WINDSONG
HOLISTIC HEALTH

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Acupuncturist & Traditional Naturopath
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New Patient Intake Form

Personal Information

Name_____ Today's Date _____

Age_____ Date of birth_____ Best number to reach you at _____

Address_____

City_____ State_____ Zip_____

Email address_____ Height _____ Weight _____

Biological Gender (M/F):_____ Gender Identified with:_____

Marital status: _____ Number/Age of Children: _____

Occupation_____ Hours per week_____

Insurance Information

Primary Care Physician: _____ Phone Nbr: _____

Emergency Contact

Name _____ Relationship _____ Phone Nbr: _____

Other: How did you find our office? _____

☐ Please do not include me in any emails for special offers, clinic updates or announcements.

Patient signature - stating all information contained on this form is true:

Signature: _____ **Date:** _____

Health Issues/Concern

What is your chief complaint? _____

_____

Other health issues in order of importance:

1) _____

2) _____

3) _____

4) _____

5) _____

Family Health History (List major health issues for parents/siblings):

_____

_____

Current Medications/Supplements

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking

1)_____ 6)_____

2)_____ 7)_____

3)_____ 8)_____

4)_____ 9)_____

5)_____ 10)_____

What Hospitalizations/surgeries have you had and when?

_____ _____

_____ _____

Testing Related Do you currently wear a pacemaker? (Y/N) _____

Health Assessment

Digestive:
- ☐ Gas/bloating
- ☐ Acid Reflux/Heart Burn
- ☐ Belching/Burping
- ☐ Vomiting/nausea
- ☐ Abdominal Pain
- ☐ Hiccupping
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood/mucous in stool
- ☐ Loose stools
- ☐ Undigested food in stool
- ☐ Hemorrhoids
- ☐ Gallstones
- ☐ Hernia
- ☐ Ulcers
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Diagnosed Celiac
- ☐ Diagnosed SIBO

Appetite:
- ☐ No appetite
- ☐ Hungry all the time
- ☐ Hypoglycemia
- ☐ Need to eat frequently
- ☐ Eat late at night
- ☐ Don't eat breakfast
- ☐ Hungry, but can't eat

Skin:
- ☐ Acne
- ☐ Tendency for dryness
- ☐ Itching
- ☐ Eczema
- ☐ Rashes/hives
- ☐ Psoriasis
- ☐ Nonspecific dermatitis
- ☐ Brown spots
- ☐ Purple spots
- ☐ Boils
- ☐ Fatty tumors
- ☐ Warts/moles
- ☐ Skin cancer _____

Energy Level: rate 1-10, 10 like energizer bunny, to a 1, barely drag self out of bed _____

Urinary:
- ☐ Pain during urination
- ☐ Cloudy urine
- ☐ Scanty urination
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Urinate during the night
- ☐ Urine has strong smell
- ☐ Bed wetting
- ☐ Pain in lower back
- ☐ Kidney stones
- ☐ Urinary tract infections
- ☐ Chronic cystitis
- ☐ Water retention/Edema
- ☐ Stress Incontinence

Sweating:
- ☐ Only on exertion
- ☐ Never sweat
- ☐ Spontaneous sweating
- ☐ When nervous
- ☐ Have damp hands/feet
- ☐ Night sweats

Eyes:
- ☐ Floaters
- ☐ Dryness
- ☐ Redness
- ☐ Pain
- ☐ Blurring of vision
- ☐ Trouble with night vision
- ☐ Sensitive to light
- ☐ Cataract/Glaucoma
- ☐ Tear easily/Watery
- ☐ Detached retina

Ears:
- ☐ Ringing/Tinnitus
- ☐ Excessive wax
- ☐ Infections
- ☐ Troubling hearing
- ☐ Pain in ear area

Nails:
- ☐ Break easy
- ☐ White spots
- ☐ Ridged
- ☐ Thin
- ☐ Toe fungus

Respiratory:
- ☐ Cough/Phlegm
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ COPD
- ☐ Past pneumonia
- ☐ Heaviness in chest
- ☐ History of asthma
- ☐ Sighing
- ☐ Trouble taking breath
- ☐ Allergies: (list)

