Nadya Waziri, LAc

Today's Date:_____

Acupuncture Initial Intake Questions

Name:_____ Date of Birth:_____ Current Age:_____

Gender/ Pronouns:_____

Have you received acupuncture in the past? ○ No ○ Yes

If yes, when was your last treatment? _____ From whom? _____

Have you taken Chinese herbs? ○ No ○ Yes

If yes, when was your last use? _____ Who prescribed? _____

Please describe your primary reasons for seeking care _____

_____

What other forms of treatment have you tried? _____

_____

What other health problems or concerns do you now have, if any? _____

_____

Allergies, food sensitivities or unusual cravings? _____

Accidents, surgeries or hospitalizations (include dates)?_____

_____

Lab results you would like considered (may attach if necessary) _____

Please indicate illnesses that you or your immediate family members have had.

Illness	*You*	*Relative*	*Date*	***Illness***	*You*	*Relative*	*Date*
Cancer	○	○	_____	Diabetes	○	○	_____
Hepatitis	○	○	_____	Heart Disease	○	○	_____
High Blood Pressure	○	○	_____	Gonorrhea	○	○	_____
Rheumatic Fever	○	○	_____	Chlamydia	○	○	_____
Infectious Diseases	○	○	_____	HIV	○	○	_____
Seizures	○	○	_____	AIDS	○	○	_____
Emotional Disorders	○	○	_____	HPV	○	○	_____
Tuberculosis	○	○	_____	Herpes	○	○	_____

List any *medications* (including over-the-counter) and/or *supplements* that you are currently taking.

Medication/ Supplement	Dose	Reason	How long	Prescribed by	Last checkup

Please indicate your use of the following.

	Y	N	Amount		Y	N	Amount		Y	N	Amount
Coffee/ Black tea	O	O	_____	Tobacco	O	O	_____	Water	O	O	_____
Pain Relievers (OC)	O	O	_____	Alcohol	O	O	_____	Soda	O	O	_____

Please indicate how you *feel* about the following aspects of your life.

	Great	Good	Fair	Poor	Bad	Comments
Significant other	O	O	O	O	O	_____
Family	O	O	O	O	O	_____
Diet	O	O	O	O	O	_____
Sex	O	O	O	O	O	_____
Self	O	O	O	O	O	_____
Work	O	O	O	O	O	_____
Exercise	O	O	O	O	O	_____
Spiritual life	O	O	O	O	O	_____

Please Respond to All That Applies

Age of first period (menarche) _____ Are you pregnant? ○ No ○ Yes

Age of last period (menopause) _____ Pregnancies (#)_____ Live births (#) _____

Number of days between periods _____ Miscarriages (#) _____ Abortions (#) _____

Number of days of flow _____

Color of flow _____

Clots? ○ No ○ Yes

Color: _____

Number of pads used per day of period: Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____ + Days _____

Location of any pain during period: ○ Lower abdomen ○ Thighs ○ Other _____

Nature of pains (indicate if the pain occurs before, after, or during menses): Cramping _____

Stabbing _____ Burning _____ Aching _____ Intermittent _____

Dull _____ Bloating _____ Consistent _____ Down-bearing _____

Please indicate whether you have been diagnosed with any of the following:

○ Fibroids ○ Fibrocystic Breasts ○ Endometriosis ○ Ovarian Cysts ○ Other _____

Libido: ○ Fair ○Low ○ Overactive/disruptive

Do you have prostate issues? If yes, please explain: _____

Do you have issues with urination? If yes, please explain: _____

Do you have any other genito-urinary or reproductive issues? If yes, please explain:

Do you have any other health history or issues that have not been addresssed in this intake form? If so, please describe below or attach a typed document.

SURVEY OF SYMPTOMS

( ) No mark = you never experience/ have experienced the symptom

(✓) Check mark = you sometimes experience/ have experienced the symptom

(×) An *X* = you commonly experience/ have experienced the symptom

___ Lack of appetite
___ Excessive appetite
___ Loose stool/ diarrhea
___ Indigestion
___ Vomiting
___ Belching & burping
___ Heartburn/ Reflux
___ Food retained in stomach
___ Other digestive problems

___ Insomnia
___ Palpitations
___ Cold hands/ feet
___ Nightmares
___ Mental restlessness
___ Laughter without reason
___ Angina-like pain
___ Tend to become obsessive about work and/ or personal relationships

___ Cough
___ Shortness of breath
___ Decreased sense of smell
___ Nasal problems
___ Skin problems
___ Claustrophobia
___ Bronchitis
___ Colitis/ Diverticulitis
___ Constipation
___ Hemorrhoids

___ Fatigue
___ Edema
___ Blood in stool
___ Black tarry stool
___ Easy bruising
___ Difficult to stop bleeding
___ Asthma
___ Catch colds easily
___ Trouble with weather changes
___ Allergies
___ Hay fever
___ Dizziness
___ Faint easily
___ High cholesterol
___ Sudden weight loss

