PranaTonic
Yoga and Wellness

807 14th Street Golden, CO 80401
303-274-5733

Name _____ Date _____

How did you hear about us? _____

Would you like appointment reminders via text? Y N

Street _____ E-Mail _____

City/State _____ Cell Phone _____

Zip _____ Other Phone _____

Occupation _____ Employer _____

Birth date/age _____ Marital Status _____ Sex _____

Emergency Contact (Name & Phone) _____

Please state your major health concerns:

1 _____ Date appeared _____

2 _____ Date appeared _____

3 _____ Date appeared _____

Related to employment? Y N Related to accident? Y (Date _____) N

Other professionals consulted? _____

Diagnosis received? _____

Have you received any treatment? What? _____

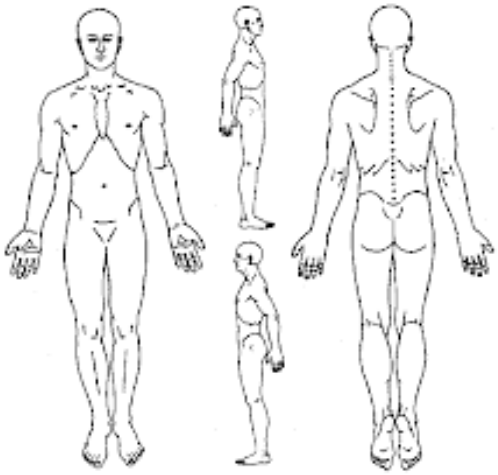
What makes it better? _____

What makes it worse? _____

Please rate your pain on 1-10 scale (1 = very little pain, 10 = worst pain of your life):

Now _____ At its worst _____

Please mark area(s) of pain on the figure(s):



Please describe your pain:

- ○ Sharp
- ○ Dull
- ○ Aching
- ○ Burning
- ○ Numbness/tingling
- ○ Other

Health History

Name _____

Please circle health challenges:

Low back pain	Neck pain	Muscle pain	Joint pain	Abdominal pain	Seizures
Strange sensations	High BP	Low BP	Skin sensitivity	Poor appetite	Excess hunger

Please circle conditions you currently have OR have had in the past:

Alcoholism	Anemia	Anxiety/depression	Arteriosclerosis	Arthritis	Cancer
Chorea	Cold sores	Diabetes	Diphtheria	Eczema	Emphysema
Epilepsy	Fibromyalgia	Goiter	Gout	Heart disease	Hemorrhoids
Hepatitis	Hernia	Herpes	HIV	Influenza	Malaria
Measles	Miscarriage	Mononucleosis	Multiple sclerosis	Mumps	Pleurisy
Pneumonia	Polio	Rheumatic fever	Scarlet fever	Sciatica	Stroke
Tuberculosis	Typhoid fever	Ulcers	Varicose veins	Venereal disease	Whooping cough

WOMEN ONLY:

Abnormal pap smear	Bleeding between periods	Breast lump	Contraceptive use
Extreme menstrual period	Hot flashes	Nipple discharge	Painful intercourse

Date of last period _____ Date of last pap smear _____

Most recent mammogram _____ Where? _____

Number of children _____ Number of pregnancies _____

MEN ONLY:

Breast lump	Erection disorder	Lump in testicles	Penis discharge	Prostate disorder	Sore penis

Surgical implants (please include date):

Spinal fusion _____ Joint replacement _____

Pacemaker _____ Other _____

List any other surgeries (please include date):

_____

Have you been involved in an automobile accident or other serious injury? Y N

Please explain: _____

Loss of consciousness? Y N Other complications: _____

Habits:

- Tobacco (per day/week) _____
- Alcohol (per day/week) _____
- Caffeine (per day/week) _____
- Recreational drugs _____
- Other _____

Exercise:

- Times per week _____
- Type _____
- None

Major Stressors (please rate each 1-10, low to high):

- Financial
- Work-related
- Family
- Relationships

Wellness Assessment (please rate 1-10, low to high):

