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? N/Y If yes, how long ago was your last treatment? Who was the provider, and were you satisfied with the results?

____

____

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? ____

Please list and describe any significant medical history, including diagnosis, accidents, surgeries or hospitalizations (include the age you were or the date, where possible)

____

____

____

____

____

____

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

____

____

List all *medications* (including over-the-counter), *supplements, herbal formulas, etc.* that you are taking.

Medication/ Supplement	Dose	How often	Reason	Prescribed by

Food and Drink: please describe your food intake (are there foods you do not eat, what is your typical breakfast, lunch, dinner, do you have any food concerns? ______

How much water do you drink per day? ______

How much caffeine do you have per day? ______

How much alcohol do you consume, if any per day/per week?______

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

	Great	Good	Fair	Poor	Bad	Comments
Family	O	O	O	O	O	______
Community	O	O	O	O	O	______
Diet	O	O	O	O	O	______
Sex/Intimacy	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	______

Is there anything else you would like me to know about your life circumstances or personal history?
If so, please describe below, attach an extra page, or feel free to talk to me during your appointment.

Please Respond to All That Applies

Age of first period (menarche) ___________

Are you pregnant? N/Y

Age of last period (menopause) __________

Pregnancies (#)______ Live births (#) _____

Number of days between periods ________

Miscarriages (#) _____ Abortions (#) ______

Color of flow _________________________

Number of days of flow ________________

Light, Heavy or spotting:

Day 1 ________ Day 2 __________ Day 3 _________ Day 4 __________ + Days ___________ Clots? N/Y

Location of any pain related to period: ○ Lower abdomen ○ Thighs ○ Breasts/Chest area ○ 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 ○ Good ○ Overactive/disruptive Please describe any concerns:

Do you have prostate issues? Yes /No 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:

SURVEY OF SYMPTOMS

___ Lack of appetite
___ Excessive appetite
___ Loose stool/ diarrhea

___ Indigestion
___ Vomiting
___ Belching & burping
___ Heartburn/ Reflux
___ Food retained in stomach
___ Other digestive problem

___ 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

___ Insomnia
___ Palpitations
___ Cold hands/ feet

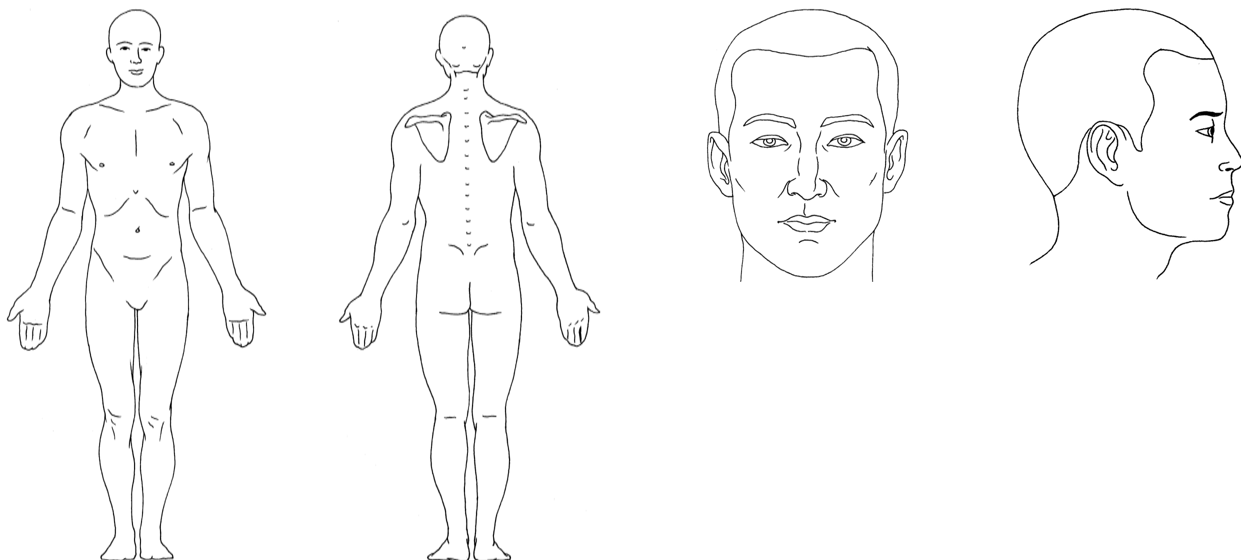
___ Nightmares
___ Mental restlessness
___ Laughter without reason
___ Angina-like pain
___ Tend to become obsessive about work and/ or personal relationships
___ Sciatic pain
___ Headaches
___ Pain or cold in genital area
___ Prostate conditions

___ 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

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

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

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 provider 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: ________________

Providersignature (Nadya Waziri, L.Ac.) ________________________________ Date: ___________

Nadya Waziri, LAc

Aeon Acupuncture, LLC
(303) 817-9727 · NadyaWaziri@gmail.com
1121 4th Ave. Iowa City, IA 52240

IOWA MANDATORY DISCLOSURE STATEMENT

Please read the following and sign below after you have had any questions answered and understand this statement to your satisfaction.
Payment is required at the time of your visit unless prior arrangements have been made. Fees: Initial intake: $145; return visit: $85.
Package Deals: 5 treatments paid in advance: $400; 10 treatments paid in advance: $750. Aeon acupuncture does not participate in insurance billing.

