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

Acupuncturist, Traditional Naturopath
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New Patient Intake – Child

Personal Information

Child's Name_____ Todays Date: _____

Biological Gender (M/F) _____ Gender Identified w/ (if different) (M/F) _____

Age_____ Height _____ Weight _____ Date of birth: _____

Address_____

City_____ State_____ Zip_____

Parent/Guardian: _____ Best number to reach you: _____

Email address_____

☐ Please do not add my email to your contact list for special offers or announcements.

Who may we thank for referring you to our office? _____

Health History

What are your child's most important health issues?

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

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 your child is taking

1)_____ 6)_____

2)_____ 7)_____

3)_____ 8)_____

4)_____ 9)_____

5)_____ 10)_____

Major Illnesses/Hospitalizations/surgeries and when?

_____ _____

_____ _____

_____ _____

_____ _____

Immunization:

Has your child been fully immunized? Y/N _____

Did you child experience any reactions to immunizations? Y/N _____

If yes, which ones and what kind of reaction? _____

_____

Health Assessment

Digestive:
- ☐ Stomach aches
- ☐ Colic as a baby
- ☐ Gas/bloating
- ☐ Spitting up frequently
- ☐ Belching/Burping
- ☐ Nausea/Vomiting
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea/loose stools
- ☐ Blood/mucous in stool
- ☐ Undigested food in stool
- ☐ Strong smelling gas/stool
- ☐ History of antibiotic use

How many bowel movements (BM's) per day? _____

Appetite:
- ☐ No appetite
- ☐ Hungry all the time
- ☐ Hypoglycemia
- ☐ Eats late at night
- ☐ Doesn't eat breakfast
- ☐ Hungry, but won't eat

Skin:
- ☐ Acne
- ☐ Tendency for dryness
- ☐ Itching
- ☐ Eczema
- ☐ Rashes/hives
- ☐ Psoriasis
- ☐ Non-specific dermatitis
- ☐ Boils
- ☐ Fatty tumors
- ☐ Warts/moles

Headache:
Does your child experience headaches? (Y/N) ____
If so, how often? _____

Energy Level:
- ☐ Low energy
- ☐ Hyperactive

Urinary:
- ☐ Pain during urination
- ☐ Cloudy urine
- ☐ Scanty urination
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Urine has strong smell
- ☐ Urinary tract infections

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

Eyes:
- ☐ Sees floaters
- ☐ Dryness
- ☐ Red or painful eyes
- ☐ Blurring of vision
- ☐ Trouble with night vision
- ☐ Sensitive to light
- ☐ Tear easily
- ☐ Watery
- ☐ Wears corrective lenses

Ears:
- ☐ Ringing/Tinnitus
- ☐ Excessive wax
- ☐ Repeated Ear Infections
- ☐ Troubling hearing

Dizziness:
- ☐ Dizziness
- ☐ Motion sickness
- ☐ Vertigo
- ☐ Has poor balance
- ☐ Faints easily

Issues at birth:
_____

_____

_____

Respiratory:
- ☐ Cough/Phlegm
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Heaviness in chest
- ☐ History of asthma
- ☐ Had Bronchitis?
- ☐ Had Pneumonia?

Allergies:
- ☐ Hay fever/outdoor
- ☐ Animals _____
- ☐ Chemicals _____
- ☐ Food _____

_____

Allergy Symptoms:
- ☐ Runny nose/itchy eyes
- ☐ Skin reactions
- ☐ Sweating
- ☐ Headache
- ☐ Digestive upset
- ☐ Body aches
- ☐ Had Anaphylactic reaction to: _____

Nose:
- ☐ Stuffy
- ☐ Mucous
- ☐ Sneeze frequently
- ☐ Sinus Infections
- ☐ Dryness
- ☐ Bloody nose

Mouth/Throat:
- ☐ Too dry
- ☐ Tonsillitis, now/previously
- ☐ Difficulty swallowing
- ☐ Swollen glands
- ☐ Mouth sores
- ☐ Dry/red cracked lips
- ☐ Gum/teeth issues
- ☐ Bell's Palsy
- ☐ TMJ
- ☐ Red/Sore
- ☐ History of Strep Throat

Lifestyle Habits:
☐ Drinks Soda/Pop
_____ / day
☐ Smokes
☐ Substance abuse issues:

_____

Dietary:
- ☐ Vegan/Vegetarian
- ☐ Gluten-free
- ☐ Casein-free
- ☐ Dairy-free
- ☐ Soy free
- ☐ Organic
- ☐ Paleo diet
- ☐ Other

_____

_____

Sports/Activities (list):

_____

_____

Weight/eating disorders:
☐ Overweight
☐ Anorexia/Bulimia
☐ Underweight/slow growth

Behavioral:
☐ ADD/ADHD
☐ ASD
☐ OCD
☐ Sensory Integration
☐ Social Anxiety
☐ Depression/Anxiety
☐ Learning Disorder
☐ Bipolar
☐ Developmental Delay
☐ Other _____

Sleep:
How many hours of sleep does your child normally get? _____

☐ Trouble falling asleep
☐ Wakes during the night
☐ Restless sleep
☐ Dream disturbed sleep
☐ Nightmares
☐ Sleeps too much
☐ Bed wetting issues
☐ Sleep Walking

Female Reproductive (for menstruating teens):

☐ Age of first cycle: _____

☐ Days in cycle: _____
☐ Moodiness/irritability w/ cycle
☐ On birth control
☐ Irregular periods
☐ Pain with period
☐ Heavy bleeding
☐ Scanty periods
☐ Clots during period
☐ Yeast Infections
☐ Endometriosis
☐ Ovarian cysts
☐ Started menses but now has stopped

Male Reproductive:
☐ Undescended testicle
☐ Groin pain

Immune System:
☐ Gets sick frequently
☐ Autoimmune, if so which one _____
☐ Cancer history, if so which type _____
☐ Vaccination reaction, if so which one(s):
_____

Circulatory:
☐ Heart Murmur
☐ Cold hands
☐ Cold feet
☐ Congenital heart issue
☐ Anemia
☐ Numbness/Tingling

Body Temperature runs:
☐ warm/hot
☐ cold
☐ just right

Muscles/Joints:
☐ Child has pain, if so where:
_____

_____
☐ Multiple Sclerosis
☐ Difficulty walking
☐ Scoliosis
☐ Poor coordination
☐ Juvenile Rheumatoid Arthritis
☐ Broken bones:
_____

☐ Other _____

Anything else you wish to mention?

_____

_____

_____

_____

WINDSONG
HOLISTIC HEALTH

Darlene Zwolinski, L.Ac, Dipl of O.M.
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(720) 507-4956

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

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_____ _____ _____

Parent/Legal Guardian Signature **Date** **Witness Signature**

Darlene Zwolinski
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Littleton, CO 80127

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HOLISTIC HEALTH

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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, cupping, 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 and Treatment	$120
Follow-up Treatment	$100

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 or Guardian's Signature Today's Date

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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:

Child's Name _____ Parent's signature _____

Date signed _____ Date of birth _____ Is female minor pregnant/nursing? (Y/N) _____

Darlene Zwolinski, L. Ac, Dipl. Of O.M., Traditional Naturopath, Certified NAET & BodyTalk Practitioner