EAST MEETS WEST Preventative Medicine

Dr. Aaron Nickamin
DAOM, AP, L.Ac, LMT, JSJP, JSPAP, CAA, KSTP.

(970) 309-0849 emwpm.com

NEW PATIENT INTAKE FORM Date: _____

Name	Marital Status:	Birthdate / / Age _____
Address_____		Male Female Ht_____ Wt
Email		Occupation
Home Phone	Work	Cell
Referred by		
Reason for visit today		Have you had acupuncture before? Chinese herbal medicine?
How long have you had this condition?		
Is it getting worse?	Does it bother your □sleep □work □other (specify)?	
What seemed to be the initial cause?		
What seems to make it better?		
What seems to make it worse?		
Are you under the care of a physician now? □ Yes □ No	if yes, for what?	
Physician's name:		Physician's phone:
Other concurrent therapies:		

Family Medical History:

☐ Allergies (list)	☐ Arteriosclerosis	☐ Cancer (type)	☐ Diabetes (Type:)	☐ Seizures
	☐ Asthma		☐ Heart Disease	☐ Stroke
_____	☐ Alcoholism	☐ Depression	☐ High Blood Pressure	
_____				

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FEE SCHEDULE

COMBINATION ACUPUNCTURE & JIN SHIN JYUTSU

* Initial Consulation	$225.00	90 Minutes
* Follow-up Treatment	$200.00	90 Minutes
* Follow-up Treatment	$135.00	60 Minutes

OTHER TREATMENTS

* Herbal Consulation	$75.00	30 Minutes
* Electro-Stimulation	$27.40	Per Unit
* House Call	$500.00	90 Minutes
* Injections	$100 & up	

Payment is expected at the time of treatment unless prior arrangements have been made.

I Dr. Aaron Nickamin have never had any license, certification or registration suspended or revoked.

Patients are entitled to receive information about methods of therapy, techniques used and the duration of therapy, if known. Any services offered by Aaron Nickamin are not intended to substitute for those offered by a licensed medical doctor when needed. Patients may seek a second opinion and may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate. Misconduct should be reported to the director of the division of registrations at the Dept. of Regulatory Agencies.

I understand that complications may result from acupuncture treatment. Among the possible complications are:
numbness, nausea, fainting, weakness, bruising, infection, pain and discomfort, pneumothorax and aggravations of present symptoms. The client further understands and agrees to hold harmless to indemnify and protect against court action, Dr. Aaron Nickamin, L.Ac, in the event of accidental injury on these premises.

Signature _____

Date _____

EDUCATION

1994 University of Arizona-Tucson, AZ Bachelors of Health Related Professions-Physical Education with a combined minor of Special Education & Rehabilitation.

1994 1st San Black Belt, Traditional Tae Kwon Do, Pima Community College, Tucson, AZ.

1996 Phoenix Therapeutic Massage College-Therapeutic, Sports and Swedish

1998 Jin Shin Jyutsu Practitioner, 2nd level Usui Reiki

2003 Emperors College of Traditional Oriental Medicine - Santa Monica, CA.
Masters of Traditional Oriental Medicine, Yai Qi Chuan and Qi Gong.

2005 Biopuncture of neck and head - Michael Yong and Joe Swartz, Longmont, CO

2012 Wat Pro Trad. Thai Massage & Yoga Thai Massage, Bangkok & Chiang Mai, Thailand.

2000-2014 Shen/NeoClassical pulse diagnosis study, Will Morris, ph.D, DAOM, L.Ac.

2009-2011 Allergy Elimination apprenticeship - Robin Cupp, L.Ac., Tucson, AZ.

2012 - Neural Prolotherapy/Lyftogt Tech. Il., USA.; 2013 Guadalajara, MX.

2013 American College of Traditional Chinese Medicine - San Francisco, CA.
Doctor of Acupuncture and Oriental Medicine (woman's health/pediatrics/pain mngmt,).

2014 Koren Specific Technique (KST). San Diego, CA.

2014 Neural Therapy - Jeff Harris, ND. Boulder, CO.

2017 Advanced Neural Therapy- Jeff Harris, Portland, OR

2026 — Acupuncture Injection Therapy (AIT), Certificate of Qualification (COQ)

PROFESSIONAL EXPERIENCE

1994 Elementary Adaptive Physical Education Specialist, Amphitheater Public Schools, Tucson, AZ.

1996 Scottsdale Princess Resort and Spa, Scottsdale, AZ. - massage therapist.

1999-2008 WIN Health Institute, senior acupuncturist/Chinese herbalist, massage therapist. Basalt, CO.

