BODIES IN RESONANCE, LLC ***CONFIDENTIAL INTAKE FORM***

J. Ladan Nabet, M.S., L.Ac., Dipl. Ac.

TRADITIONAL EAST ASIAN MEDICINE: ACUPUNCTURE & TUI NA MANUAL THERAPY

DATE: _____

CLIENT INFORMATION

Name: _____ Preferred Name: _____

Pronoun: _____ Date of Birth: _____ Age: _____

Gender: _____ Phone: _____

Home Address: _____ Email: _____

_____ Relationship Status: _____

Occupation: _____ Full time/Part time/Retired (Circle one)

Emergency Contact: _____ Relationship to Client: _____

Contact's Phone: _____

REFERRED BY: _____

Date of last medical examination: _____ Date of last GYN exam: _____

Would you like to receive my periodic e-newsletter? Y N

Please list any Life Threatening Allergies _____

Do you have a pacemaker? Yes No

Do you have a port? Yes No If Yes, Date Implanted _____ Date of Anticipated Removal_____

CURRENT HEALTH CARE TEAM

Primary Care Physician: _____

Specialist: _____ Specialty: _____

Specialist: _____ Specialty: _____

Specialist: _____ Specialty:_____

Other health care team members (Naturopath, PT, Massage Therapist, Nutritionist, Psychotherapist, etc.)

Practitioner: _____ Specialty: _____

Practitioner: _____ Specialty: _____

Practitioner: _____ Specialty: _____

Practitioner: _____ Specialty: _____

MEDICAL QUESTIONNAIRE

I. PRIOR EXPERIENCE

- Have you received acupuncture before? YES NO
- Have you received bodywork before? YES NO If yes, what types?

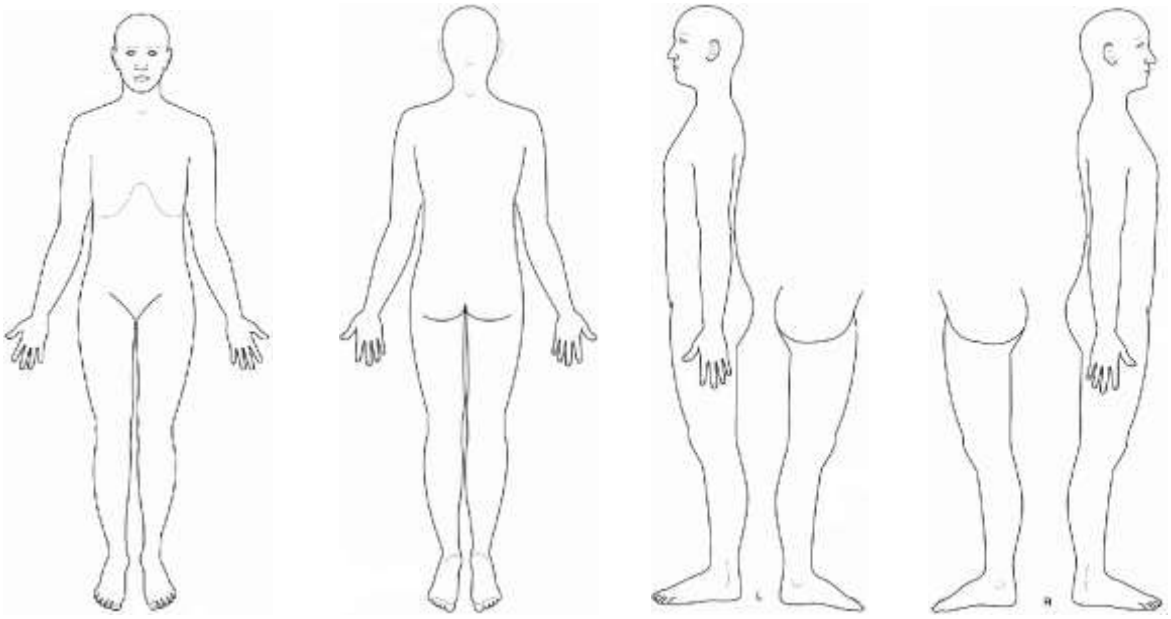
- If yes, for what conditions and what was the outcome?

