Dear treasured clients,

Welcome to 2026! We are excited to continue being an integral part of your healing journey so you can participate in your life more fully! Please note the following policies/recommendations:

*__All cancellations need to be made by calling the office__. A late cancellation is defined as an appointment not cancelled 24 hours prior to your scheduled appointment. If you have a Monday appointment that needs to be rescheduled, please call and leave a message on our office message machine 970-256-8449.
Please initial _____

*Your first late cancellation or no-show appointment in each calendar year will not be charged as we certainly understand things happen in life that make it impossible or pose a significant hardship to keep our agreed session time to focus on your health. *Please initial*_____

*After the first "free" late cancellation or no-show appointment in a calendar year, clients will be charged for the full rate of the appointment. *Please initial*_____

*After using your first “free” late cancellation or no-show appointment **and** paying for a late cancellation or no-show appointment, we will ask that you have a credit card on file for scheduling future appointments. We will notify you of the late cancellation or no-show appointment and the amount prior to charging your card.
Please initial _____

*Also, we respectfully recommend you do not smoke cigarettes or be under the influence of any recreational mind-altering substance the day of your service so that you may reap the full benefits of the service rendered.

With gratitude and appreciation,
Your Healing Horizons Healing Team

_____ **2026**
Signature Date

Healing Horizons

Integrated Health Solutions

Welcome to Healing Horizons Integrated Health Solutions

ACUPUNCTURE CONSENT

Thank you for choosing Healing Horizons. We look forward to providing quality healthcare in order to assist you in achieving your health-related goals. In order to serve you as efficiently as possible, please answer all of the following questions and read and sign all forms. All information will be held in the strictest of confidence.

Name_____ Age_____ DOB_____ M F Marital Status_____ Phone_____

Address_____City/State_____Zip_____

Cell_____ If we may send you information, please provide your email_____

Occupation_____ Emergency Contact_____ Relation_____ Phone_____

Who referred you to Healing Horizons? _____ May we thank him/her? Y N

*I voluntarily consent to be treated with acupuncture by April L. Schulte-Barclay, DAOM, LAc, Joseph Ellerin, LAc, LMT, Dip. Hom, CST, and/or Kimberly Brown, Lac, WEMT,.at Healing Horizons and/or my home residence and/or Functional Medicine by April L. Schulte-Barclay.

*I understand acupuncture is performed by the insertion of needles through the skin at certain points on the surface of the body. The effect of acupuncture is to treat energetic imbalances resulting in illness, to modify or prevent the perception of pain, and to normalize the body's physiological functions. I have been informed that only sterile, single-use needles will be used.

*I have been made aware that certain adverse side effects may result. These may include, but are not limited to, local bruising, minor bleeding, fainting, temporary pain or discomfort, and the temporary aggravation of symptoms existing prior to acupuncture treatment.

*I understand the following techniques may also be used in treatment by my practitioner:

Electro-acupuncture involves electrical stimulation to the needles. There is a small risk of shock with this procedure.

Tuina is a form of Chinese massage. Possible side effects may include, but are not limited to, local bruising and soreness.

Moxabustion is the burning of the herb mugwort, either above the skin or applied directly to the skin, in order to warm the area and to increase blood circulation. This procedure involves a small risk of local burning.

Cupping uses suction in glass cups applied to the body. It causes markings on the body that will go away within a few days.

Chinese herbs may be prescribed for internal or external use. Possible side effects when taken internally are usually gastro-intestinal in nature, such as stomachache, nausea and/or diarrhea. There are other possible side effects and I have been advised to contact Healing Horizons should I experience any questionable symptoms.

Bloodletting is an ancient technique which involves releasing a few drops of blood from specific acupuncture points. It is very effective and can produce dramatic results in some cases.

Gua sha is a scraping technique used to stimulate blood flow and healing which may result in light bruising.

Functional Medicine analyzes blood work.

*I am aware that acupuncture is licensed in Colorado and the FDA classifies acupuncture as a medical procedure. I understand that no guarantees are given to me concerning its use and effects, and that I am free to stop or refuse treatment at any time.

