joysoma

...acupuncture...

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

Your first visit includes a comprehensive evaluation and formation of a comprehensive treatment plan. The treatment modalities performed may include, but are not limited to: acupuncture, electro stimulation, dry needling, heat therapy/moxibustion, cupping, gua sha, abdominal massage, Tuina massage, traditional Chinese dietary therapy, lifestyle and behavior education, breathing techniques, exercise or other complementary therapies. I will immediately notify the practitioner of any unanticipated or unpleasant effects associated with treatment. _____ (Patient initials here)

I understand that acupuncture is a generally safe method of treatment, however potential side effects may include bruising, numbness or tingling near the site of needle insertion, pain or discomfort at the site of needle insertion, dizziness, fainting, nausea, and the possible exacerbation of problematic symptoms existing prior to acupuncture treatment. Unusual risks include nerve damage and organ puncture. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion or other heat therapies. I understand that while the major risks are described in this document that other possible side effects or risks may occur: _____ (Patient initials here)

I understand the importance of providing a current and/or updated health history that includes notifying the licensed professional of any changes in the following: prescribed medications, over the counter medications, nutritional supplements, etc. that I might be taking or that have been prescribed to me: _____ (Patient initials here)

It is my intention that this consent form functions to cover the entire course of treatment for any present and future condition(s) for which I may seek treatment from Joyce Kawalchuk, L.Ac. I acknowledge that no guarantee or assurance has been made to me regarding the acupuncture treatment that I have requested and authorized for myself. I have had full opportunity to discuss and ask questions regarding the treatment, and all questions have been answered to my satisfaction.

_____

Patient Printed Name

_____ _____

Patient Signature Date

PRIVACY PRACTICES

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

FINANCIAL AGREEMENT

JOYSOMA Acupuncture operates on a fee-for-service basis and does not accept insurance. Payment is due in full at the time of service. Cash, personal checks, and all major credit cards are accepted.

If you intend to file a claim for potential reimbursement with your insurance, we can provide you with a superbill upon request. It is the patient's responsibility to submit the superbill to their insurance company. JOYSOMA Acupuncture does not determine insurance reimbursement eligibility and does not guarantee coverage or reimbursement.

CANCELLATIONS & RESCHEDULING

Appointments must be canceled or rescheduled at least 24 hours before the scheduled start time. Changes made within this 24-hour window will incur a charge for the full appointment fee.

Proper patient care requires the full amount of time allotted for visits. Patients arriving more than 10 minutes late may need to reschedule and will be charged the price of the visit. We will do our best to accommodate you, however the appointment is not guaranteed.

By signing below, I acknowledge that I have read and agree to the **Financial Policy, Cancellation Policy, and Rescheduling Policy**.

_____ _____

Patient Signature Date

NEW PATIENT HEALTH INTAKE

Please complete this document as thoroughly as possible. All information is strictly confidential.

Patient Information & Contact Details

Patient Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____/_____/_____ Age _____ Sex ___F ___M ___Other Height ____'____" Weight _____lbs

Patient Phone _____ Email Address _____

Emergency Contact & Phone _____

Primary Physician & Phone _____ Date last seen _____

Occupation _____. Employer _____

How did you hear about JOYSOMA Acupuncture? _____

Reason for Visit

What is the reason(s) for your visit? _____

_____

How long has this been occurring? _____

What treatments have you tried to address this? _____

Chronic Conditions & Surgical History

Please list (with approx. dates) any current medical diagnoses, serious illnesses, injuries, or hospitalizations:

_____

_____

_____

Medications & Supplements

Please list any medications or supplements you are currently taking:

_____

_____

Allergies

Please list any allergies: *(medication, food, environmental)*

_____

Lifestyle & Habits

Describe your typical diet, including preferences and restrictions: *(e.g. omnivore, gluten free, etc.)*

_____

How often do you exercise? _____ What type of exercise? _____

How many hours do you work per week? _____

Any recent significant weight loss / gain? ___ no ___ yes

Do you have a history of addiction or substance abuse? ___ no ___ yes

How many hours do you sleep per night? _____

Do you experience any of the following during sleep?

