Exhale
MASSAGE AND YOGA

ACUPUNCTURE INTAKE FORM

Name:_____

Date of Birth:_____ Age:_____

Preferred Pronouns he/she/they/etc):_____

Address (incl city and state):_____

Phone:_____

Email:_____

Occupation:_____

Referred by:_____

✦Is this your first acupuncture treatment? Yes / No

✦Are you currently under the supervision of a medical doctor for the condition you are seeing us for? **Yes / No**

Physician's Name & Phone Number:_____

Emergency Contact: (Name/Number/Relationship)_____

Reason for today's visit:_____

_____

Have you or any blood relatives had any of these conditions? Please check all that apply.

Asthma____ Arthritis_____ Allergies_____ Anemia_____ Alcoholism/Addiction_____ Cancer_____

Colitis_____ Congenital Heart Disease_____ Diabetes____ Heart Disease____ High Blood Pressure____

Hay Fever_____ Kidney Disease_____ Leukemia_____ Mental Illness_____ Migraine_____

Rheumatism_____ Rheumatic Fever_____ Stroke_____ Stomach Ulcers_____

Other (please list) _____

HABITS Daily OR Weekly Consumption

Do you smoke? Y / N _____ Drink Coffee? Y / N _____ Drink Alcohol? Y / N _____

Fall Asleep Easily? **Yes/No** Awaken Early? **Yes/No**

What medications and supplements are you currently taking?_____

_____

Operations, Hospitalizations, Injuries, or Serious Illness you have had (year): _____

_____

ALLERGIES:_____

_____

Do you exercise regularly? Yes / No If Yes, How Often?_____

What Type of Exercise?_____

WOMEN Please check all that apply:

Are you still having regular monthly periods? Yes / No ☐ Bleeding between periods? ☐ Depression

☐ Use/Used birth control ☐ Discharge ☐ Irritability How many days of flow? _____

☐ Heavy Bleeding ☐ Miscarriage: If yes, how many?_____ How many days cycle? _____

☐ Bloating ☐ Gas No. of children born alive?_____ ☐Brownish Blood ☐ Headaches?

No. of stillbirths? _____ ☐ Clotting ☐ Low Back Pain? Complications with pregnancy? Yes / No

☐ Dark purple blood ☐ Cramping?

*** Are you or do you suspect that you might be pregnant now? Yes / No

MEN Please check all that apply:

☐ Loss of sexual activity ☐ Treatment for genitals ☐ Prostate trouble ☐ Discharge from penis

☐ Hernia (rupture) ☐Other? _____

ALL GENDERS Please check all that apply: ☐Headaches ☐Chest tightness ☐Dizziness

☐Shortness of Breath ☐Mucous in stool ☐Trouble sleeping ☐Ringing in the ears ☐Constipation

☐ Palpitations (feeling heartbeat?) ☐ Undigested food in stool ☐ Anxiety-filled dreams ☐ Blurred vision

☐Pain in calves ☐Excessive Thirst ☐ Low Back Pain ☐Stuffy/Runny Nose ☐Tingling in legs at night

☐Low Thirst ☐Fatigue ☐Coughing / Wheezing ☐Blood in urine ☐Excessive Appetite ☐Low Appetite

☐Sweating other than with exertion ☐ Sore throat ☐Kidney stones ☐Numbness? Where?_____

☐Acid Reflux / Heartburn ☐Difficult or frequent urination ☐Recent Rapid Weight Gain/Loss

☐Bad taste in mouth ☐ Diarrhea ☐Bleeding gums ☐Cold Hands & Feet ☐Pain in abdomen

Anything else you would like to add?_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Vashni Nilon, LAc.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including but not limited to: bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician or midwife. Some possible side effects of taking herbs are: nausea, gas, stomachache, vomiting, liver or kidney damage, headache, diarrhea, rashes, hives, and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

CLIENT NAME (print) : _____DATE: _____

ACUPUNCTURIST NAME: **Vashni Nilon L.Ac.**

CLIENT SIGNATURE _____
(Or Patient Representative) (Indicate relationship if signing for patient)

Payments, Policies and other Housekeeping for Exhale Massage and Yoga, LLC

We accept credit cards, cash and Venmo (always appreciated) and FSA/HSA.

As far as policies we ask that you treat us the way you would like to be treated. If you haven't yet, please read the policies page of our website to view our sick/covid exposure policy and our 24 hour cancellation policy. By signing this document, you affirm that you have read these policies in full and have agreed to them, including that last minute cancellations and no shows may be expected to pay up to the full amount of your session fee, as you have already reserved our time.

I have read the payment, sick and cancellation policies of Exhale Massage and Yoga and agree to abide by all such policies acknowledging that they may be modified at any time.

Additionally, I understand that Vashni Nilon, L.Ac. is an independent contractor (CONTRACTOR) within the space of Exhale Massage and Yoga, LLC (COMPANY). CONTRACTOR accepts all responsibility for her services and practice. COMPANY is not responsible for, nor accepts any liability on behalf of, clients of CONTRACTOR. By signing below, I hereby waive and release COMPANY from any liability relating to any of CONTRACTOR'S services, now or in the future.

CLIENT SIGNATURE: _____

Thank you, and have a wonderful session!