2009-2014 East meets West Preventative Medicine - private practice, Roaring Fork Valley, CO.

2013-2016 AAOM - Cancun, MX., 2013-2016 LAOM Lima, Peru & 2014 AAOM Guadalajara, MX.
prolotherapy missions.

2015 Jin Shin Jyutsu Animal Practitioner Certification (acupressure)

2015 Animal Acupuncture Certification Program
Maryland University of Integrative Health, Laurel, MD.

2017 NeoClassical Pulse Diagnosis - Dr. William Morris - Teacher Certification

2022 Gracie University Jiu-Jitsu Certified Instructor

2025 NCCAOM. Injection Therapy Task Force- injection therapy specialist contributor.

2026 Jin Shin Guild Phase 1 certified instructor Art of Jin Shin (Japanese "like" acupressure)

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Your Past Medical History:

☐ AIDs/HIV
☐ Alcoholism (Date:)
☐ Allergies
☐ Appendicitis
☐ Arteriosclerosis
☐ Asthma
☐ Birth Trauma (your own birth)
☐ Chicken Pox
☐ Diabetes (Type:)
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Gout
☐ Heart Disease
☐ Hepatitis (Type:)
☐ Herpes (Type:)
☐ High Blood Pressure
☐ Measles
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Scarlet fever
☐ Seizures
☐ Stroke
☐ Thyroid disorders
☐ Cancer type: treatment: _____
☐ Surgery (list)
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Venereal disease
☐ Whooping cough
☐ Other
☐ Major trauma (car, fall, pls list)

Your Diet:

Appetite ☐ Low ☐ High
☐ Coffee/Tea ☐ Soft Drinks/ day: Fruit Juices
☐ Artificial ☐ Sugar Sweeteners ☐ Salty foods
Protein Intake ☐ Low ☐ High
Thirst for water: # glasses per

Pharmaceuticals (name and dosage):

Vitamins/Supplements (name and dosage):

Your Lifestyle:

☐ Alcohol
☐ Tobacco
☐ Marijuana
☐ Drugs
☐ Stress
☐ Occupational hazards

Regular Exercise
Type_____ Frequency_____
Type_____ Frequency_____

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General Symptoms:

- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Like cold drinks
- ☐ Like hot drinks
- ☐ Weight loss/gain
- ☐ Poor sleep
- ☐ Heavy sleep
- ☐ Dream-disturbed sleep
- ☐ Fatigue
- ☐ Lack of strength
- ☐ Bodily heaviness
- ☐ Cold hands or feet
- ☐ Poor circulation
- ☐ Shortness of breath
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Muscle cramps
- ☐ Vertigo/dizziness
- ☐ Bleed or bruise easily
- ☐ Peculiar taste (Describe)

_____

_____

_____

Head, Eyes, Ears, Nose, Throat

- ☐ Glasses (age?)
- ☐ Eye strain
- ☐ Eye pain
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in eyes
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Night blindness
- ☐ Myopia/Presbyopia
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Teeth problems
- ☐ Grinding teeth
- ☐ TMJ
- ☐ Facial pain
- ☐ Gum problems
- ☐ Sores on lips/tongue
- ☐ Dry mouth
- ☐ Excessive saliva
- ☐ Sinus problems
- ☐ Excessive phlegm Color:
- ☐ Recurrent sore throat
- ☐ Swollen glands
- ☐ Lumps in throat
- ☐ Enlarged thyroid
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Earaches
- ☐ Headaches
- ☐ Migraines
- ☐ Concussions

Other head or neck problems

_____

_____

_____

Respiratory

- ☐ Difficulty breathing wh lying down
- ☐ Shortness of Breath
- ☐ Tight chest
- ☐ Asthma/wheezing
- ☐ Difficult inhale? Exhale?
- ☐ Cough

Wet or Dry? _____

Thick or thin? _____

- ☐ Color of phlegm: _____
- ☐ Coughing up blood
- ☐ Pneumonia

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Blood clots
- ☐ Fainting
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Tachycardia
- ☐ Heart palpitations
- ☐ Phlebitis
- ☐ Irregular heartbeat/ Afib

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Acid regurgitation
- ☐ Gas
- ☐ Hiccup
- ☐ Bloating
- ☐ Bad breath
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stools
- ☐ Bloody stools
- ☐ Mucous in stools
- ☐ Hemorrhoid
- ☐ Itchy anus
- ☐ Intestinal pain/ cramps
- ☐ Burning anus
- ☐ Rectal pain
- ☐ Anal fissures
- ☐ Laxative use

What kind?

