PranaTonic
Yoga and Wellness

1224 Washington Ave. #210 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? _____

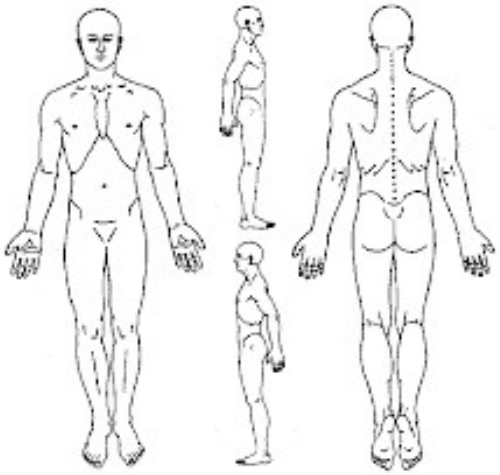
What makes it better? _____

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_____

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)

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: _____

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

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 recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could including receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:

Name _____

Date _____

Parent / Guardian Signature _____

Name _____

Date _____

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 EYRT500 yoga and meditation teacher. She works with clients one on one in a 6 month Ayuervedic Lifestyle Coaching Program, Ayurvedic Consults, and private yoga sessions called "Yoga for Healing."

FEESCHEDULE

Initial Acupuncture Treatment and Examination	$130
Acupuncture Follow-up includes Chinese medical modalities and herbal recommendations	$90
Cupping Therapy	$45
Massage	$55 Per 30 Minutes, $90 Per 60 Minutes, $130 Per 90 Minutes
Auricular Therapy	$35
Herbal Consultation	$60 Per 60 Minutes
Follow Up Herbal Consultation	$30 Per 30 Minutes
Kinesio Taping	$10
Lifestyle Coaching First Visit and Follow Up	$200
Ayurvedic Lifestyle Coaching	$150
Ayurvedic Consult	$90

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
1224 Washington Ave. #210
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)

PranaTonic

303.274.5733
www.pranatonic.com

Acupuncture Informed Consent

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 Chiropractic Therapy and Acupuncture Informed Consent 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. All new patient documents are located at www.https://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):