physicians. These companies were created by doctors like me for doctors like me that "know the difference" and they cater to my particular, critical and demanding standards. Further, they often make available substances that only doctors like me know to use, and that the lay market does not know, understand and therefore demand so that they are not found in the lay market. I am able to use quality, potent materials that produce dramatic results for people working to improve their health. This is vital to the success of my patients.

**Fee Schedule:**

Initial Visit (1 hour)-----	\$180
Return visit intermediate (45 minutes)-----	\$135
Return visit limited (30 minutes)-----	\$90
Return visit brief (15 minutes)-----	\$45
Acupuncture initial visit-----	\$180
Acupuncture follow up-----	\$75
Regeneration injection therapy (prolotherapy)-----	\$150
Constitutional Hydrotherapy-----	\$55
FCT (allergy elimination)-----	\$75
Naturopathic spinal manipulation-----	\$65
BIA (body composition analysis)-----	\$45
EAV (Bodyscan 2000)-----	\$180/hour
Chelation-----	\$115
Telephone consult -----	\$3.00/minute
Rates based on -----	\$180 / hour

I have read the above information and my signature edorses my understanding of these conditions.

Signature\_\_\_\_\_Date \_\_\_\_\_

**\*Very Important Information \***

Please Read Carefully and Sign After Reading

We at the Three Rivers Natural Medicine are here to help you take care of your health in the best way that we know how. We realize you came in about health and not finances. The following is to assist you in understanding the Three River Natural Medicine financial policies. Payment Requirements: Appointments must be paid for at time of service. We accept Visa, Master Card, check, cash, or Travelers checks. Please contact our desk for more details. You will be charged a \$25 fee for returned checks. Appointments: We require 24 hours notice if you need to change or cancel your appointment. You will be charged a fee of 50% of the total cost of any missed appointment if the 24 hour advance cancellation policy was not met. Records: We keep a record of your health care. We charge a small fee for copies of your medical records. We will not disclose your record to others unless you direct us to do so or unless the law authorizes us to. Insurance and Medicare: Three Rivers Natural Medicine does not bill insurance companies. Our doctors are not preferred providers for any insurance company. You may submit your paid invoice to your insurance for reimbursement. Please request this upon checkout if you wish to do this. We are not a Medicare provider. Medicare will not reimburse you for services rendered at the Three Rivers Natural Medicine and you should not seek reimbursement from Medicare. I understand that I will have asked a practitioner of the Three Rivers Natural Medicine for help and that he/she will help to the best of his/her ability.

I have read and understand the above statements.

Printed Name\_\_\_\_\_

Signature\_\_\_\_\_Date \_\_\_\_\_  
(signed by guardian if under-age)

Printed Name of Doctor\_\_\_\_\_Date \_\_\_\_\_

Signature of Doctor\_\_\_\_\_Date \_\_\_\_\_

**THREE RIVERS NATURAL MEDICINE PC - A NATURAL HEALTH CLINIC**

**Dr. Buffy Binder, ND**

**Dr. Mark Kelley, ND, LAc**

**Members Colorado Association of Naturopathic Physicians [www.coanp.org](http://www.coanp.org)**

**American Association of Naturopathic Physicians [www.naturopathic.org](http://www.naturopathic.org)**

**American College for Advancement in Medicine [www.acam.org](http://www.acam.org)**

Welcome to the Three Rivers Natural Medicine clinic! We are honored that you have chosen us to help in your search for optimum health. This is your New Patient Information Packet. Please read, fill out and sign the attached forms and fax, mail or drop off to reach us at least 24 hours prior to your appointment. This allows our doctors and staff to use your appointment time most efficiently. Bring any prior lab work and your supplements with you to your appointment. If you wish to cancel or reschedule your appointment, please notify our office 24 hours or more before your appointment. We charge a fee of one-half of the cost of the visit for missed appointments if less than 24 hours notice is given. It is our office policy to confirm appointments by phone one to two business days before your appointment. If you have an answering machine or voice mail, a message will be left. Many of our patients are sensitive to environmental substances, therefore we ask all patients to refrain from wearing strongly scented hair sprays, colognes, perfumes, aftershaves, etc. on the days you are here. If you have any questions please call our office at (970) 223-7425. We look forward to meeting you!

Date \_\_\_\_\_

Full Name \_\_\_\_\_

Birthdate \_\_\_\_\_

Address( Number, Street, City, State, Zip) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone: Home(\_\_\_\_)\_\_\_\_\_

Work \_\_\_\_\_ Email \_\_\_\_\_

Employed by \_\_\_\_\_

Occupation \_\_\_\_\_

Referred by (or how did you find us?) \_\_\_\_\_

Emergency contact (Name, Telephone) \_\_\_\_\_

\_\_\_\_\_

Are you currently under the care of a medical practitioners? (write names)

\_\_\_\_\_

\_\_\_\_\_

Have you ever worked with an alternative health care provider?