- Physical
- Mental
- Emotional
- Spiritual

COLORADO MANDATORY DISCLOSURE STATEMENT
PRACTITIONER EDUCATION & EXPERIENCE

Kimball Cicciu, L.Ac., E-RYT, Certified Group Exercise Instructor (AFAA)

Kimball Cicciu graduated from Florida Institute of Traditional Chinese Medicine and was awarded a diploma in 1999. Following this three-year program including 2082 didactic hours and more than 800 clinical training hours, Kimball was certified as a Licensed Acupuncturist by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), February 1999 and has been practicing ever since. She has successfully completed the Clean Needle Technique course offered by NCCAOM. Kimball Cicciu is trained in and qualified to prescribe Chinese Herbs. She is also trained in Chinese diagnostic technique, acupuncture treatments, cupping, moxibustion therapy, auricular therapy, electrical stimulation, and massage (tui-na). Kimball has been teaching fitness and yoga since 1990 and is a Certified Group Exercise Instructor (AFAA) and an Experienced Registered Yoga Teacher (Yoga Alliance).

Dr. Drew Peterson D.C.

Dr. Peterson has been a licensed Chiropractor in California, Florida and Colorado since 1980. He administers Sacral Occipital, Activator non-force techniques as well as Gonstead traditional chiropractic technique utilizing infrared technology for a precise diagnosis. Dr. Peterson is one of a handful of chiropractors with a Chinese medical degree offering over 250 raw herbs for conditions ranging from indigestion, elimination, hormone issues, sleep disorders and much more. He was an associate editor and researcher for the California Journal Of Oriental Medicine's 15,000 subscribers, instructor at the Colorado School Of Traditional Chinese Medicine and the Han Tang School Of Acupuncture. He was on peer review for the Harvard-UCLA consortium Natural Standard with the likes of Dr. Andrew Weil, certified by the University Of Colorado Pharmacy School in botanical medicine and a fellow of the Institute Of Post Graduate Medicine. He utilizes Dr. Tan's Balance Method, Korean Constitutional and Five Element Acupuncture with Serin painless acupuncture needles exclusively.

Greg Cicciu, L.Ac

Greg graduated from Florida Institute of Traditional Chinese Medicine and was awarded a diploma in 1998. Following this three-year program including 2082 didactic hours and more than 800 clinical training hours, Greg was certified as a Licensed Acupuncturist by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), September 1998 and has been practicing ever since. He has successfully completed the Clean Needle Technique course offered by NCCAOM. Greg Cicciu is trained in and qualified to prescribe Chinese Herbs. He is also trained in Chinese diagnostic technique, acupuncture treatments, cupping, moxibustion therapy, auricular therapy, electrical stimulation, and massage (tui-na).

FEE SCHEDULE

Initial Acupuncture Treatment and Examination	$130
Acupuncture Follow-up includes Chinese medical modalities and herbal recommendations	$80
Cupping in conjunction with Acupuncture	$10
Initial Chiropractic Treatment and Examination	$49
Chiropractic Follow-up (includes soft tissue therapies)	$49
Additional Therapies, E-Stim with Chiropractic	$15
Additional Therapies, Acupuncture with Chiropractic	$25
Massage	$50 Per 30 Minutes, $85 Per 60 Minutes $120 Per 90 Minutes
CBD Topical in conjunction with Massage	$10
Cupping Therapy	$40
Auricular Therapy	$35
Herbal Consultation	$60 Per 60 Minutes
Follow up herbal consultation	$30 Per 30 Minutes
Kinesio Taping	$10

PATIENT'S RIGHTS

The patient has the right 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.

PranaTonic LLC and its agents all comply with the rules and regulations promulgated by the Colorado Department of Health and Environment, including the proper cleaning and sterilization of needles, and the sanitation of equipment the acupuncture offices. Only single-use, factory-sterilized, disposable needles are utilized. The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, CO, 80202. Or at (303) 894-7800. This disclosure statement is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Statute Title 12 Article 29.5.