II. PRIMARY HEALTH CONCERNS

In order of importance, please list your primary health concerns for which you're seeking acupuncture or bodywork.

	CONCERN	**ONSET**	**FREQUENCY**	**SEVERITY**	**Physician Diagnosis**
	Ex. Back Pain	*March 2015*	*3 times/wk*	*mild/moderate/severe*	*Arthritis*
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

On the diagram, please shade or mark the areas where you feel symptoms associated with your concerns.



What are your goals for this appointment:

What other current or past therapies are you are doing/have you done for these concerns (e.g. physical therapy, medications, supplements, chiropractic, naturopathy, etc.)? Have they been help?

III. MEDICATIONS, SUPPLEMENTS, VITAMINS & HERB

List or attach a list of what you are **CURRENTLY** taking:

Medication/Supplement/Vitamin/Herb	Dosage	Purpose	Date Started	Prescribed By

LIST ANY ALLERGIES (medications, supplements, herbs, foods, latex, etc. & reactions):

_____

_____

IV. DAILY LIFE

SLEEP Hours of sleep per night: _____ Quality of sleep: Poor / Fair / Good

FOOD & DRINK

Dietary Restrictions _____

Food Cravings _____

How would you describe your relationship with food? _____

_____

Taste preferences: Salty Sweet Spicy/Hot Neutral Sour/Pickled Home Cooked Pre-Made/Restaurant

Appetite: Excessive Good Poor Irregular

Thirst: Excessive Moderate Little None

Preferred Drink Temperature: Hot Cold Room Temp.

# of cups/day: Water _____ Coffee _____ Black Tea_____ Soda/Soft Drinks: _____

Alcohol: Wine / Beer / Cocktails per week _____

Cigarettes/Vaping/Smoking Daily Weekly Occasionally

If you no longer smoke, when did you stop? _____ How many years did you smoke? _____

PHYSICAL ACTIVITY List the types of physical activity and exercise you do regularly & the frequency:

What are the major stressors in your life?

What are your interests/hobbies?

Overall satisfaction with your life at this time:

Unsatisfied / Somewhat Satisfied / Moderately Satisfied / Very Satisfied

V. PERSONAL MEDICAL HISTORY

I. BIRTH: Describe anything significant or challenging about your birth

II. **VACCINATION HISTORY:** Any unusual reactions, lack of vaccination or unique vaccinations?

III. **SURGERIES, ACCIDENTS, MAJOR ILLNESSES & INJURIES** Please list year and event

- **CHILDHOOD**

- **ADOLESCENCE**

- **ADULTHOOD**

V. FAMILY MEDICAL HISTORY

Please note all major illnesses (e.g. diabetes, heart disease, hypertension, neurological issues, mental illness/anxiety/depression/suicide, blood disorders, cancer, high cholesterol, etc.)

MOTHER _____

FATHER _____

SIBLINGS _____

MATERNAL GRANDPARENTS _____

PATERNAL GRANDPARENTS _____

VI. SYMPTOM OVERVIEW BY SYSTEM

Please check all symptoms that you either CURRENTLY experience AND/OR experience FREQUENTLY. Please circle if the symptom:

- A = Acute (under 3 months)
- C = Chronic (over 3 months; experience at some point most days)

MUSCULOSKELETAL

- ☐ A C Joint clicking
- ☐ A C Limitation of movement
- ☐ A C Stiffness
- ☐ A C Spasms or cramps
- ☐ A C Swelling
- ☐ A C Weakness
- ☐ A C Pain: Full body
- ☐ A C Pain: Facial (e.g. jaw)
- ☐ A C Pain: Neck
- ☐ A C Pain: Upper Back
- ☐ A C Pain: Mid Back
- ☐ A C Pain: Low Back
- ☐ A C Pain: Shoulder
- ☐ A C Pain: Elbow
- ☐ A C Pain: Wrist
- ☐ A C Pain: Hand
- ☐ A C Pain: Hip
- ☐ A C Pain: Knee
- ☐ A C Pain: Ankle
- ☐ A C Pain: Foot
- ☐ A C OTHER (Please list)