(naturopathic doctor, acupuncturist, chiropractor, herbalist, nutritionist)

\_\_\_\_\_

List the main problems that you are having, or reason for this

appointment: Please attach additional page if necessary

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Past Medical History/Major Illnesses and Year:**

(IE. arthritis, asthma, autoimmune disease, blood clots or disorders, cancer, diabetes, edema or swellings, heart disease, joint or spine issues, liver disorders, osteoporosis, major infections, seizures)

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**Accidents/Major Trauma (scars - please give location):**

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**Hospitalizations/Surgeries (please give month/year if possible):**

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**Dental Procedures (root canals, approximate #, type of fillings, etc.):**

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**Past Medications, any adverse reactions?: (current meds list on last page)**

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**Allergies and Sensitivities (medication, foods, environmental, ever tested?):**

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**Occupational and/or Exposures (chemicals, sprays, residence near industry):**

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**Vaccinations:**

- ( ) DPT (Diphtheria, Pertussis, Tetanus) Year(s)\_\_\_\_\_
- ( ) Booster (Usually DT) Year(s)\_\_\_\_\_
- ( ) Polio injection ( ) Polio oral Year(s)\_\_\_\_\_
- ( ) MMR (Measles, Mumps, Rubella)Year(s)\_\_\_\_\_
- ( ) HBV (Hepatitis B Vaccine) Year(s)\_\_\_\_\_
- ( ) Other (Flu shots, etc.) Year(s)\_\_\_\_\_

**Lifestyle factors (Please fill in approximate amounts and frequency):**

- Never -Occasionally- Weekly -Daily
- Coffee/Decaf\_\_\_\_\_
- Alcohol\_\_\_\_\_
- Sodas/Soft drinks\_\_\_\_\_
- Fried foods (french fries, fried chicken)\_\_\_\_\_
- Black/Green Tea\_\_\_\_\_
- Recreational Drugs\_\_\_\_\_

Sleep Hours a night \_\_\_\_\_ sleeping and waking time \_\_\_\_\_  
wake refreshed \_\_\_\_\_ wake tired or groggy \_\_\_\_\_  
trouble falling asleep \_\_\_\_\_ trouble staying asleep \_\_\_\_\_  
recurrent or troublesome dreams \_\_\_\_\_

**Exercise Activities and Common Physical Activity (length of time and frequency)**

Never- Minutes- Hours- Weekly -Daily-Any aggravations or pain from activity?

Swim \_\_\_\_\_ Run \_\_\_\_\_ Walk \_\_\_\_\_  
Dance \_\_\_\_\_ Bike \_\_\_\_\_ Garden \_\_\_\_\_  
Golf \_\_\_\_\_ Tennis \_\_\_\_\_ Ski \_\_\_\_\_  
Stretching \_\_\_\_\_ Yoga/Pilates \_\_\_\_\_ Martial Arts \_\_\_\_\_  
Weights \_\_\_\_\_ Horseback Riding \_\_\_\_\_  
Computer Work \_\_\_\_\_ Desk sitting \_\_\_\_\_  
Bending/Lifting \_\_\_\_\_  
Other \_\_\_\_\_

**Review of Systems** - Please circle if experienced and write location

Energy: overall - High(time of day) \_\_\_\_\_ Low (time of day) \_\_\_\_\_  
Stress: level - low \_\_\_\_\_ moderate \_\_\_\_\_ high \_\_\_\_\_  
Circulation: do you have feelings of hot/cold and where? \_\_\_\_\_  
Sweating: excess in day \_\_\_\_\_ night sweats \_\_\_\_\_ never sweat \_\_\_\_\_  
Skin: dry \_\_\_\_\_ clammy \_\_\_\_\_ itchy \_\_\_\_\_ burning \_\_\_\_\_ frequent rashes \_\_\_\_\_  
acne \_\_\_\_\_ dry scalp \_\_\_\_\_ boils \_\_\_\_\_ bruises easy \_\_\_\_\_ hives \_\_\_\_\_  
moles changing \_\_\_\_\_ warts \_\_\_\_\_ lumps \_\_\_\_\_ hair loss \_\_\_\_\_  
Headaches: how often \_\_\_\_\_ where \_\_\_\_\_  
Vision: do you wear contacts, prescription glasses or have had corrective surgery?  
\_\_\_\_\_

**Respiratory & Chest:**

chronic sinusitis \_\_\_\_\_ nasal polyps or septum issues \_\_\_\_\_  
any shortness of breath \_\_\_\_\_ trouble breathing at night \_\_\_\_\_ palpitations \_\_\_\_\_  
wheezing \_\_\_\_\_ chronic cough \_\_\_\_\_ coughing blood or phlegm \_\_\_\_\_  
pain in chest \_\_\_\_\_ color of sputum \_\_\_\_\_  
Blood pressure: if known \_\_\_\_\_ blood type \_\_\_\_\_