I have been informed that acupuncture and it's auxiliary treatments are safe methods of treatment but that they may have side effects including discomfort, pain, dizziness, bruising, burning, or numbness at site of procedure. Unusual and rare risks include nerve damage, organ puncture including lung puncture, infection, and spontaneous miscarriage. Other side effects and risks may occur. If I suspect that I am pregnant, I will immediately inform the health care provider.

I will inform my providers of any medications I am using or treatments I am undergoing from another healthcare provider.

I understand that there are no guarantees regarding cure or improvement of my condition. I do not expect the acupuncturist to anticipate and explain all possible risks and complications, and I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist judges to be in my best interests based upon the facts then known. I understand that I have the choice to accept or reject treatment at any time.

I declare that I have read or have had read to me and understand this document. I have had the opportunity to ask questions about its content, and by signing below, I agree to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition for which I seek treatment.

Patient or Guardian's Signature_____ Date _____

Print Name_____

PranaTonic

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www.pranatonic.com

Chiropractic Therapy and Acupuncture Informed Consent

Informed Consent

Informed consent for your chiropractic care is a process and dialogue with your chiropractic physician about the goals, risks, and alternative treatment options to allow you to participating in and make knowledgeable decisions about your health. It is important that you, the patient, read this document in its entirety. As a patient, it is essential that you participate knowledgeably in decisions regarding the nature and course of your chiropractic treatment. It is essential that you ask questions concerning the nature and course of your treatment with your chiropractic physician and understand the potential risks, proposed benefits, and alternatives to your proposed chiropractic treatment plan.

DO NOT SIGN this document until you have read this document in its entirety and have had the opportunity to ask questions about your care and fully understand the care to be rendered.

Chiropractic Treatment

The practice of chiropractic medicine includes many standard examination and testing procedures. These may include a physical examination, orthopedic and neurological testing, palpation, specialized instruments, laboratory tests, radiology examinations, physical therapy modalities, taping procedures, and rehabilitative procedures among others.

A primary therapy utilized in chiropractic treatment is spinal manipulative therapy or adjustments. There are a number of different adjusting techniques, some utilizing specially designed equipment or instruments. Adjustments are usually performed by hand, but may be performed by hand-guided instruments. A chiropractic adjustment is the application of a quick precise movement to a specific contact point of a vertebrae or other joint. Joint function can be compromised in a number of ways and can affect a patient's overall health. Chiropractic manipulations or adjustments are utilized by chiropractors to improve overall joint function, inhibit the formation of joint adhesions, and reduce joint/muscle pain, tonicity, and and/or inflammation. A chiropractic manipulation or adjustment may cause an audible "pop" or "click", similar to what you may have experienced if you have "cracked" your knuckles. You may also feel a sense of movement at the area adjusted.

Probability and Nature of Risks Inherent in Chiropractic Adjustment or Treatment

As with any health care procedure, there are certain complications that may arise during chiropractic manipulation and therapy. The relationship of complications from manipulation has been the subject of tremendous disagreement. Some literature has suggested that rarely you may incur fractures, disc injuries, dislocations and burns. Occasionally after manipulation and therapy, you may feel muscle strain, muscle bruising with instrument assisted manipulations (osseous and soft tissue), cervical spinal cord compression known as myelopathy, separations, or new, increased or radicular tingling, numbness or pain. Some patients will feel some soreness or stiffness after the first several days of treatment.

Some manipulations of the neck have been associated with exceedingly rare injuries to arteries in the neck or stroke, paralysis, or neurologic dysfunction. The incidence of stroke is exceedingly rare and estimated to be between one in 5.85 million cervical manipulations.[1]

I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with chiropractic manipulation.

Acupuncture Treatment

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 the acupuncturist(s) who now or in the future treat me.

I understand that methods of treatment may include, but are not limited to, acupuncture, Chinese herbal medicine/botanical supplementation, cupping and nutritional counseling. 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 have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including redness, soreness, warmth, bruising, numbness or tingling near the needling sites that may last a few days, and possible dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax - 2 cases per 2.2 million treatments [2]). 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 results are not guaranteed.