EYES, EARS, NOSE & THROAT

- ☐ A C Loss of vision
- ☐ A C Eye pain
- ☐ A C Tearing or eye dryness
- ☐ A C Eye discharge
- ☐ A C Eye redness
- ☐ A C Ear discharge
- ☐ A C Ear itching
- ☐ A C Ear pain &/or infections
- ☐ A C Loss of hearing
- ☐ A C Ringing or buzzing in ears
- ☐ A C Problems with balance (vertigo)
- ☐ A C Olfaction (sense of smell) impaired
- ☐ A C Nose obstruction (stuffiness)
- ☐ A C Nose bleeds
- ☐ A C Sinus pain, pressure &/or infections
- ☐ A C OTHER (Please list)

RESPIRATORY

- ☐ A C Chest pain &/or tightness
- ☐ A C Bluish discoloration of skin
- ☐ A C Cough
- ☐ A C Coughing up blood (hemoptysis)
- ☐ A C Shortness of breath (dypsnea)
- ☐ A C Sore throat
- ☐ A C Sputum production
- ☐ A C Voice changes
- ☐ A C Wheezing
- ☐ A C OTHER (Please list)

CARDIOVASCULAR

- ☐ A C Changes in skin temperature & color
- ☐ A C Chest pain &/or pressure
- ☐ A C Edema
- ☐ A C Fainting (syncope)
- ☐ A C Fatigue
- ☐ A C Palpitations
- ☐ A C Swelling of the ankles &/or legs
- ☐ A C OTHER (Please list)

DIGESTIVE

- ☐ A C Abdominal distention/bloating
- ☐ A C Abdominal mass
- ☐ A C Abdominal pain
- ☐ A C Acid regurgitation &/or Heartburn
- ☐ A C Alternating constipation/diarrhea
- ☐ A C Rectal bleeding
- ☐ A C Constipation
- ☐ A C Diarrhea
- ☐ A C Gas
- ☐ A C Eating disorder
- ☐ A C Indigestion
- ☐ A C Jaundice (yellow tint to skin &/or eyes)
- ☐ A C Nausea
- ☐ A C Vomiting
- ☐ A C OTHER (Please list))

UROGENITAL

- ☐ A C Difficulty with urine flow
- ☐ A C Incontinence
- ☐ A C Painful urination (dysurea)
- ☐ A C Rashes
- ☐ A C Red urine
- ☐ A C Urinary tract infection (UTI)
- ☐ A C OTHER (Please list)

NEUROLOGICAL

- ☐ A C Changes in consciousness
- ☐ A C Confusion
- ☐ A C Difficulty concentrating
- ☐ A C Dizziness
- ☐ A C Dysphasia (impaired ability to speak)
- ☐ A C Headache
- ☐ A C Numbness and/or tingling
- ☐ A C Loss of consciousness
- ☐ A C Paralysis
- ☐ A C Post shingles pain
- ☐ A C Problems coordinating movements
- ☐ A C Severe forgetfulness
- ☐ A C Tremor
- ☐ A C Visual disturbance
- ☐ A C Weakness
- ☐ A C OTHER (Please list)

INTEGUMENTARY (SKIN)

- ☐ A C Changes in hair
- ☐ A C Changes in nails
- ☐ A C Changes in skin color
- ☐ A C Itching (pruritis)
- ☐ A C Never sweat
- ☐ A C Rash and/or skin lesion
- ☐ A C Unusual sweating
- ☐ A C Wounds that will NOT heal
- ☐ A C OTHER (Please list)