*At times you may wish to contact Healing Horizons via email, or vice versa, for communication which may contain protected health information. ***Please initial for consent***_____

*I understand that the following providers will be present at Healing Horizons collaborative care meetings in which my care may be discussed: *April Schulte-Barclay,* DAOM, LAc; *Joseph Ellerin,* LAc, LMT, Dip.Hom, CST; *Kimberly Brown*, Lac, WEMT*; Paula King,* PhD; *Mariel Steel*, LMT; *April Ordaz,* LMT; *Judith Olesen*, BA; *Markus Wettstein,* MD; *Adam Henby*, DC. I also understand that other methods of collaboration, such as confidential email and private electronic group communication, may be used to coordinate my care in accordance with HIPAA regulations. ***Please initial for consent***_____

I understand payment is due at the time of service and I agree to address any financial concerns with Healing Horizons prior to treatment. Healing Horizons gladly accepts cancellations up to24 hours in advance without penalty. The first late cancel or missed appointment is without penalty. Subsequent late cancel or missed appointments will be charged 100% of the scheduled treatment. Please initial_____

I have carefully read and I understand all of the above information. I am fully aware of what I am signing.

_____

Signature (Patient/Parent/Guardian) Date Rev 7/7/2026

(970) 256-8449 • 12th Street Plaza • 2139 N. 12th St #7 • Grand Junction, Colorado 81501
www.hhacumed.com

Healing Horizons

Integrated Health Solutions

Acupuncture Symptom Survey

Name: _____ **Age:** _____ **Date:** _____

This survey will allow your practitioner to evaluate your whole person more completely in order to provide you with individualized care. All information will be held confidential.

What are your primary health concerns for which you are seeking treatment?

1. _____ **2.** _____ **3.** _____

Do you have a primary care physician? Please name: _____

Have you received any prior treatment for the above complaints? If so, please list the nature of the treatment(s), the approximate date(s), and whether or not it was helpful:

_____

_____

_____

_____

Have you had any Western medical tests such as x-rays, MRI's, or blood tests for the above complaints? Please indicate the results and the approximate dates below:

_____

_____

_____

_____

Do you have any known allergies?

Food: _____ MSG: _____

Medications: _____ Chemicals: _____

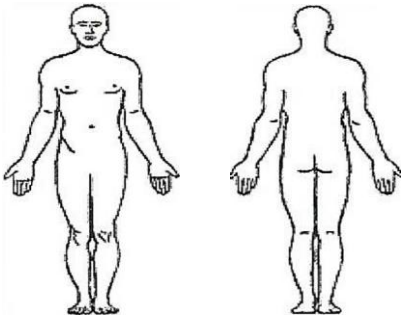
Pollens: _____ Other: _____

Pet: _____ _____

Subjectively, does your body normally run hot or cold? _____

****On the next two pages, please place a check mark next to those symptoms which you NOW experience or have experienced in the PAST. If there are one or more words in a line which describe your specific symptoms,* ***please circle those words.***

GENERAL SYMPTOMS	NOW	PAST	GENERAL SYMPTOMS	NOW	PAST
Tired, weak, low energy			Sweat too much/too little		
Depression, irritability			Night sweats		
Worry, anxiety, nervousness			Dizziness, fainting, convulsions		
Sleeplessness, sleep too much			Loss of weight, weight gain		
Headaches, migraines			Other:		
EYES	**NOW**	**PAST**	**EARS**		
Blurred vision			Earaches		
Dryness, burning, itchy			Ear ringing		
Bloodshot, redness, puffy			Ear discharge, excess wax		
Floaters			Loss of hearing		
Other:			Other:		
NOSE AND THROAT	**NOW**	**PAST**	**RESPIRATORY**	**NOW**	**PAST**
Dry mouth or nose			General shortness of breath		
Nose bleeds			Shortness of breath on exertion		
Dry lips			Spitting or coughing up mucus		
Sore throat			Spitting or coughing up blood		
Clear throat frequently			Chest tightness		
Sore, red, or cracked tongue			Chest pain		
Cold sores, herpes			Other:		
Inability to smell or taste					
Bleeding gums					
Other:					
SKIN AND HAIR	**NOW**	**PAST**	**SKIN AND HAIR**	**NOW**	**PAST**
Acne, pimples			Numbness/tingling		
Skin rashes			Burning sensation in feet		
Hives, itchy skin			Athletes foot		
Skin ulcers or sores			Hair loss, hair thinning		
Dryness, roughness, scaling skin			Dry hair, coarse hair		
Brown spots			Bruise easily		
Moles, warts			Other:		
Other:			**GASTROINTESTINAL**	**NOW**	**PAST**
GASTROINTESTINAL	**NOW**	**PAST**	Diarrhea or loose stools		
Loss of appetite			Constipation		
Difficulty swallowing			Alternating diarrhea/constipation		
Nausea, vomiting			Light colored or greasy stools		
Bad breath			Dark stools		
Metallic or bitter taste in mouth			Blood in stools		
Food cravings			Undigested food in stool		
Heartburn			Foul odor of stool or gas		
Indigestion			Hemorrhoids		
Heaviness after eating			Avoidance of certain foods		
Gas, bloating, belching			Gallbladder stones		
Tender or painful abdomen			Pain under ribs		
Symptoms relieved by eating			Other:		
Symptoms worse after eating					