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. By voluntarily signing below, I show 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 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.

I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with acupuncture therapy.

Instrument Assisted Soft Tissue Mobilization (IASTM)

IASTM is a form of treatment used to "break up" or "soften" scar tissue and tissue adhesions, thus allowing for the improvement of function in the area being treated. The use of stainless steel myofascial releasing instruments of different sizes and contours may be employed to help reduce tissue adhesions and enhance range of motion.

IASTM is designed to minimize discomfort; however the above reactions are normal, and in some instances desirable and unavoidable. Redness, bruising, swelling, soreness, and/or pain 72 hours post-treatment is not uncommon with the use of this technique.

I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with IASTM treatment.

Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Medical care and prescription drugs such as an anti-inflammatory, muscle relaxants, pain killers, and others
- Hospitalization
- Surgery

If you choose any of the above noted other treatments, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

Risks and Dangers of Remaining Untreated

Remaining untreated may result in persistent or increased pain or other symptomatology, increased loss of function, formation of adhesions contributing to a pain reaction further reducing mobility, or worsening of your condition. Over time, if you choose to remain untreated, this may complicate future treatments, and make future treatment more difficult and less effective the longer the treatment is postponed.

References:

1. Haldeman S, Carey P, Townsend M, Papadopoulos C. Arterial dissections following cervical manipulation: the chiropractic experience. CMAJ 2001; 165(7):905-6.
2. Stenger M, Bauer NE, Licht PB. Is pneumothorax after acupuncture so uncommon? Journal of Thoracic Disease. 2013;5(4):E144-E146. doi:10.3978/j.issn.2072-1439.2013.08.18.

Office Policies

Payment: We accept Cash, Personal Checks, Master Card, Visa and Discover as forms of payment. All returned checks are subject to a $30 fee. (Please note that if two or more checks have been returned from the same party, then we will no longer be able to accept checks from that party.) All services and products must be paid for at the time of purchase.

Discounts: We offer a 10% discount on Services and Product for Students, Yoga Teachers and Acupuncturists, with a valid/current ID/License. These discounts are not to be combined with any other discounts or promotional offers.

Late Arrival Policy: If you find that you cannot be on time, please notify our office as soon as possible. We will do our best to accommodate our patients who come late to their scheduled treatment time. If you are more than **fifteen (15) minutes late** for your appointment, we may reschedule your appointment for a later date.

24 - Hour Cancellation Policy: If you need to cancel an appointment, we require 24 hours advance notice. You may leave a message on our after-hours voicemail. **Missed appointments are subject to the full appointment fee. Cancellations less than 24 hours in advance are also subject to the same fees.**

Confirmation E-mails: You will receive a reminder about your appointment via e-mail. If you do not receive your appointment reminders, please call to confirm that we have your correct e-mail address.

Insurance Responsibility: PranaTonic will contact your insurance company to see if Acupuncture services our covered under your policy. **Payment** is expected at time of services. You will be responsible for co-payments and any charges that are not covered by your policy.

Herbs: We are pleased to offer herbal formulas in raw, tincture and pill form. PranaTonic does not accept returns on raw, or bottled herbal formulas, including sealed packages of herbs. This policy is in keeping with industry standards and legal guidelines.

Cell Phone Use: We try to keep the center area free of noise and other distractions. In consideration of our patients, please turn off your cell phone in the clinic area.

Pets: No pets are allowed at PranaTonic with exception of service dogs.

ACKNOWLEDGEMENT OF INFORMED CONSENT AND OFFICE POLICIES
DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE INFORMATION EXPLAINED IN THE INFORMED CONSENT.

I have read or have had read to me the above explanation of the chiropractic manipulation, acupuncture therapy, IASTM and related treatments. I have discussed the goals, risks, and alternative treatment options with the provider(s). I have had all of my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and hereby consent to any or all of the aforementioned chiropractic treatments referred to in this consent.

I understand that this waiver will be in place and will apply to all future visits at PranaTonic unless I choose to revoke this waiver.

