



Nadya Waziri, LAc

Today's Date: _____

Acupuncture Initial Intake Questions

Name: _____ Date of Birth: _____ Current Age: _____

Gender/ Pronouns: _____

Have you received acupuncture in the past? N/Y If yes, how long ago was your last treatment? Who was the provider, and were you satisfied with the results?

Please describe your primary reasons for seeking care: _____

What other forms of treatment have you tried? _____

What other health problems or concerns do you now have, if any? _____

Allergies, food sensitivities or unusual cravings? _____

Please list and describe any significant medical history, including diagnosis, accidents, surgeries or hospitalizations (include the age you were or the date, where possible)

Lab results you would like considered (may attach if necessary)

List all medications (including over-the-counter), supplements, herbal formulas, etc. that you are taking.

Medication/ Supplement	Dose	How often	Reason	Prescribed by

Food and Drink: please describe your food intake (are there foods you do not eat, what is your typical breakfast, lunch, dinner, do you have any food concerns? _____

How much water do you drink per day? _____

How much caffeine do you have per day? _____

How much alcohol do you consume, if any per day/per week? _____

Please indicate how you feel about the following aspects of your life.

	Great	Good	Fair	Poor	Bad	Comments
Family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Diet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Sex/Intimacy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Self	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Spiritual life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

Is there anything else you would like me to know about your life circumstances or personal history?
If so, please describe below, attach an extra page, or feel free to talk to me during your appointment.

Please Respond to All That Applies

Age of first period (menarche) _____

Are you pregnant? N/Y

Age of last period (menopause) _____

Pregnancies (#) _____ Live births (#) _____

Number of days between periods _____

Miscarriages (#) _____ Abortions (#) _____

Color of flow _____

Number of days of flow _____

Light, Heavy or spotting:

Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____ + Days _____ Clots? N/Y

Location of any pain related to period: Lower abdomen Thighs Breasts/Chest area Other

Nature of pains (indicate if the pain occurs before, after, or during menses): Cramping _____

Stabbing _____ Burning _____ Aching _____ Intermittent _____

Dull _____ Bloating _____ Consistent _____ Down-bearing _____

Please indicate whether you have been diagnosed with any of the following:

 Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts Other _____**Libido:** Fair Low Good Overactive/disruptive Please describe any concerns:

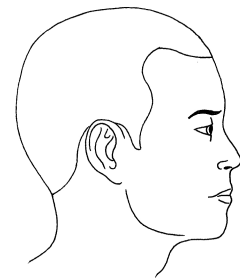
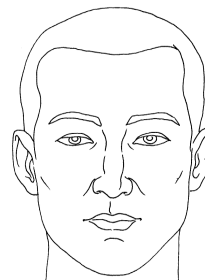
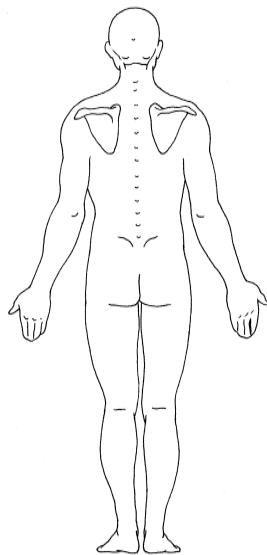
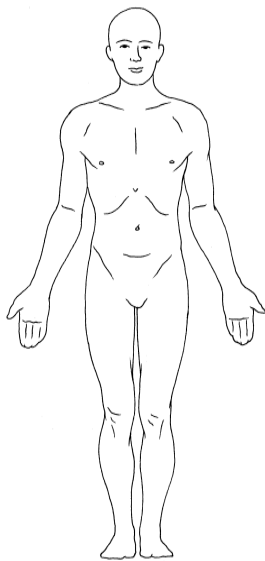
Do you have prostate issues? Yes /No If yes, please explain:

Do you have issues with urination? If yes, please explain:

Do you have any other genito-urinary or reproductive issues? If yes, please explain:

