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

Acupuncturist, NAET Practitioner, & Traditional Naturopath
2594 S. Lewis Way, Unit E
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(720) 507-4956

New Patient - Child

Personal Information

Child's Name: _____ Today's Date: _____

Age: _____ Date of birth: _____ Height:_____ Weight: _____

Biological Sex: _____ Gender identified with: _____

Parent/Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip _____

Email address: _____ Best Number to reach you: _____

Other: How did you find our office? _____

☐ Please do not include me in any emails for special offers, clinic updates or announcements.
☐ Check if you have any objection to the use of supplements derived from animals.

Parent/Guardian's signature - stating all information contained on this form is true:

Signature: _____ **Date:** _____

Health Issues/Concern

What is your child's chief complaint?

_____

_____

Other health issues in order of importance:

1) _____

2) _____

3) _____

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 are taking

1)_____ 5)_____

2)_____ 6)_____

3)_____ 7)_____

4)_____ 8)_____

Hospitalizations/surgeries

_____ _____

_____ _____

Has your child been fully immunized? Y/N _____

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

Health Assessment

Digestive:
- ☐ Gas/bloating
- ☐ Stomach aches
- ☐ Colic as a baby
- ☐ Vomiting/nausea
- ☐ Abdominal Pain
- ☐ Hiccupping
- ☐ Constipation
- ☐ Diarrhea/loose stools
- ☐ Blood/mucous in stool
- ☐ Ulcers
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Diagnosed Celiac

How many bowel movements per day? _____

Appetite:
- ☐ No appetite
- ☐ Hungry all the time
- ☐ 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
- ☐ Boils
- ☐ Warts/moles

Energy Level:
Low/medium/high: _____

Hair:
- ☐ Dandruff
- ☐ Eczema/Psoriasis on scalp

Urinary:
- ☐ Pain during urination
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Urinate during the night
- ☐ Urine has strong smell
- ☐ Bed wetting

Sweating:
- ☐ Only on exertion
- ☐ Excessive sweating
- ☐ Spontaneous sweating
- ☐ When nervous
- ☐ Has damp hands/feet

Eyes:
- ☐ Redness
- ☐ Pain
- ☐ Itchy eyes
- ☐ Dark circles under eyes
- ☐ Frequent conjunctivitis
- ☐ Tear easily/Watery

Ears:
- ☐ Excessive wax
- ☐ Reoccurring Infections
- ☐ Troubling hearing
- ☐ Pain in ear area
- ☐ Had/has ear tubes

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

Issues at birth:

_____

_____

_____

Respiratory:
- ☐ Cough/Phlegm
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Has had COVID-19
- ☐ COVID-19 vaccinated
- ☐ Past pneumonia
- ☐ Frequent bronchitis
- ☐ History of asthma
- ☐ Allergies: (list)

_____

_____

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

Mouth/Throat:
- ☐ Dry
- ☐ Red/sore
- ☐ History of tonsillitis
- ☐ TMJ
- ☐ Difficulty swallowing
- ☐ Swollen glands
- ☐ Mouth sores
- ☐ Dry/cracked lips
- ☐ Gum/dental issues
- ☐ Thyroid issues
- ☐ History of Strep throat

Body Temperature runs:
- ☐ Warm/hot
- ☐ Feels cold
- ☐ Just right

Lifestyle Habits:
☐ Soda ___ X per week

Exercise, type & hours/week:
_____

_____

Daily Caffeine intake:
_____ cups/glasses

Daily water intake? ___ oz

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

Headaches:
Do your child have frequent 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:
- ☐ Moodiness/depression
- ☐ On birth control
  Type? _____
- ☐ Irregular periods
- ☐ Not having periods
- ☐ Pain with period
- ☐ Heavy bleeding
- ☐ Scanty periods
- ☐ Clots during period
- ☐ Vaginal discharge

Age of first period _____

For Males only:
- ☐ Undescended testicle
- ☐ Groin pain

Immune System:
- ☐ Gets sick frequently
- ☐ Autoimmune, if so which one(s)? _____

☐ Cancer history, if so which type? _____

Emotional/Behavioral:
- ☐ Anxiety
- ☐ Depression
- ☐ ADD/ADHD
- ☐ ASD
- ☐ Eating disorder
- ☐ Bi-polar
- ☐ Addiction, _____
- ☐ Social Anxiety
- ☐ Sensory Integration Disorder
- ☐ Learning disorder
- ☐ OCD

Circulatory:
- ☐ Heart murmur
- ☐ Anemia
- ☐ Congenital heart issue
- ☐ Shaky hands