___ Difficulty falling asleep ___ Difficulty staying asleep ___ Grinding teeth

___ Nightmares ___ Snoring ___ Wake easily / often

Family Medical History

___ Cancer ___ Diabetes ___ Heart disease
___ High blood pressure ___ Mental health conditions ___ Stroke

Orthopedic & Musculoskeletal Intake *(if applicable)*

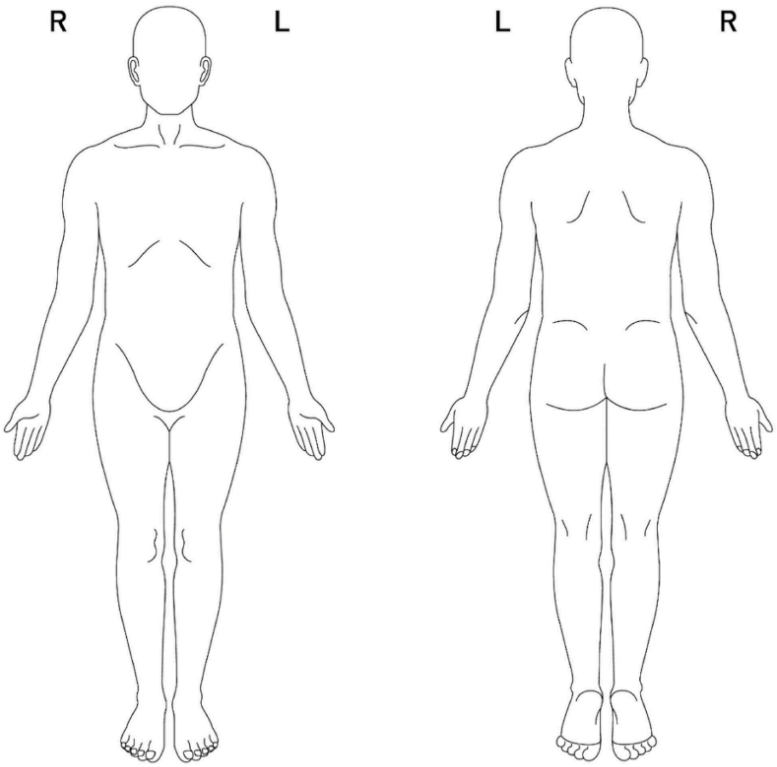
Rate the pain on a scale of 0-10 (10 highest)
_____

Is the pain *(check all that apply)*:
___Sharp ___Dull
___Fixed ___Radiating
___Sudden ___Lingering
___Other _____

What makes the pain **better**?
___Cold
___Heat
___Massage
___Exercise / Movement
___Rest
___Other_____

What makes the pain **worse**?
___Cold
___Heat
___Massage
___Exercise / Movement
___Rest
___Other_____

Please mark any areas of pain AND any scarring:



Reproductive & Hormonal Intake *(if applicable)*

Current menstrual cycle status: ____ Regular ____ Irregular ____ Absent

If cycles are absent, when and why did this change? _____

Number of days period lasts? _____ Number of days between periods? _____

Are you currently?

___ Pregnant (Due date:_____)
___ Trying to conceive
___ Receiving fertility treatments
___ Nursing
___ History of pregnancy loss or complications

How many childbirths have you had? _____

Do you experience any of the following?

___ Clotting ___ Low libido ___ Pain with intercourse
___ Heavy menstrual bleeding ___ Menopausal symptoms ___ Pelvic pain
___ Irregular cycles ___ Menstrual pain ___ Vaginal dryness

Holistic Review of Systems *(check all that apply):*

Behavioral	Cardiovascular	Digestive	Energy & Immune	Head & Neck
___ADD or ADHD	___Arrhythmia	___Acid reflux	___Chronic fatigue	___Concussion
___Anger / Irritable	___Chest pain	___Bloating / Gas	___Frequent infections	___Dry eye
___Anxiety	___Edema	___Bowel urgency	___Seasonal allergies	___Glasses / Contacts
___Depression	___Heart attack	___Constipation	___Slow wound healing	___Hair loss
___Eating disorder	___High blood pressure	___Diarrhea		___Headaches
___Overthinking	___Low blood pressure	___Frequent belching		___Impaired hearing
___Poor memory	___Pacemaker	___Nausea / Vomiting		___Impaired vision
___Suicidal ideation	___Palpitations			___Migraine
	___Stroke			___Teeth clenching / grinding
	___Varicose veins			___Tinnitus

Hormonal & Metabolic	Neurological	Urinary & Reproductive	Respiratory	Skin
___Diabetes	___Fainting	___Endometriosis	___Asthma	___Botox / Dermal fillers
___Hot flashes / Night sweats	___Loss of balance	___Frequent UTI	___Chronic cough	___Cold sores
___Hyperthyroidism	___Paralysis	___Incontinence	___COPD	___Dry Skin
___Hypothyroidism	___Seizures / Epilepsy	___Kidney stones	___Deviated septum	___Eczema
___PCOS	___Tremors	___Painful urination	___Nasal polyps	___Itching / Rashes
	___Vertigo / Dizziness	___Pelvic prolapse	___Sleep apnea	___Psoriasis
		___Yeast infections		___Shingles

Patient Priorities & Goals

What is your greatest health concern? _____

How does it limit you the most? _____

What areas of your life are impacted by this?

___ Energy ___ Exercise ___ Hobbies / Leisure

___ Mood ___ Sleep ___ Work

How committed are you towards making valuable changes in regards to your health?

Little Moderate Very

Patient signature: _____ Date: _____

Provider signature: _____ Date: _____