SURVEY OF SYMPTOMS

- | | | |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Lack of appetite | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Loose stool/ diarrhea | <input type="checkbox"/> Cold hands/ feet | <input type="checkbox"/> Decreased sense of smell |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Nasal problems |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Mental restlessness | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Belching & burping | <input type="checkbox"/> Laughter without reason | <input type="checkbox"/> Claustrophobia |
| <input type="checkbox"/> Heartburn/ Reflux | <input type="checkbox"/> Angina-like pain | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Food retained in stomach | <input type="checkbox"/> Tend to become obsessive about work and/ or personal relationships | <input type="checkbox"/> Colitis/ Diverticulitis |
| <input type="checkbox"/> Other digestive problem | <input type="checkbox"/> Sciatic pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Pain or cold in genital area | |
| <input type="checkbox"/> Black tarry stool | <input type="checkbox"/> Prostate conditions | |
| <input type="checkbox"/> Easy bruising | | |
| <input type="checkbox"/> Difficult to stop bleeding | <input type="checkbox"/> Eye problems | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice (yellow eyes/ skin) | |
| <input type="checkbox"/> Catch colds easily | <input type="checkbox"/> Difficulty digesting oils | |
| <input type="checkbox"/> Trouble with weather changes | | |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gall stones | |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Pale stool | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Soft/ brittle nails | |
| <input type="checkbox"/> Faint easily | <input type="checkbox"/> Easily angered/ agitated | |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Difficulty making decisions | |
| <input type="checkbox"/> Sudden weight loss | <input type="checkbox"/> Muscle spasms/ twitching | |

AREAS OF PAIN OR DIFFICULTY (mark areas with a small circle)

CONSENT TO TREATMENT

Acupuncture & Moxibustion

I understand that acupuncture is performed by the insertion of needles through the skin and/ or by the application of heat to the skin (moxibustion) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time. Regarding direct moxibustion (applied directly on the skin), I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I also understand that I may refuse this therapy.

Chinese Herbal Medicine

I understand that substances from the East Asian Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems that I associate with these substances I should suspend taking them and call my practitioner, Nadya Waziri, L.Ac., as soon as possible.

Acupressure / Tui-Na (Therapeutic Massage)

I understand that I may also be given acupressure/ tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture

I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my provider for a more detailed explanation. I give my permission and consent to treatment.

Patient or guardian name (print) _____ Date of Birth _____

Patient or guardian name (signature) _____ Date: _____

Providersignature (Nadya Waziri, L.Ac.) _____ Date: _____



Aeon Acupuncture, LLC
 (319) 569-4154 • NadyaWaziri@gmail.com
 1121 4th Ave. Iowa City, IA 52240

Nadya Waziri, LAc

IOWA MANDATORY DISCLOSURE STATEMENT

Please read the following and sign below after you have had any questions answered and understand this statement to your satisfaction.

"Payment is required by the time of your visit unless prior arrangements have been made. Fees: Initial intake: \$145; return visit: \$85. Package Deals: 5 treatments paid in advance: \$400; 10 treatments paid in advance: \$750. Aeon acupuncture does not participate in insurance billing."

Education and Experience

Nadya Waziri earned her Master of Science in Traditional East Asian Medicine from Southwest Acupuncture College in August 2009. This four-year program consisted of 3,045 hours of education including 1140 hours of clinical practice. She is nationally board certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). This includes certification in Clean Needle Technique and Chinese Herbology. As part of her training, Nadya Waziri studied in the People's Republic of China at the Heilongjiang Chinese Medical University in Harbin. Nadya Waziri's training includes adjunct therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations. She was in private practice in Colorado from 2010-2019.

No license, certificate or registration has ever been revoked or suspended. This clinic complies with the rules and statutes set by the Iowa Board of Medicine. Only single-use, disposable, factory-sterilized needles are utilized. The Iowa Board of Medicine regulates the practice of acupuncture.

Any services offered by Nadya Waziri are not intended to substitute for those offered by a licensed medical doctor when needed and must not be regarded as a medical opinion or advice. A license to practice Acupuncture does not authorize someone to practice medicine and surgery in Iowa. Referrals are made for further workup and treatment when appropriate.

Communications and Correspondence

Aeon Acupuncture solely provides non-emergency services by scheduled appointments only.

Aeon Acupuncture offers appointments outside of standard business hours in order to benefit clients who work traditional M-F/9-5 schedules. Therefore, although we strive to be as timely as possible in our response, outside of Aeon Acupuncture's scheduled work times, we may be unavailable to respond to your message within the typical 24-hour, next-business day period.

Voicemail and e-mail are monitored during Aeon scheduled work times, however, we do not respond while with clients, and we will get back to you as soon as possible. When leaving a voicemail, we ask that you leave detailed information, including times when you are available to speak if you would like a call back, and we will do our best to reach you during the time frame detailed in your message. Aeon Acupuncture does not accept text messages, or messages over social media such as Facebook messenger. Mailing address for official correspondence: Aeon Acupuncture, LLC., 1121 4th Ave. Iowa City, IA, 52240.

Cancellation Policy

All appointments must be cancelled at least 24 hours before the appointment time. Missed appointments or appointments cancelled with less than 24 hours notice will result in a \$50 fee, which must be paid before the next treatment can be scheduled. Repeated violations will result in a requirement to pay in advance for your subsequent appointments with no refund given for missed or late cancellations. Arriving 15 minutes or more later than the scheduled treatment time may be considered a no-show and may result in a cancelled treatment. All exceptions to this policy are given at the discretion of the provider. Cancellations due to weather will be based on Iowa City Public Schools weather closures, see www.iowacityschools.org.

