Shining Light Wellness
Sugandhi Brown, R.Ac.

New Patient Intake and Information Packet

Thank you for choosing Shining Light Wellness to support your health and wellbeing. I'm honored you have trusted me to support you and look forward to working with you.

This packet contains the following:

1. New patient health history and intake form
2. Financial Policy
3. Privacy Policy and Consent to Care

The intake and health history form are quite detailed. Successful health and preventative care are only possible when the practitioner has a complete understanding of the patient and their history, including the physical, mental and emotional state. Please complete this form as completely as possible. If you are unsure of how to answer a question or section, leave a question mark in that spot.

Please complete this packet and return it via email to hello@shininglightwellness.com at least **1 day or min 24 hours prior** to your scheduled appointment. I need adequate time to review this information prior to the appointment so that we can make the best of our time together.

<u>In addition, include the following photos with these forms:</u>

1. 2 tongue photos: see instructions here
2. Close up of your face
3. 3 full-length photos of you in fitting attire from the front, back and side

How to take tongue photos:
In Chinese Medicine diagnosis, we analyse how your tongue looks in terms of color, moisture, shape and "geographic" areas of the tongue. This helps us to assess what areas of your body need the most help. Follow these instructions to take a proper photo of your tongue that can be used for diagnosis:

1. If possible, take the pictures first thing in the morning before brushing your teeth or eating/drinking.
2. Take the photos in natural light 1.e by a window or outdoors.
3. Take two photos:
    1. One of the bottom of the tongue, so place the tip of your tongue against the roof of the mouth and open your jaws as much as possible. The idea is to expose the veins on the underside of the tongue
    2. One on the front of your tongue. Open your mouth as wide as possible and stick your tongue out. If you have trouble taking the photo, don't let the tongue dry out, you can close your mouth and stick it out again. Extension of the tongue should be done naturally without excessive force, let it fall like a dog that is panting. This allows me to see the natural shape of the tongue.

Shining Light Wellness
New Patient Intake Form – Nourishing Life Consultation

General Information

Full Name: ____
Date:___________________________
Email: __________________________ Phone/Cell ______________________
Address: ______________________
City_____________________ State_______ Zip Code___________

DOB: _______________ Age: _____________

Occupation: ___________________ Employer_______________
Hours worked a week ___________
Relationship Status: Single_____ Married ____ Separated ____ Divorced____

Emergency Contact:
Phone # _____________________ Relation: ____________________

Are you presently under the care of a health care provider? ☐ Yes ☐ No
Who and what for? _________________________________
If no, when did you last receive care from a provider & for what? _________________________

What are your most important health concerns? Please list in order of importance:
1.
2.
3.
4.
5.

What are your top 3 health goals?
1.
2.
3.

Weight: _________________ Height ____________________ Weight 1 year ago?____________
Max weight: _________________ When? _________________
When is your energy the best in the day? _________________
The worst? _________________

Health History

What is the primary reason for which you are seeking care?

____

What was the initial cause?

When did it begin? ____________________

What have you done about it previously?

Do you have any known contagious diseases at this time? Y N

If yes, what?____________________

Do you have any diagnosed medical conditions? Y N

If yes, please list: ____

____

Please list past hospitalizations and surgeries, including the date:

What Happened?	Date

List significant traumas and when occurred (accidents, falls, emotional, sexual, etc):

What Happened?	Date

Imaging and special studies? X-rays, CT Scans, MRIs , ECGs or other imaging or investigations:

Type of Imaging or investigation & Result	Date

Childhood illness:

Scarlet fever?____ Diphtheria?______ Rheumatic Fever?_____ other?_____
Mumps?______ Measles? _______ German Measles?_____ Ear infections/tubes? _____
Frequent antibiotic use?_______ Asthma?_____ Frequent cold/flu?_____

Medications & Supplements:

Are you allergic to any of the following?