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 is nationally board certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). 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. Nadya Waziri's training includes adjunct therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations. She was in private practice in Colorado from 2010-2019.

No license, certificate or registration has ever been revoked or suspended. This clinic complies with the rules and statutes set by the Iowa Board of Medicine. Only single-use, disposable, factory-sterilized needles are utilized. The Iowa Board of Medicine regulates the practice of acupuncture.
Any services offered by Nadya Waziri are not intended to substitute for those offered by a licensed medical doctor when needed and must not be regarded as a medical opinion or advice. A license to practice Acupuncture does not authorize someone to practice medicine and surgery in Iowa. Referrals are made for further workup and treatment when appropriate.

Communications and Correspondence

Aeon Acupuncture solely provides non-emergency services by scheduled appointments only.
Aeon Acupuncture offers appointments outside of standard business hours in order to benefit clients who work traditional M-F/9-5 schedules. Therefore, although we strive to be as timely as possible in our response, outside of Aeon Acupuncture's scheduled work times, we may be unavailable to respond to your message within the typical 24-hour, next-business day period.
Voicemail and e-mail are monitored during Aeon scheduled work times, however, we do not respond while with clients, and we will get back to you as soon as possible. When leaving a voicemail, we ask that you leave detailed information, including times when you are available to speak if you would like a call back, and we will do our best to reach you during the time frame detailed in your message. Aeon Acupuncture does not accept text messages, or messages over social media such as Facebook messenger. Mailing address for official correspondence: Aeon Acupuncture, LLC., 1121 4th Ave. Iowa City, IA, 52240.

Cancellation Policy

All appointments must be cancelled at least 24 hours before the appointment time. Missed appointments or appointments cancelled with less than 24 hours notice will result in a $50 fee, which must be paid before the next treatment can be scheduled. Repeated violations will result in a requirement to pay in advance for your subsequent appointments with no refund given for missed or late cancellations. Arriving 15 minutes or more later than the scheduled treatment time may be considered a no-show and may result in a cancelled treatment. All exceptions to this policy are given at the discretion of the provider. Cancellations due to weather will be based on Iowa City Public Schools weather closures, see www.iowacityschools.org.

Patient/Provider Conduct Agreement

Aeon Acupuncture is a place of healing for people of all walks of life. To foster comfort and respect of the people within the clinic, we ask that the following expectations be met:

- All interactions between the patient and provider be non-sexual and non-flirtatious in nature. Front of chest, groin area, and buttocks should remain covered by clothing or by the coverings provided by the clinic. If access to any of those areas is required for the purposes of treatment, this will be carefully communicated during that portion of the treatment, and proper draping of the immediate surrounding areas will occur. The patient always retains the right to choose how and if any particular area of their body is exposed or treated.
- All communication will remain respectful. Aeon Acupuncture does not tolerate hateful comments or verbal harassment. This be is to be understood as unwanted, unwelcomed, and uninvited comments or behavior that demeans, threatens, or offends based on race, ethnicity, religion, national origin, gender, sexual orientation, age, class, disability or genetic information.
- Aeon Acupuncture does not allow weapons on the premises. Weapons include, but are not limited to, guns, knives or swords with blades over four inches in length, explosives, and any chemical whose purpose is to cause harm to another person. Regardless of whether a patient possesses a concealed weapons permit (CCW) or is allowed by law to possess a weapon, weapons are prohibited on company property.
- Patients are required to wear civilian clothing while on the premises and inside of the clinic.

Attending your appointment:

It is important that you come to your appointment hydrated, sober, and that you have eaten an adequate amount of food that day. You may wish to wear loose shorts and a tank-top during your appointment, although the clinic will also provide sheets as covering. We ask that no strong odors, such as perfume, cigarette smoke, or body odor accompany you to your session.
We ask that you arrive to your appointment no earlier than 15 minutes before your scheduled time. Please park in the driveway, near the sidewalk front door. If there is another vehicle parked there already, please park on the street as close to the front of the house as possible. Please enter the front door without knocking, which will be unlocked if it is within 15 minutes before your appointment. Please remove your shoes and be seated in the waiting area until the provider comes to get you. You may not access the treatment room until the provider comes to bring you there. The restroom will be clearly labeled: any attempt to access parts of the house other than the waiting area or restroom may result in immediate termination of service and immediate removal from the property. We ask that you wait quietly, turn all electronic devices to silent, and refrain from making voice calls, etc. while waiting. Only scheduled clients may enter the house, unless for purposes of accessibility (ie.: mobility access or interpreters). We are not able to accommodate folk (including children) waiting for you on the property during your appointment. There are shops, cafes, a park and a mall all within walking distance of the clinic where your loved ones may wait for you during your session.

By signing this document, I agree to uphold all expectations of Aeon Acupuncture as laid out in the terms above and understand that any violations of the terms will result in termination of service.

Patient or guardian name (print) ______________________________________

Patient or guardian name (signature) __________________________________ Date: ________________