PSYCHOLOGICAL

- ☐ A C Feelings of grief
- ☐ A C Feeling of sadness
- ☐ A C Feeling fearful/anxious/nervous
- ☐ A C Difficulty managing anger
- ☐ A C Feeling manic
- ☐ A C Feeling worried or overly pensive
- ☐ A C Feelings of panic
- ☐ A C Feeling overwhelmed
- ☐ A C Extreme mood swings
- ☐ A C Extreme lack of emotion
- ☐ A C OTHER (Please list)

SLEEP

- ☐ A C Difficulty falling asleep
- ☐ A C Dream disturbed sleep
- ☐ A C Wake up & cannot fall back asleep
- ☐ A C OTHER (Please list)

MISCELLANEOUS

- ☐ A C Extremely low energy/fatigue
- ☐ A C OTHER (Please list)

REPRODUCTIVE / HORMONAL

- ☐ A C Pain during or after sex
- ☐ A C Pelvic pain
- ☐ A C Sexual dysfunction
- ☐ A C Unusual discharge
- ☐ A C Prostate problems
- ☐ A C Abnormal vaginal bleeding
- ☐ A C Changes in hair distribution
- ☐ A C Fertility concerns
- ☐ A C Irregular menstruation
- ☐ A C Menopausal symptoms
- ☐ A C No menses
- ☐ A C Pain with menses (dysmenorrhea)
- ☐ A C OTHER (Please list)

AGE OF FIRST MENSTRUAL CYCLE_____

NORMAL FLOW DURATION (DAYS)_____

NUMBER OF DAYS BETWEEN CYCLES_____

AGE OF MENOPAUSE _____

Are you pregnant OR trying to become pregnant?
YES NO

Have you ever been pregnant? YES NO
If yes, how many pregnancies: _____
Births _____
Miscarriages _____
Abortions _____

VII. MEDICAL DISEASES/CONDITIONS.

Please check all that apply AND indicate (by circling) if it is current or in the past, but now resolved.

- C = Current condition
- P = Past condition, but is now resolved

☐ C P AIDS/HIV
☐ C P Alcoholism &/or substance addiction
☐ C P Allergies (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P Anemia
☐ C P Asthma
☐ C P Bell's Palsy
☐ C P Blood clotting disorder (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P Bipolar disorder
☐ C P Cancer (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P Crohn's Disease &/or Colitis
☐ C P Chronic Fatigue Syndrome (CFIDS)
☐ C P Depression (Major)
☐ C P Diabetes
☐ C P Eczema
☐ C P Endometriosis
☐ C P Epstein Barr Virus
☐ C P Fibroids
☐ C P Infertility
☐ C P Lung disease, e.g. COPD (If yes, pls indicate diagnosis & history)

_____

☐ C P Fibromyalgia
☐ C P Gallstones
☐ C P Heart disease (If yes, pls indicate diagnosis & history)

_____

☐ C P Hepatitis A / B / C
☐ C P Hernia
☐ C P Herpes
☐ C P Hypertension
☐ C P Hypoglycemia
☐ C P Irritable Bowel Syndrome (IBS)
☐ C P Joint Replacement (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P Kidney Stones and/or Disease (If yes, pls indicate diagnosis & history)

_____

☐ C P Lupus
☐ C P Lyme Disease
☐ C P Lymph node removal
☐ C P Mitral valve prolapse
☐ C P Mood Disorder

☐ C P Mononucleosis
☐ C P Multiple Sclerosis
☐ C P Organ removal or transplant (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P Osteoarthritis
☐ C P Osteoporosis
☐ C P Pacemaker (heart or stomach)
☐ C P Parkinson's Disease
☐ C P Pelvic Inflammatory Disease
☐ C P Polio
☐ C P Psoriasis
☐ C P PTSD (Post-Traumatic Stress)
☐ C P Reflux esophagistis (GERD)
☐ C P Rheumatic fever
☐ C P Rheumatoid arthritis
☐ C P Scarlet Fever
☐ C P Schizophrenia
☐ C P Scoliosis
☐ C P Seizures and /or epilepsy
☐ C P Shingles
☐ C P Sleep Disorder
☐ C P Stroke
☐ C P Schizophrenia
☐ C P Thyroid disease (If yes, pls indicate diagnosis & history)