**Musculoskeletal:**

pain in toes \_\_\_\_\_ ankles \_\_\_\_\_ knees \_\_\_\_\_ hips \_\_\_\_\_  
low back \_\_\_\_\_ mid back \_\_\_\_\_ upper back \_\_\_\_\_ neck \_\_\_\_\_  
fingers \_\_\_\_\_ hands \_\_\_\_\_ wrists \_\_\_\_\_ elbows \_\_\_\_\_ shoulders \_\_\_\_\_  
loss of grip \_\_\_\_\_ loss of feeling in hands/feet \_\_\_\_\_ stiff all over \_\_\_\_\_  
deep bone pain \_\_\_\_\_ leg cramps \_\_\_\_\_  
muscle cramps \_\_\_\_\_ herniated disc \_\_\_\_\_ scoliosis \_\_\_\_\_

**Digestion:**

problems before or after eating \_\_\_\_\_ how long \_\_\_\_\_  
hungry all the time \_\_\_\_\_ rarely hungry \_\_\_\_\_ appetite changes \_\_\_\_\_  
thirsty a lot \_\_\_\_\_ rarely thirsty \_\_\_\_\_ how many ounces of water daily \_\_\_\_\_  
feel weak and shaky when miss a meal \_\_\_\_\_ can easily skip meals \_\_\_\_\_  
heartburn \_\_\_\_\_ frequent burping/belching \_\_\_\_\_ bad taste in mouth \_\_\_\_\_  
bad breath \_\_\_\_\_ sores in mouth \_\_\_\_\_ cold sores on lips \_\_\_\_\_  
stomach cramps \_\_\_\_\_ nausea \_\_\_\_\_ vomiting \_\_\_\_\_ bloating \_\_\_\_\_

weight change, how much in what length of time \_\_\_\_\_  
Favorite foods: \_\_\_\_\_ Disliked foods \_\_\_\_\_  
Crave: salt \_\_\_\_\_ sweets \_\_\_\_\_ spicy \_\_\_\_\_ sour \_\_\_\_\_ bitter \_\_\_\_\_  
Bowel Movements: # a day \_\_\_\_\_ thin or thick \_\_\_\_\_ color \_\_\_\_\_  
constipation \_\_\_\_\_ diarrhea \_\_\_\_\_ hemorrhoids \_\_\_\_\_  
bleeding or mucous in stool \_\_\_\_\_ lower bowel gas \_\_\_\_\_ bloating \_\_\_\_\_  
frequent gas/flatus \_\_\_\_\_ extreme foul odor of stool or gas \_\_\_\_\_

**Urination:**

frequent at night \_\_\_\_\_ pain or burning on urination \_\_\_\_\_  
dribbling or intermittent \_\_\_\_\_ loss of control \_\_\_\_\_  
strong smelling urine \_\_\_\_\_ frequent infections \_\_\_\_\_

**Mental/emotional:**

loss of concentration \_\_\_\_\_ memory loss \_\_\_\_\_ depression \_\_\_\_\_  
mood swings \_\_\_\_\_ anxiety \_\_\_\_\_ nervousness \_\_\_\_\_ easily angered \_\_\_\_\_  
irritability \_\_\_\_\_ frequent crying \_\_\_\_\_ suicidal \_\_\_\_\_

**Neurological:**

dizziness \_\_\_\_\_ poor coordination \_\_\_\_\_ loss of touch sensation \_\_\_\_\_  
numbness or tingling in limbs \_\_\_\_\_ tremors \_\_\_\_\_ muscle weakness \_\_\_\_\_  
toes catch when walking \_\_\_\_\_ feel weak/shaky overall \_\_\_\_\_

**Women:**

Currently pregnant (Y/N) \_\_\_\_\_ Birth control use \_\_\_\_\_  
Last Pap \_\_\_\_\_ History of Abnormal Pap (year) \_\_\_\_\_  
First day of last menstrual period \_\_\_\_\_ age started menses \_\_\_\_\_ stopped \_\_\_\_\_  
# of children \_\_\_\_\_ Ages \_\_\_\_\_ miscarriage or abortion \_\_\_\_\_  
do you perform self breast exam? \_\_\_\_\_ any breast tenderness or swelling \_\_\_\_\_  
vaginal discharge (normal, thick, whitish, yellow, itchy, odor) \_\_\_\_\_  
issues with period? (irregular, painful, heavy, clotting) \_\_\_\_\_  
other hormone issues? (change in sex drive, food cravings, hot flashes, ovarian  
cyst, extreme mood changes) \_\_\_\_\_  
sexually transmitted diseases (past, present) \_\_\_\_\_

**Men:**

Last Prostate Exam \_\_\_\_\_ PSA Lab \_\_\_\_\_  
Sex drive high, low, or problems with erection or ejaculation \_\_\_\_\_  
Urinary dribbling, pain, or burning \_\_\_\_\_  
urethral discharge \_\_\_\_\_ penile warts or lesions \_\_\_\_\_  
sexually transmitted diseases (past, present) \_\_\_\_\_

**Other:**

Please use this space to write down anything else you would like to inform us about and give your typical breakfast, lunch, dinner and snacks.