How often?

Bowel movements:

Frequency_____ Texture/form_____

Color_____ Odor_____

Musculoskeletal

- ☐ Neck/shoulder pain
- ☐ Muscle pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Joint pain
- ☐ Rib pain
- ☐ Limited range of motion
- ☐ Limited use
- ☐ Other _____

Skin and Hair

- ☐ Rashes
- ☐ Hives
- ☐ Ulcerations
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Dandruff
- ☐ Itching
- ☐ Hair Loss
- ☐ Change in hair/skin texture
- ☐ Fungal infections

Other (Specify)

_____

_____

Neuropsychological

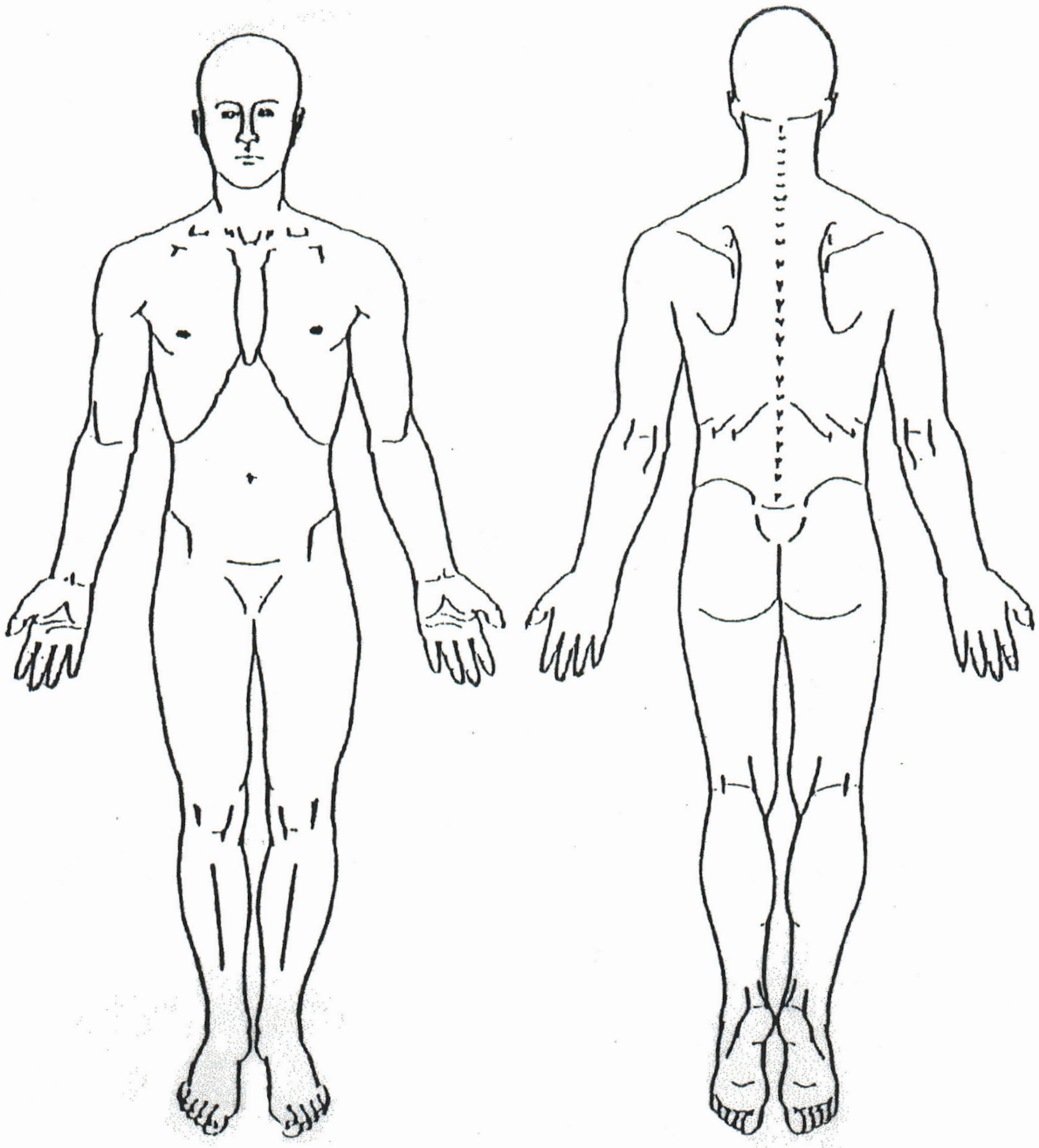
- ☐ Seizures
- ☐ Numbness
- ☐ Tics
- ☐ Poor memory
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Easily sressed
- ☐ Abuse survivor
- ☐ Considered/attempted suicide
- ☐ Seeing a therapist