Attending your appointment:

It is important that you come to your appointment hydrated, sober, and that you have eaten an adequate amount of food that day. You may wish to wear loose shorts and a tank-top during your appointment, although the clinic will also provide sheets as covering. We ask that no strong odors, such as perfume, cigarette smoke, or body odor accompany you to your session.

We ask that you arrive to your appointment no earlier than 15 minutes before your scheduled time. Please park in the driveway, near the sidewalk front door. If there is another vehicle parked there already, please park on the street as close to the front of the house as possible. When you arrive, please call or text 303-817-9727, I will come out to welcome you and escort you to the treatment room. Only scheduled clients may enter the house, unless the additional person is there for purposes of accessibility (ie.: mobility access or interpreters). We are not able to accommodate folk (including children) waiting for you on the property during your appointment. There are shops, cafes, a park and a mall all within walking distance of the clinic where your loved ones may wait for you during your session.

Patient/Provider Conduct Agreement

Aeon Acupuncture is a place of healing for people of all walks of life. To foster comfort and respect of the people within the clinic, we ask that the following expectations be met:

- Aeon Acupuncture does not allow weapons on the premises. Weapons include, but are not limited to, guns, knives or swords with blades over four inches in length, explosives, and any chemical whose purpose is to cause harm to another person. Regardless of whether a patient possesses a concealed weapons permit (CCW) or is allowed by law to possess a weapon, weapons are prohibited on company property.
- Patients are required to wear civilian clothing while on the premises and inside of the clinic.
- The restroom will be clearly labeled: any attempt to access parts of the house other than the waiting area or restroom may result in immediate termination of service and immediate removal from the property.
- Front of chest, groin area, and buttocks should remain covered by clothing or by the coverings provided by the clinic. If access to any of those areas is required for the purposes of treatment, this will be carefully communicated during that portion of the treatment, and proper draping of the immediate surrounding areas will occur. The patient always retains the right to choose how and if any particular area of their body is exposed or treated.
- All communication will remain respectful. Aeon Acupuncture does not tolerate romantic or sexual advances made toward the practitioners or employees, comments that are hateful, or verbal harassment. This be is to be understood as unwanted, unwelcomed, and uninvited comments or behavior that demeans, threatens, or offends based on race, ethnicity, religion, national origin, gender, sexual orientation, age, class, disability or genetic information.

By signing this document, I agree to uphold all expectations of Aeon Acupuncture as laid out in the terms above and understand that any violations of the terms will result in termination of service.

Patient or guardian name (print) _____

Patient or guardian name (signature) _____ Date: _____



Nadya Waziri, LAc

Today's Date: _____

Contact Information

Please fill out all sections of this form. This information will be used for communication such as scheduling, billing and record keeping. Your info will never be used by third parties. We may also send Aeon newsletters, such as info about classes, sales, and health tips. Opt out of Aeon newsletters by initialing here: _____.

Name: _____

Date of Birth: _____

Primary Phone Number: _____

Alternative Phone Number: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Email Address: _____

Mailing Address: _____ Apartment/Suite: _____

City: _____ State: _____ ZipCode: _____

Patient Safety in the time of Covid 19

As a medical professional, I will continue to follow proper sanitary procedures. Additionally, due to the unknown nature of community spread of Covid-19, the following changes will be implemented.

- I will minimize physical interactions with clinic materials, such as doorknobs, intake forms, pens, etc. Therefore, prior to your visit, please fill out your intake forms, then scan and e-mail them back to me. I will be moving to software that allows an online intake soon. When you book your appointment, I will send you an invoice via Square, which you can pay before your treatment.
- Rather than using the waiting room I am instead asking you to please wait in your vehicle. When you arrive call (303-817-9727) or text (303-817-9727). I will let you know when your treatment room is ready and will escort you in.
- I will request that all people wear face masks when in the common areas of the clinic. If you wish to remove the mask in the treatment room, or during your treatment, please feel free to do so.
- Please refrain from bringing in unnecessary visitors. Care workers and dependent family are still welcome. Ideally they would wait in your vehicle while you get your treatment.
- If you have any signs of Covid-19 illness (fever, cough, shortness of breath) or have had direct contact with someone who has, I will respectfully ask you not to enter. However, please let me know if you are in need of herbal medicine and I can do an herbal consult with you via phone. As with all illnesses, there are a number of traditional herbal and lifestyle remedies that can help. I do not want you to miss anything that can help your body and mind in this time of stress and community dis-ease.