Dated: _____
Patient's Printed Name: _____
Patient's Signature: _____
Signature of Parent or Guardian (if the patient is a minor): _____

PranaTonic

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www.pranatonic.com

Patient's Bill of Rights

These rights can be exercised on the patient's behalf by a designated surrogate or proxy decision maker if the patient lacks decision-making capacity, is legally incompetent, or is a minor.

- The patient has the right to considerate and respectful care.
- The patient has the right to and is encouraged to obtain from physicians and other direct caregivers relevant, current and understandable information concerning diagnosis, treatment and prognosis.
- Patients have the right to know the identity of physicians, nurses, residents, interns, or other trainees. The patient also has the right to know the immediate and long term financial implications of treatment choices, insofar as they are known.
- The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and clinic policy, and to be informed of the medical consequences of this action. In case of such refusal, the patient is entitled to other appropriate care and services that the clinic provides or transfer to another health care provider. The clinic should notify patients of any policy that might affect patient choice.
- The patient has the right to have an advance directive (such as a living will, health care proxy, or durable power of attorney for health care) concerning treatment or designating a surrogate decision maker with the expectation that the clinic will honor the intent of that directive to the extent permitted by law.
- The patient has the right to every consideration of privacy. Case discussion, consultation, examination, and treatment should be conducted so as to protect each patient's privacy. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential by the clinic, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the clinic will emphasize the confidentiality of this information when it releases it to any other parties entitled to review information in those records.
- The patient has the right to review the records pertaining to his/her medical care and to have the information explained or interpreted as necessary, except when restricted by law.

Medication Form, Supplements and Herbs

Patient Name: _____Date: _____

Exercise extreme caution when prescribing herbal formulas to patients currently taking the "Big 3".

1. Warfarin/Coumadin (anticoagulant)
2. Phenytoin/Dilantin (antiepileptic)
3. Lithium (mania/bipolar)

DRUGS YOU NOW TAKE
Painkillers, Muscle Relaxers, Blood Pressure, Antidepressants, and Birth Control. Please list your current Medications and Supplements: Multi Vitamins, Individual Vitamins, Herbs, Homeopathic, and Other.

Drug Name	Indication	Dosage	Date Prescribed

Please list Allergies:

Drug: _____

Food: _____

Environment: _____

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ACKNOWLEDGEMENT OF INFORMED CONSENT, PATIENT BILL OF RIGHTS, AND OFFICE POLICIES DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE INFORMATION EXPLAINED IN THE INFORMED CONSENT, PATIENT BILL OF RIGHTS AND OFFICE POLICIES.

I have read or have had read to me the above explanation of the chiropractic manipulation, acupuncture therapy, IASTM and related treatments. I have discussed the goals, risks, and alternative treatment options with the provider(s). I have had all of my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and hereby consent to any or all of the aforementioned chiropractic treatments referred to in this consent.

I understand that this waiver will be in place and will apply to all future visits at PranaTonic unless I choose to revoke this waiver.

Dated: _____
Patient's Printed Name: _____
Patient's Signature: _____
Signature of Parent or Guardian (if the patient is a minor): _____

PranaTonic
807 14th Street
Golden, CO 80401

Patient Acknowledgement Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a patient Rights section describing you rights under the law. You have the right to review our notice before signing this form. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting this office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent, PranaTonic provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient acknowledges that: (please initial each line)

___ PranaTonic has a Notice of Privacy Practices and that the patient has received a copy of this notice and opportunity to review this notice.
___ Protected Health Information may be disclosed or used for treatment, payment or healthcare operations.
___ PranaTonic reserves the right to change the Notice of Privacy Practices.
___ The patient has the right to restrict the uses of their protected health information, however PranaTonic does not have to agree to those restrictions.
___ The patient may revoke this Consent in writing at any time, and all future disclosures will then cease.

_____ _____
Name of Patient or Patient Representative (Print) Date

_____
Signature of Patient or Patient Representative

_____
Relationship to Patient (if other than patient)