☐Pharmaceutical Drugs ☐Foods ☐Herbs ☐Other (airborne, chemical)

Please List:

____

Do you take or use regularly or intermittently? (please circle)

Laxatives? Y N Pain relievers? Y N Antacids? Y N Cortisone? Y N
Appetite suppressant? Y N Antibiotics? Y N Tranquilizers? Y N Sleeping Pills? Y N
Prednisone? Y N Hormone replacement therapy? Y N

List all supplements:

____

____

List all medications:

____

____

System & Symptom Review

Please check the box if you are currently experiencing the following symptoms or have had it in the last one year:

General

☐Anemia
☐bleed or bruise easily
☐ loss/ gain appetite
☐weight gain/ loss
☐cold parts of the body
☐dizziness/vertigo
☐dry mouth/ throat
☐fatigue/ low energy
☐feel cold/ hot often
☐fever/chills
☐heat in hands, feet or chest
☐night sweats
☐poor memory
☐insomnia/ sleep difficulty
☐ excess sweating
☐strong thirst
☐swelling of hands, feet, or limbs
☐ preference for hot or cold drinks (circle)

LU, HT

☐asthma
☐chest pain
☐cough
☐disturbing or excessive dreams
☐dry skin
☐frequent colds/flus
☐hiccups
☐mental confusion/ restlessness
☐ nasal congestion
☐nose bleeds
☐palpitations
☐phlegm: color____
☐ shortness of breath
☐sinus problems
☐skin rash
☐sore throat
☐depression
☐sadness/ grief

GI Tract (SP, ST, SI, LI)

☐abdominal pain or cramps
☐acid reflux or heart burn
☐anal itching/ burning
☐anxiety or worry
☐bad breath
☐foul smelling stools
☐gas/ flatulence
☐hemorrhoids
☐lack of taste
☐laxative use
☐constipation
☐dry stools
☐loose stool/ diarrhea
☐nausea/vomiting
☐sores on lips/tongue
☐varicose veins
☐weak limbs
☐heavy limbs or head
☐brain fog

How many bowel movements do you have a day? ________ **Do you feel fully evacuated afterwards?** ☐ Yes ☐ No

LR/ GB

☐ bitter taste in mouth
☐ depression/ anger
☐dry, red, itchy eyes
☐easily susceptible to stress
☐ burnout
☐headache/ migraine
☐jaundice (yellow skin/eyes)
☐lump in throat
☐muscle spasm/ weakness
☐brittle or dry nails
☐pain below ribs on in chest
☐genital pain, sores, or itching
☐prostate issues (men)
☐ringing in ears
☐sighing frequently
☐spots in front of eyes
☐tremors/convulsions

KI/UB

☐ abundant urination
☐blood in urine
☐burning or painful urination
☐frequent bladder infection
☐frequent urination
☐gum problems
☐hair loss
☐urinary incontinence
☐poor hearing
☐teeth problems
“–p0o98
☐ urgent urination
☐dribbling urination
☐infertility
☐ear aches

Musculo-skeletal

☐Arthritis
☐back pain
☐carpal tunnel
☐elbow pain
☐foot/ ankle pain
☐hand/ wrist pain
☐hip pain
☐jaw clicking or pain
☐lack of coordination
☐ muscle tension/ pain
☐knee pain
☐neck pain
☐numbness/tingling
☐osteoporosis
☐shoulder pain

Women's Health History

Date of last menstruation _______________ Age of 1st menstruation _______ Age of onset of menopause ___________
Length of cycle______________ No. of Pregnancies _____ No. of Births _____ Are you currently pregnant? ☐ Yes ☐ No
Miscarriages?_______ Abortions?_____ Sexually Active?_____
Ages of children: ___________ C-sections?_____ Vaginal births_______
On birth control? ☐ Yes ☐ No Type ________ For how long? _______ Do you plan to become pregnant? ☐ Yes ☐ No

☐bleeding outside menstruation
☐cramps before/during period
☐heavy/excessive flow
☐difficulty conceiving
☐breast distension or lumps
☐PMS symptoms
☐uterine fibroids
☐pain during intercourse
☐clots
☐irregular menstruation
☐amenorrhea
☐STD/STI history
☐endometriosis
☐ovarian Cysts
☐excessive discharge
cervical dysplasia

Men's health History *Skip if N/A

☐Hernia ☐Testicular pain ☐prostate disease ☐testicular masses
☐Discharge/sores ☐impotence ☐premature ejaculation ☐sexually active
☐birth control?______ ☐History of STD/STI
Number of children: _____ Ages_________

Nutrition, Lifestyle & Habits

Do you regularly use any of the following? If so, what is the frequency?
☐ Tobacco _____________ ☐ Alcohol _______________ ☐ Marijuana_______________
☐ Recreational Drugs ______________
☐ Coffee ___________ ☐ Black tea ___________ ☐ Refined Sugar _______________ ☐Pop/soda ________
☐ Previous tobacco use How many years?_____

How much water do you drink daily? ________
Do you follow any particular diet? _______________________

How many hours a night do you sleep? __________
Do you feel well rested in the morning?___________
Rate the quality of your sleep, 5 being great, 1 being poor (circle the appropriate box): 1 2 3 4 5

List exercise and physical activities and frequency:

Typical food intake:
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Drinks: ____
Foods your crave: ____
Foods you dislike: ____
List all food sensitivities, allergies or intolerances: ____

Do you cook for yourself and/or your family ? Y N Frequency: ___________________________
Does someone else in your household do the cooking? Y N
Do you eat out? Y N Frequency:_______________________
Do you do the grocery shopping, or does someone else do it for you?___________________________________
____
Do you go on diets or restrict calories often?____
How many meals do you eat a day?____

Main interests and hobbies?