_____

☐ C P Ulcer
☐ C P Trigeminal Neuralgia
☐ C P Tuberculosis
☐ C P Vascular disease (e.g. phlebitis) (If yes, pls indicate diagnosis & history)

_____
_____

☐ C P OTHER (pls list)

_____
_____

Informed Consent to Treatment

I understand that I am the decision maker for my health care. Information is provided to assist me in making informed choices. This process is 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 the acupuncturist indicated below.

I understand that **methods of treatment** provided may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), guasha, Chinese herbal medicine, movement re-education, lifestyle 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 and guasha. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this practice 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. 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.

I understand I have the right to refuse or discontinue treatment at any time.

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 the 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 and recommendations.

X_____

Signature of Patient / Legal Guardian *Date*

X_____

Print Name of Patient

X_____

Print Legal Guardian Name (if applicable)

Jennifer Ladan Nabet, L.Ac

Acupuncturist Name

Notice of Privacy Practices

Consent for Use or Disclosure of Health Information

This acupuncture practice is committed to protecting your privacy. The purpose of this consent form is to give Jennifer Ladan Nabet, L.Ac. and Bodies in Resonance, LLC permission to use your health information to provide treatment, collect payment (from you or a third-party entity) and conduct general administrative business.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. This communication is typically preauthorized and requested by you.

- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of our services. As an out-of-network provider, this does not typically apply to this practice.

- We may need to use your health information within our practice in our effort to provide you with quality health care.

You have the right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

You have the right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read the consent policy and agree to its terms. I also acknowledge that I may access and obtain a copy of this notice of privacy practices.

_____ _____

Signature of Patient and/or Guardian Date

_____

Print Name of Patient

Financial Policies

Explanation of Health Insurance Coverage for Acupuncture & Tui Na Manual Therapy:
This practice is an **out-of-network provider** with all insurance carriers. As a self-pay client, you have a right to receive a good faith estimate for services. **A schedule of fees for self-pay clients is available** for your reference and subject to periodic updates.

Health insurance coverage of acupuncture varies from plan to plan. You are encouraged to research whether your plan has coverage for out of network acupuncture benefits including your deductible amount, percentage of coverage, and approved conditions treated by acupuncture and acupuncturists. Some health insurance plans do not provide coverage for tui na manual therapy or movement therapies when rendered by an acupuncturist, although this is a part of our training and scope of practice.

Payment: Payment is due in full at the time of service. Payments may be made by **check, credit/debit card, HSA/FSA funds**. There is a $35 fee for all returned checks.

Release of Information: Medical information will only be released with your prior authorization. You may also request a copy of your medical record or a medical report. An administrative fee is charged for the preparation, copy and transmittal of these documents when applicable.

Other Services: This practice offers other wellness services (Nervous System Resilience Sessions, Energy Healing, etc.). These services do not provide a Traditional East Asian Medicine assessment and are educational in nature. As such, they are not considered medical expenses, are not covered by health insurance plans and are not eligible for payment from HSA/FSA funds.

Cancellations, Rescheduling, No Shows & Forgotten Appointments:

A **minimum of 48 hours prior notice** is required when cancelling or rescheduling sessions. You are responsible for the full out-of-pocket cost for sessions missed, forgotten or cancelled with less than 48 hours notice, except in the case of family and medical emergencies or illness. In the case of inclement weather, sessions may be rescheduled.

_____ ***(please initial)***

Please indicate your understanding and acceptance of these policies by signing below.

_____ _____

Signature of Patient / Legal Guardian Date

_____

Print Name of Patient / Legal Guardian

Rev. 8/6/2025