_____

_____

Nose:
- ☐ Stuffy
- ☐ Mucous
- ☐ Sneeze frequently
- ☐ Bleeding
- ☐ Sinusitis
- ☐ Blow nose frequently
- ☐ Dryness
- ☐ Post nasal drip

Mouth/Throat:
- ☐ Dry
- ☐ Red/sore
- ☐ Tonsillitis
- ☐ TMJ
- ☐ Difficulty swallowing
- ☐ Feels lump/pit in throat
- ☐ Swollen glands
- ☐ Mouth sores
- ☐ Dry/cracked lips
- ☐ Red lips
- ☐ Gum issues
- ☐ Thyroid issues
- ☐ Bell's Palsy

Hair:
- ☐ Hair breaking/falling out
- ☐ Dandruff

Body Temperature runs:
- ☐ Warm/hot
- ☐ Cold
- ☐ Just right

Lifestyle Habits:

☐ Drink alcohol, if so how many per week? _____

☐ Smoke, if so how many per day? _____

☐ Drink Soda/Pop, if so how many per day? _____

☐ Use recreational drugs
What type? _____
How often? _____

Exercise, type & hours/week:
_____

_____

Daily Caffeine intake:
_____ cups/glasses

How much water do you drink most days? _____ oz

Dietary:
- ☐ Vegan/Vegetarian
- ☐ Dairy Free
- ☐ Gluten Free
- ☐ Paleo
- ☐ FODMAP
- ☐ Other dietary program: _____

Headaches:

Do you experience headaches? (Y/N) ____
How often? _____

Headache pain feels like:

☐ dull ☐ stabbing
☐ throbbing ☐boring

Where is headache pain?

☐ Forehead ☐ Temples
☐ Back ☐ Top
☐ Around like a band

For Females Only:

☐ Hysterectomy
☐ Miscarriages
☐ Infertility
☐ Endometriosis
☐ Ovarian cysts
☐ Breast lumps
☐ Fibroids ☐ PCOS
☐ Vaginal pain
☐ In Menopause
☐ Hot flashes/night sweats
☐ Moodiness/depression
☐ On birth control
Type? _____
☐ Irregular periods
☐ Not having periods
☐ Pain with period
☐ Heavy bleeding
☐ Scanty periods
☐ Clots during period
☐ Vaginal discharge
☐ STD _____
☐ Low sex drive
☐ Currently pregnant
☐ Currently nursing

Age of first period _____

For Males only:

☐ Prostate Issues
☐ Low sex drive
☐ Impotence
☐ Premature ejaculation
☐ Night seminal emissions
☐ Genital pain
☐ Groin pain
☐ Enlarged testicles
☐ Testicular pain
☐ Reduced urine flow
☐ Discharges
☐ STD _____

Mark if you have:

☐ Hepatitis type _____
☐ HIV Positive
☐ Aids
☐ Tuberculosis (TB)

Circulatory:

☐ Palpitations in chest
☐ Cold hands
☐ Cold feet
☐ Varicose veins
☐ High cholesterol
☐ Blood Pressure
☐ Diagnosed heart issue
☐ Anemia
☐ Numbness/Tingling in Hands/arms
☐ Shaky hands

Dizziness:

☐ When standing up
☐ Motion sickness
☐ Vertigo
☐ Have poor balance
☐ Faint easily

Sleep:

How many hours of sleep do you normally get? _____

☐ Trouble falling asleep
☐ Wake up during the night
☐ Restless sleep
☐ Dream disturbed sleep

Muscles/Joints:

☐ Arthritis
☐ Multiple Sclerosis
☐ Rheumatoid Arthritis (RA)
☐ Fibromyalgia
☐ Sciatica
☐ Osteoporosis
☐ Joint replacement
_____

Emotional Health:

☐ Anxiety
☐ Depression
☐ Bi-polar
☐ Addiction, _____

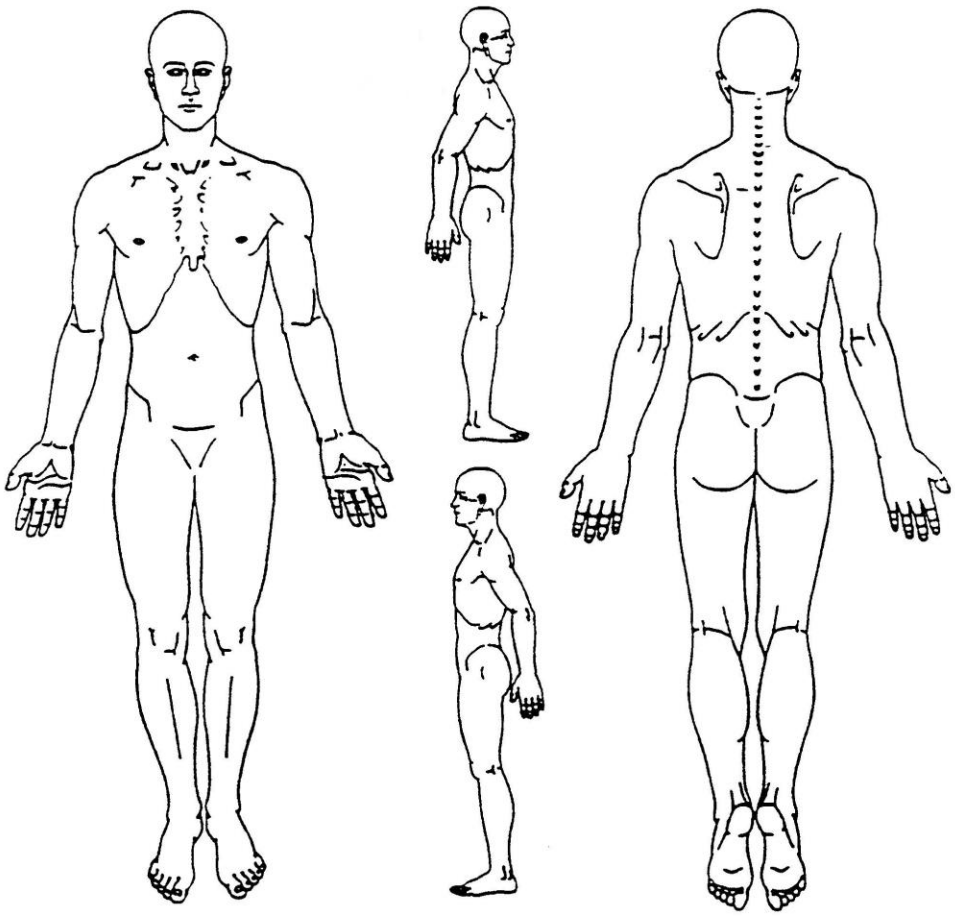
Any issue with the use of homeopathic remedies immersed in alcohol? _____

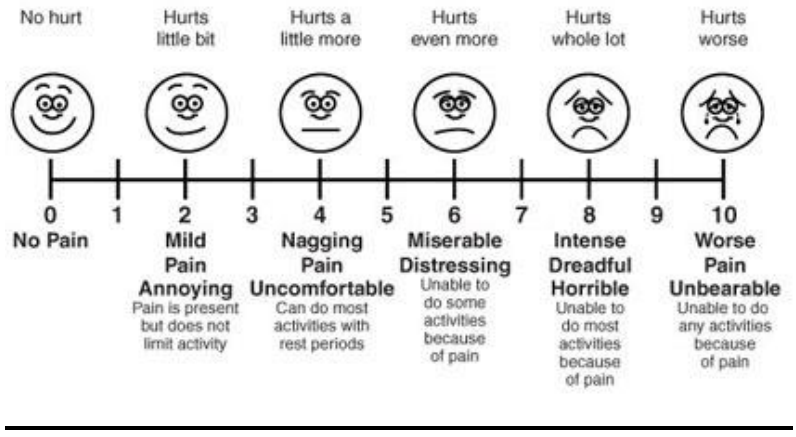
Pain Assessment:

Describe major area of pain: _____

When did pain start? _____

Mark all areas below where you are feeling pain:





Using the pain scale below, please rate your pain from 1-10:

At it's worse: _____

Average pain: _____

On your best day: _____

Nature of pain: (stabbing, sharp, throbbing, dull, achy, heavy, burning):

_____

My pain is worse with:

- ☐ Weather change
- ☐ Cold
- ☐ Heat
- ☐ With movement
- ☐ Going up stairs
- ☐ On standing
- ☐ After sitting
- ☐ On waking

My pain is better with:

- ☐ Massage
- ☐ Ice
- ☐ Heat
- ☐ With movement
- ☐ After resting

Treatments received for the pain:

- ☐ Chiropractic
- ☐ Massage
- ☐ Physical Therapy
- ☐ Steroid Injections
- ☐ Other: _____

_____

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Traditional Naturopath
Acupuncturist

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By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or other Oriental Medicine and Naturopathic procedures by the licensed acupuncturist named below.

I understand that methods or treatments may include, but are not limited to, Acupuncture, moxabustion, cupping, bloodletting, Gua Sha, electrical stimulation, Tui Na massage, TDP lamp, Chinese or Western Herbal Medicine, Homeopathic remedies, nutritional counseling and/or supplementation, testing with Asyra Biofeedback machine, NAET allergy elimination work and BodyTalk energy work.

Acupuncture attempts to normalize physiological functions, to modify perception of pain, and to treat certain diseases of dysfunction of the body. I have been informed that Acupuncture is a safe method of treatment, but occasionally there may be bruising or tingling near the needling sites that may last a few days. There have been rare instances reported of fainting, infection and scarring. There have been extremely rare instances of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping or Gua Sha. I do not expect the Acupuncturist to be able to anticipate all risks and complications. I wish to rely on the Acupuncturist to exercise judgment during the course of the procedure which the Acupuncturists feels is best at the time, based on the facts then known, in my best interest. _____ **initials**

The herbs, homeopathics and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese and Naturopathic Medicine. I understand the same herbs may be inappropriate during pregnancy and/or nursing or in combination with certain medications. I will inform my practitioner immediately of pregnancy status and of any additions or changes to my medications or supplements. If I experience any gastro-intestinal reactions to the supplements, I will inform my Acupuncturist immediately. _____ **initials**

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I also understand that there is always a possibility of unexpected complication and I understand that no guarantee can be made concerning results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss any emergency situation and/or share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reason listed above.

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.

Informed Consent Signature:

Patient's name _____ **Patient's signature** _____

Date signed _____ **Date of birth** _____ **Pregnant or Nursing? (Y/N)** _____

Darlene Zwolinski, Lic Ac, Dipl of O.M.

COLORADO MANDATORY DISCLOSURE AGREEMENT

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Education and Experience

Darlene Zwolinski earned her Master of Science in Acupuncture degree from the Colorado School of Traditional Chinese Medicine in April of 2015 and a Master of Science in Traditional Chinese Medicine in August, 2017. The 36 month program consist of 3,250 hours of education including 820 hours of clinical practice. She was certified as a Diplomate in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in April of 2015. This includes certification in Clean Needle Technique as well.

Darlene's training includes adjunctive therapies such as moxibustion, Tui Na, Gua Sha, cupping, e-stim, auriculotherapy and dietary and lifestyle recommendations.

Darlene is a member of the Acupuncture Association of Colorado and the American Association of Oriental Medicine. She is a licensed acupuncturist in Colorado. Darlene is a certified NAET (Nambrudripad's Allergy Elimination Technique) practitioner and a CBT (Certified Body Talk Practitioner). None of these licenses or certificates has ever been suspended or revoked.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule

Intake Consultation/Treatment (Adult/Child)	$150/$110
Follow-up Treatment	$100
Late Cancellation Fee	$25

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 second opinion from another healthcare 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 the Division of Professions and Occupations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Professions and Occupations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturist Licensure, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone is (303) 894-7800.

I have read and understand this document.

_____ _____

Patient's Signature Today's Date

Darlene Zwolinski, L.Ac, Dipl of O.M.
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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS (HIPAA Agreement)

Name: _____ **Birthdate:** _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

_____

_____

Patient:

X_____ _____

Patient Signature or Legal Representative **Date**