Do you have any spiritual, religious, or mindfulness practice? If so, please elaborate?

Do you enjoy your work and find it fulfilling? Y N ____
Do you take vacations?
Do you frequently travel for work? Y N If yes, please elaborate____

Do you spend time outside? Y N How much?____
Do you read read? Y N
Watch television or streaming? Y N How many hours per week? _________________________

Have you been treated for substance dependence or abuse recently or in the past? Y N

How does your condition affect you?

What do you think is happening?

Why do you think this is happening?

What do you feel needs to happen for you to get better?

What is your biggest challenge right now, in your life overall?

What do you enjoy most about your life?

How much effort are you willing to make at this time to improve your health?

☐minimal ☐some ☐ complete

Thank you for your time and effort in thoroughly completing this form

Shining Light Wellness

Financial Policy & Agreement

Thank you for choosing Shining Light Wellness as part of your health care team. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

This letter is to keep you informed of the policies regarding your payment responsibilities.

We recognize and appreciate that health & wellness care can involve major financial commitment. We aim to provide you with effective and affordable health care.

All major credit cards are acceptable forms of payment. Venmo and Zelle transfer is accepted in the US and Interact etransfer in Canada – please email hello@shininglightwellness.com to avail these alternate payment options.

By initialing and signing this form in the designated spots below, I acknowledge and accept the following:

Please initial:

As a patient of Shining Light Wellness, I am responsible for the total charges incurred from each visit to your practitioner and that charges are to be paid at the time of booking.

I understand that, at this time, insurance is not accepted and superbills for reimbursement are not available.

I understand that it is my responsibility to purchase any recommended supplements through the Fullscript website after my evaluation or follow-up visits. I acknowledge that a personalized account will be activated by Sugandhi through Fullscript and that I will be required to access the account and set up a password before ordering the recommended supplements. I understand that Sugandhi & Shining Light Wellness does not keep supplements in stock.

I understand that I am required to give Shining Light Wellness 24 hours notice if I need to cancel or reschedule my appointment. If I cancel within 24 hours or NO SHOW for my scheduled appointment time, I accept that I will be charged the full appointment fee and no refund will be issued.

Please feel free to contact me regarding any questions.

____ ______________________________

Signature: Date:

I have read the above stated policies of Shining Light Wellness and will comply with them henceforth.

Shining Light Wellness

Consent Form & Privacy Policy

I, _____________________________ (PLEASE PRINT NAME), give consent to Shining Light Wellness to provide Nutrition Counseling and Health Coaching to myself or the client for which I am legally responsible. The consult will provide information and guidance about health factors within my own control: my diet, nutrition, and lifestyle. I acknowledge the purpose of nutritional counseling is to support wellness, a healthy attitude, lifestyle, and diet and that results are not guaranteed. I understand that Sugandhi Jordan Brown is practicing nutrition counseling and health coaching under her scope of practice as a Registered Acupuncturist. She will enhance my knowledge of health through food, dietary supplements, and eating behaviors.

While nutritional support can be an important compliment to my health and disease management, I understand these services are not a substitute for medical care. Additionally, I understand that any information provided is a recommendation for improving health and not a prescription. Nutritional counseling and health coaching is an important compliment to health and disease management, but is not a substitute for medical diagnosis, treatment, or the care of a medical physician. Additionally, I promise to provide a complete and accurate account of any medical conditions that I may have and any medications that I am taking.

Medical records, personal information and history divulged in session to Shining Light Wellness will be kept confidential unless I consent to sharing my medical information. I hereby release and discharge, indemnify, and hold harmless Shining Light Wellness and Sugandhi Jordan Brown, their officers, agents, employees, and persons acting on their behalf, from all claims, demands, costs and expenses, and causes of action, either in law or equity arising out of or in any way connected to services I receive from Shining Light Wellness. I have read this consent form and terms contained herein carefully. I understand the terms of this form fully and voluntarily agree to be bound by them.

____ _______________________________

Signature: Date: