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

# COLORADO MANDATORY DISCLOSURE

## Education and Experience

**Dr. April L. Schulte-Barclay** earned her Master of Oriental Medicine degree in 2004, and her Doctorate in 2008, both from the Oregon College of Oriental Medicine. These intensive programs consisted of 4328 hours of education and 1000 hours of clinical practice combined. She was certified as a Diplomate in Acupuncture and Traditional Chinese Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (now known as the National Certification Board for Acupuncture and Herbal Medicine or NCBAHM) in September, 2004, certification #25875. This includes certification in Clean Needle Technique and Chinese Herbology.

**Joseph Ellerin** earned his Diploma of Acupuncture from the Santa Barbara College of Oriental Medicine in June 1988. This three-year training consists of 2200 hours of education including 500 hours of clinical practice. He was certified as a Diplomate in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (now known as the National Certification Board for Acupuncture and Herbal Medicine or NCBAHM) in 1987, certification #21839.

**Kimberly Brown** earned her Master of Acupuncture and Oriental Medicine in 2006 from the Natural University of Natural Medicine. This 4 year, 3370 hour program included more than 1070 hours of clinical experience. She was certified in 2006 by the National Certification Commission of Acupuncture and Oriental Medicine (now known as the National Certification Board for Acupuncture and Herbal Medicine or NCBAHM), certification #100191. In 2017 she was certified as a Wilderness EMT, #E3348052.

April L. Schulte-Barclay (license #1056), Joseph Ellerin (license #1406), and Kimberly Brown (license #2385) have never had their licenses, certificates, or registrations revoked.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health; only single-use, disposable, factory-sterilized needles are utilized.

## Fee Schedule

| | |
|---|---|
| Dr. April Schulte-Barclay Initial Intake Consultation / Treatment/Acupuncture Fee | $210 |
| Dr. April Schulte-Barclay Follow-up Treatment / Acupuncture | $104 + cost of herbs |
| Joseph Ellerin Initial Intake Consultation and Treatment / Acupuncture Fee | $180 |
| Joseph Ellerin Follow-up Treatment / Acupuncture | $94 + cost of herbs |
| Kimberly Brown Initial Intake Consultation and Treatment/ Acupuncture Fee | $180 |
| Kimberly Brown Follow-up Treatment Acupuncture | $94 + cost of herbs |

## Patient's Rights

* Healing Horizons Integrated Health Solutions is HIPAA (Health Insurance Portability and Accountability Act) compliant. A complete copy of HIPAA guidelines is available upon request.
* The patient is entitled 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.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Director of Professions and Occupations, Acupuncturist Licensure, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-7800, dora_acupunctureboard@state.co.us.

I have read and understand this document.

_____ _____

Patient's or Guardian's Signature Date Rev 6/22/2026

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: _____

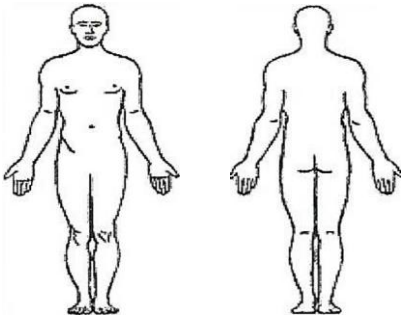
Pollens: _____ Other: _____

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<br>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? _____

_____

_____

_____