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

Sleep:
How many hours does your child typically sleep?
_____

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

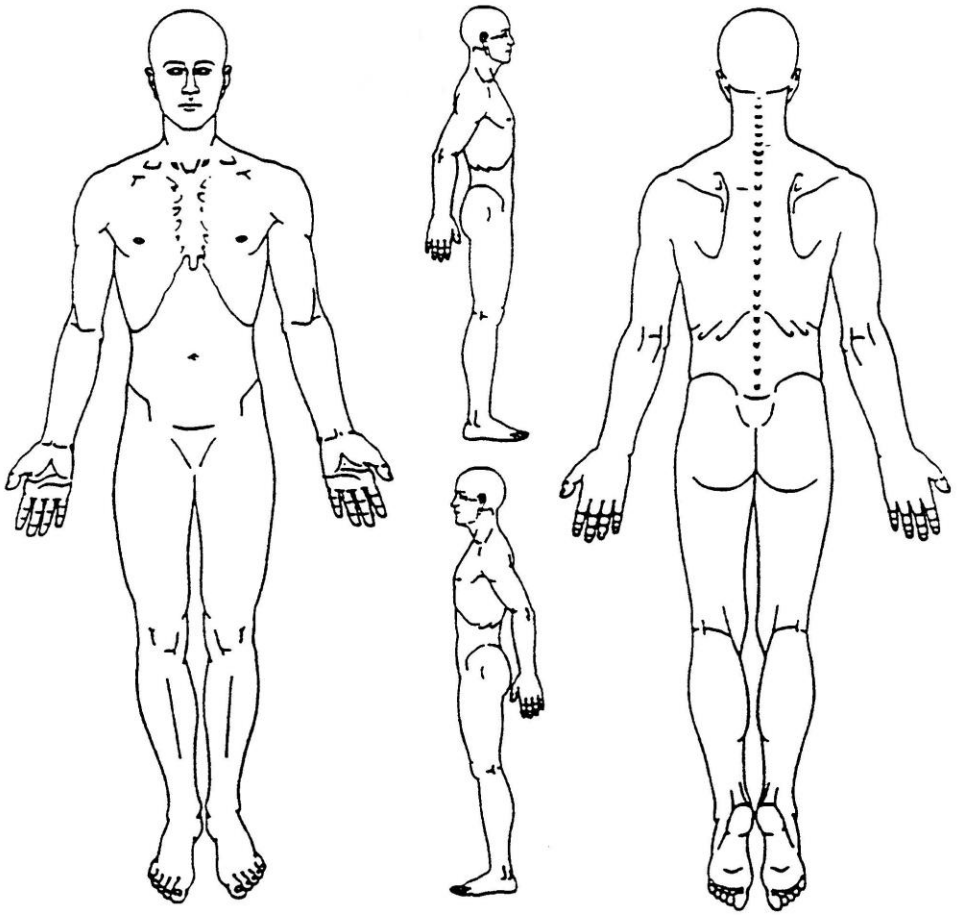
Muscles/Joints:
- ☐ Multiple Sclerosis
- ☐ Difficulty walking
- ☐ Scoliosis
- ☐ Juvenile Rheumatoid Arthritis
- ☐ Frequent bone breakages

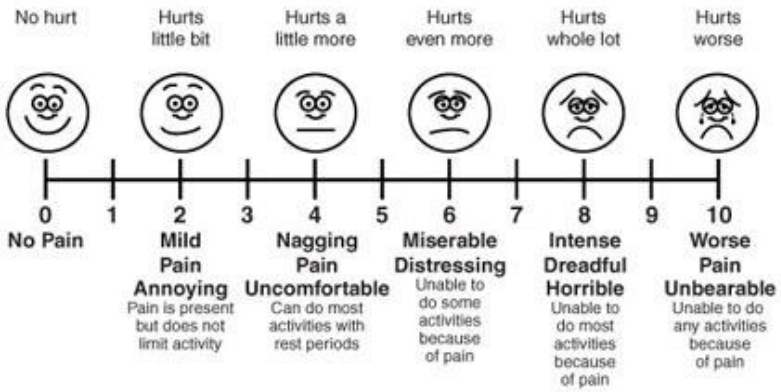
Pain Assessment:

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: _____

_____

WINDSONG
HOLISTIC HEALTH

Dr. Darlene Zwolinski, L. Ac, DACM
Traditional Naturopath, NAET
Practitioner, & 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 procedure which the Acupuncturists feels is best at the time, based on the facts then known, in my best interest. **_____ initials**

The herbs, homeopathic 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 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 _____ Parent's signature _____

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

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 graduated from Pacific College of Health and Science in 2021 with a Doctorate in Acupuncture and Chinese Medicine (DACM). 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, the American Association of Oriental Medicine, and the Society for Acupuncture Research. She is a licensed acupuncturist in Colorado. Darlene is a certified NAET (Nambudripad 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

Initial Consultation (Asyra Scan/NAET) (Adult/Child)	$195/$125
Follow-up Consultation (Asyra Scan/NAET)	$125
Initial Acupuncture (NAET treatment included)	$130
Ongoing Acupuncture (NAET treatment included)	$75
Single NAET Treatment / 2 family Members / 3 family members	$60/$80/$100
Late Cancellation Fee (< 24-hour notice or no-show)	$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.

_____ _____

Parent's Signature Today's Date

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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_____ _____

Parent's Signature **Date**