CARDIOVASCULAR	NOW	PAST	URINARY	NOW	PAST
Leg pains when walking			Bladder infection		
Varicose veins/spider veins			Kidney infection		
Tendency towards anemia			Kidney stones		
High/Low blood pressure			Low back pain		
Other:			Other:		
MUSCULOSKELETAL	**NOW**	**PAST**	**HABITS**	**NOW**	**PAST**
Muscle stiffness			Cigarettes/tobacco		
Swollen, painful, stiff joints			Amount per day		
Bone pain			Coffee or black tea		
Tremors, twitches			Amount per day		
Loss of strength			Alcohol: Amount per day		
Hernia			Amount per week		
Muscle wasting			Marijuana or other drugs		
Broken bones			Amount per week		
Other:			Soda: Amount per day		
Circle areas of pain below: 			Artificial sweeteners Amount per day		
			FEMALE PATIENTS	**NOW**	**PAST**
			Irregular menstruations		
			Pain prior to menses		
			Depressed/irritable with menses		
			Painful or swollen breasts		
			Discharge from breasts		
			Lumps in breasts		
			Hot flashes		
MALE PATIENTS	**NOW**	**PAST**	Diminished sexual desire		
Prostate problems			Excessive sexual desire		
Discomfort in genital area			Date of last period:		
Pain in genital area			Number of days:		
Diminished sexual desire			Length of cycle:		
Excessive sexual desire			Date of last pap smear:		
Difficulty maintaining an erection			Was it normal? Yes No		
Penile discharge			Birth control now? Yes No		
Other:			Method?		
OCCUPATIONAL ENVIRONMENT	**YES**	**NO**	Past methods used:		
Heavy lifting			Currently pregnant? Yes No		
Work stress					
Work related trauma(s)					
Comments regarding above:			**DISEASE/DISORDER**	**YOU**	**FAMILY**
			Learning problems		
			Obsessions		
DISEASE/DISORDER	**YOU**	**PAST**	Thinking problems		
Addiction			Schizophrenia		
Anorexia			Suicide		
Anxiety disorder			Physical health problems		
Attention deficit			Loss or trauma		
Bulimia			Victim of a crime		
Bi-polar			Marital problems		
Compulsions			Parent/child problems		
Depression			Other:		

Have you been exposed in significant or long term doses of chemicals, radiation, toxins, or other? If so, please explain:_____

_____

Please indicate any incidents (and approximate dates) for which you may have had surgery or have been hospitalized for a serious accident or illness:_____

_____

_____

_____

_____

Do you have any chronic illnesses? If so, please explain: _____

_____

_____

Do you have any contagious diseases? If so, please list:_____

_____

_____

Have you traveled outside of the USA within the last two years? Where? _____

_____

_____

Height: _____ Current weight: _____ Past maximum weight: _____ When: _____

Are you happy with your current weight? _____ Most recent blood pressure reading: _____

Vitamins (please list)

_____

_____

_____

_____

Over the counter supplements (please list)

_____

_____

_____

_____

Prescription medication(s) and dosage(s):

_____

_____

_____

_____

_____

Please describe your current diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

_____

What is your current exercise pattern? What physical activities do you enjoy? _____

_____

_____

_____