

PranaTonic

Yoga and Wellness

1224 Washington Ave STE #210, Golden, CO 80406, 303-274-5733
pranatonic@gmail.com

Name _____ Date _____

How did you hear about us? _____

Would you like appointment reminders via text? Y _____ N _____

Street _____ Email _____

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 an accident? Y (Date _____) N _____

Other professionals consulted? _____

Diagnosis received? _____

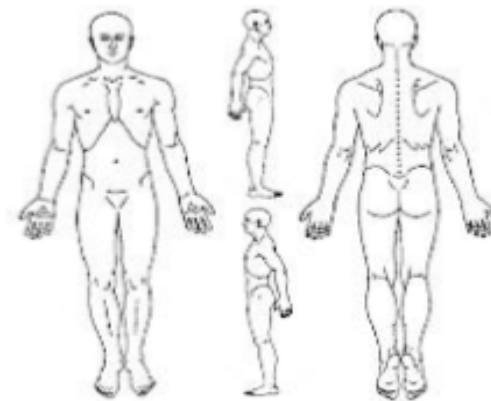
Have you received any treatment? What? _____

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 _____

<p>Please mark area(s) of pain on the figure(s):</p> 	<p>Please describe your pain:</p> <ul style="list-style-type: none"><input type="radio"/> Sharp<input type="radio"/> Dull<input type="radio"/> Aching<input type="radio"/> Burning<input type="radio"/> Numbness/tingling<input type="radio"/> Other
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Health History

Name _____

Please circle health challenges:

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



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: _____

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).

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).

Shanti Pitschka

Shanti Pitschka graduated from the Institute of Integrative Nutrition in 2018 and became an Ayurvedic Health Practitioner in 2019 at the New World Ayurvedic School (NWA). Shanti is a teacher at NWA and has been teaching yoga since 2011. She is a registered ERYT500 yoga and meditation teacher. She works with clients one on one in a 6 month Ayurvedic Lifestyle Coaching Program and Ayurvedic Consults using a variety of Ayurvedic modalities.

Scott Pridgen

Scott's original training was in Neuromuscular Therapy and Sports Massage which has led him to dive further into learning other types of massage. He studied Thai Massage extensively in Thailand and all over the US and has taught Thai Massage at Naropa University as well as places all over the country. Through his study of yoga, he was led to the study of Ayurveda, which is at the roots of Thai Massage, leading to traveling and studying yoga, Ayurveda, Kirtan, sound healing and other forms of massage in India, Thailand, and in the US.

FEE SCHEDULE

Acupuncture First Visit Treatment and Examination	\$150 per 90 minutes
Acupuncture Follow-up includes Chinese medical modalities and Herbal Recommendations	\$105 per 60 minutes
Acupuncture First Visit with Cupping or Massage	\$165
Acupuncture Follow-up with Cupping or Massage	\$120
Cupping Therapy	\$65
Auricular Therapy	\$65
Herbal Consultation	\$75 per 60 minutes, \$50 per 30 minutes
Massage	\$75 per 30 minutes, \$115 per 60 minutes, \$130 per 75 min, \$150 per 90 minutes
Thai Massage	\$125 per 60 minutes, \$160 per 90 minutes
Ayurvedic Consult	\$90 per 60 minutes
Ayurvedic Lifestyle Coaching	\$200 per session
Ayurvedic Abhyanga Oil Massage	\$150 per 90 minutes
Ayurvedic Marma Point Therapy or Udvartana Herbal Body scrub	\$90 per 60 minutes
Ayurvedic Shirodhara Warm Oil Treatment	\$130 per 60 minutes
Ayurvedic Abhyanga Oil Massage with add on of Shirodhara or Udvartana	\$200 per 120 minutes
Trance-Formational Coaching or Ayurvedic Lifestyle Coaching	\$200 per session

Patient Acknowledgement of Privacy Practices

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 your 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 use 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)

Acupuncture Informed Consent and 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 at 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 its 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 _____

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 Emails: You will receive a reminder about your appointment via email. If you do not receive your appointment reminders, please call to confirm that we have your correct email address.

Insurance Responsibility: PranaTonic will contact your insurance company to see if Acupuncture services are 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 Acupuncture Informed Consent explanation of 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. All new patient documents are located at [www.https://www.pranatonic.com/forms/](https://www.pranatonic.com/forms/).

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 Name: _____

Patient's Signature: _____

Signature of Parent or Guardian (if minor): _____