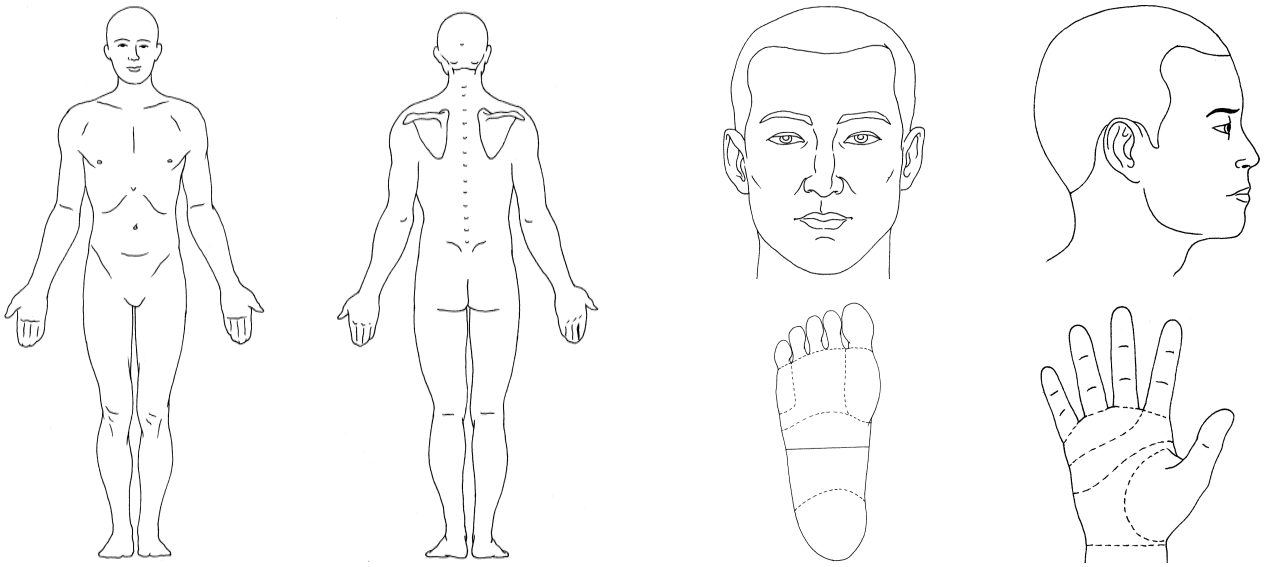
___ Abdominal pain
___ Sciatic pain
___ Headaches
___ Pain or cold in genital area
___ Prostate conditions

___ Eye problems
___ Jaundice (yellow eyes/ skin)
___ Difficulty digesting oils
___ Gall stones
___ Pale stool
___ Soft/ brittle nails
___ Easily angered/ agitated
___ Difficulty making decisions
___ Muscle spasms/ twitching

Other symptoms

_____
_____
_____
_____
_____
_____
_____
_____
_____

AREAS OF PAIN OR DIFFICULTY (mark areas with an small circle)



CONSENT TO TREATMENT

Acupuncture & Moxibustion

I understand that acupuncture is performed by the insertion of needles through the skin and/ or by the application of heat to the skin (moxibustion) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time. Regarding direct moxibustion (applied directly on the skin), I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I also understand that I may refuse this therapy.

Chinese Herbal Medicine

I understand that substances from the East Asian Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems that I associate with these substances I should suspend taking them and call my practitioner, Nadya Waziri, L.Ac., as soon as possible.

Acupressure / Tui-Na (Therapeutic Massage)

I understand that I may also be given acupressure/ tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture

I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Cancellation Policy_____

I understand that all appointments must be cancelled at least 24 hours before the appoinment time. All appointments cancelled with less than 24 hours notice, or no-show appoinments may be charged at full price, and must be paid before the next treatment is given. If arriving 15 minutes or more later than the scheduled treatment time may result in a cancelled treatment subject to the same policy. We will, however, make every attempt to be fair and accommodating in extenuating circumstances. Cancellations due to weather will be based on Denver Public Schools weather closures.

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.

Patient or guardian name (print) _____ Date of Birth _____

Patient or guardian name (signature) _____ Date: _____

Practitioner signature (Nadya Waziri, L.Ac.) _____ Date: _____

Nadya Waziri, LAc

Aeon Acupuncture, LLC

(303) 817-9727 • NadyaWaziri@gmail.com

COLORADO MANDATORY DISCLOSURE STATEMENT

Welcome to this office. Please read the following and sign below after you have had any questions answered and have understood this statement to your satisfaction.
Payment is required at the time of your visit unless prior arrangements have been made. Fee schedules are as follows: Please see pricing schedule at location of treatment.

Education and Experience

Nadya Waziri earned her Master of Science in Traditional East Asian Medicine from Southwest Acupuncture College in August, 2009. This four-year program consisted of 3,045 hours of education including 1140 hours of clinical practice. She was certified as Diplomate in Acupuncture and Traditional Chinese Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in October 2009. This includes certification in Clean Needle Technique and Chinese Herbology. As part of her training, Nadya Waziri studied in the People's Republic of China at the Heilongjiang Chinese Medical University in Harbin, earning a certificate of training of 105 hours. Nadya Waziri's training includes adjunct therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations. Nadya Waziri is a member of the American Association of Acupuncture and Oriental Medicine. She received her Colorado licensure in 2009.

No license, certificate or registration has ever been revoked or suspended. This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized. Any services offered by Nadya Waziri are not intended to substitute for those offered by a licensed medical doctor when needed. Referrals are made for further workup and treatment when appropriate.

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 Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, CO 80202. Telephone (303) 894-2440.

I have read and understand this document.

_____ _____

Patient's or Guardian's Signature Date