Other (Specify)

_____

_____

On the figures below, please circle any areas of **pain**
and place a number of **1 (MILD)** to **10 (SEVERE)**



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INFORMED CONSENT TO TREAT

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 above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, tuina (Chinese massage), Chinese herbal medicine, nutritional counseling, botanical medicine, cosmetic acupuncture, applied kinesiology/clearing, homeopathy, gua sha, reiki, Tai Qi Chuan/Tai Chi, Qi Gong, KST (Koren Specific Technique), Jin Shin Jyutsu (like Japanese Acupressure), Nasal Release Therapy NRT, and acupuncture injection therapy/acupoint injection therapy/AIT. , prolotherapy, protein rich plasma, autosanguis, neural therapy, perineural, Chinese herbal and nerve hydrodissection injections and biopuncture). I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs, or any nutritional/botanical supplement. I have been informed that acupuncture and acupuncture injection therapy are generally safe methods of treatment, but that it may have some side effects, including 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 injection therapy. Unusual risks of acupuncture and AIT. include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment, at all times.

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.

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 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.

PATIENT SIGNATURE _____ DATE _____

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FINANCIAL RESPONSIBILITY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we required you to read and sign prior to any treatment.
All patients must complete our Patient Information sheet before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER AND AMERICAN EXPRESS.

Regarding Insurance: We can provide you with a Super Bill, that you can send to your insurance company for reimbursement, at your request. You are responsible for full payment at time of service.

Usual and Customary Rates (UCR): Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Should a punch pass be in force upon missing an appointment without 24 hours' notice, one visit from said package shall be forfeited. Your treatments will be more effective if you follow your doctor's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping scheduled appointments. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I understand that I am responsible for the payment of this account, and hereby assume and guarantee payment of all expenses incurred during my office visit. In the event a credit (refund) balance appears on this account, I hereby irrevocably authorize the office to transfer and apply such credit on any outstanding account with FHC incurred by myself, or my dependents. Should legal action be required to secure payment of this account, I agree to pay a reasonable collection expense, all court costs and a reasonable attorney's fee incurred thereby.

I have read the Financial Policy. I understand and agree to this Financial Policy. A photocopy of this form shall be considered as effective as the original.

_____ _____

Patient/Authorized Person/Responsible Party Date

We require Credit Card information for our records to hold any appointments and for our cancellation policy.

_____ EXPIRATION _____ CVC CODE _____

Client information is confidential and will not be shared outside of the clinic

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NOTICE OF PRIVACY POLICIES

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations. During the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations. You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not provide your health information to any external agency or entity for marketing communications without your written authorization. This office may send birthday cards, newsletters, event notices and appointment reminders, by calls, post cards or letters. Upon written request this office will withhold any or all such communications.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

YOUR HEALTH INFORMATION RIGHTS

1. Upon written request you have the right to access, review or receive copies of your healthcare records used by us to make decisions about you. A reasonable copying charge may apply.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to receive a copy of this Notice of Privacy Policies.
4. You have the right to request that this office place additional restrictions on disclosure of your
5. Protected Health Information for treatment, payment, and health care operations. However, we reserve the right not to agree to the requested restriction.
6. You have the right to request that we amend your Protected Health Information; the request must be in writing.

Our Responsibilities

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain.
I have read and understand the above.

Print Name _____

Signature _____

Date _____

If you have questions, complaints or want more information contact this office.

Dr. Aaron Nickamin : Privacy Officer
970.309.0849.