Reset Medical Solutions
New Patient Paperwork

A. Consent Form

Name: _____ Date of Birth: _____ AGE: ____
Address: _____City: _____ State: _____
Zip Code: _____Phone: _____ Email: _____

I, _____, consent to undergo acupuncture therapy performed by Brenna Galves L.A.c., Dipl. OM, at Reset Medical Solutions. I understand that acupuncture involves the insertion of fine needles into specific points on the body to promote healing and alleviate symptoms.

Key Points of Consent:

1. Nature of Treatment: I understand that acupuncture involves the insertion of sterile, disposable needles into specific points on the body to stimulate energy flow, relieve pain, or address specific health conditions. I have been made aware that certain adverse side effects may result which could include, but are not limited to; local bruising, minor bleeding, fainting, temporary 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. Acupressure/Massage: I understand that I may be given acupressure or Oriental massage as part of my treatment to modify or prevent pain perception and/or to normalize physiological functions in an attempt to treat disease or dysfunction of the body. I have been made aware that certain adverse side effects may result which could include, but are not limited to; muscle soreness and the possible temporary aggravation of symptoms existing prior to treatment. I understand that I may stop this therapy if this is uncomfortable. Furthermore, I understand that this procedure is for therapeutic purposes only and that in a professional relationship sexual intimacy is never appropriate. Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to modify or prevent pain perception and/or to normalize physiological functions in an attempt to treat disease or dysfunction of the body. 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 have been made aware that certain adverse side effects 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 the acupuncture clinic as soon as possible.

2. Procedure Explanation: The practitioner has explained the treatment plan, including the number of sessions, duration, and expected benefits or potential risks.

3. Risks and Benefits: I understand that while acupuncture is generally safe, potential risks may include bruising, soreness, or slight bleeding at needle insertion sites. Rare complications like infection or nerve damage could occur but are extremely uncommon.

4. Alternatives and Options: I have been informed of alternative treatments or therapies available for my condition and have chosen acupuncture after considering these options.

5. Confidentiality: I acknowledge that my health information will be kept confidential and will only be shared with other healthcare providers if necessary for my treatment.

6. Consent for Treatment: I voluntarily consent to undergo acupuncture treatment and understand that I have the right to withdraw my consent at any time.

7. Cost and Payment: I understand the cost of the acupuncture sessions and the payment arrangements. I have been informed about insurance coverage, if applicable.

Clinic Fee Schedule (payment is due at time of service):

Initial Consultation and Treatment (90 minutes) $165.00 + the cost of herbs
Cosmetic Wellness Consultation and Treatment-New and Returning (90 minutes) $165.00
Cosmetic Wellness Facial (non-needle treatment) (60 minutes) $100.00
30 Minute Reset- $55 + the cost of herbs
45 Minute Reset- $70 + the cost of herbs
60 Minute Reset-$100 + the cost of herbs
75 Minute Reset-$120 +the cost of herbs
90 Minute Reset- $150 + the cost of herbs
2 Hour Reset- $200 + the cost of herbs

Please note that we only offer a package deal to save money on 75 Minute Reset. You must purchase 2 or more 75 Minute Resets to receive a discount on services. Please also note that discounts are not to be combined unless otherwise advised/stated on a case-by-case basis.

Signature and Date: By signing below, I acknowledge that I have read and understood the information provided above and agree to undergo acupuncture treatment.

Patient's Signature: _____ Date: _____
(Minor under the age of 18 must have parent sign for legal documentation BELOW in addition to signature of minor ABOVE)

Legal Guardian Signature: _____ Date: _____

Please Circle YES or NO:

Do you currently have a pacemaker? Yes No
Have you recently had an organ transplant or blood transfusion? Yes No

B. Patient Health History

Marital Status:_____ Occupation:_____ Hours per week:_____
Employer:_____ Email address:_____
Emergency Contact: _____ Phone:_____ Relationship:_____
Referred by (So I can thank them!) or how you heard of me_____
Chief Complaint/Reason for visit:
_____
When did this condition begin?
_____
Describe symptoms you are currently having
_____
_____
Please state diagnosis (if known)
_____
What diagnostic tests (if any) have been done?
_____

What treatment(s) have you already received for this condition?
_____

Has any treatment helped (if yes, please explain)?
_____

Do you have any other health concerns? (please list in order of importance)
1) _____
2) _____
3) _____
4) _____
5) _____
Are you allergic or hypersensitive to any foods, drugs, or environmental allergens? YES/ NO
If yes, please describe:
_____
Do you have any infectious/contagious disease? YES/ NO
If yes, please explain:
_____

Are you currently suffering from any chronic illness? YES/ NO
If yes, please explain:
_____

Major Medical

Please list any hospitalizations, surgeries, significant illnesses, or traumas you have experienced in your life:

1) _____ Date: _____
2) _____ Date: _____
3) _____ Date: _____
4) _____ Date: _____
5) _____ Date: _____

Current Medications

Please list all prescription medication (including hormones or birth control pills), over-the-counter medications, vitamins, herbs, or supplements you are taking and your reason for taking them (you may attach your own copy if that is easier):

1) _____ Dosage: _____ Reason: _____
2) _____ Dosage: _____ Reason: _____
3) _____ Dosage: _____ Reason: _____
4) _____ Dosage: _____ Reason: _____
5) _____ Dosage: _____ Reason: _____
6) _____ Dosage: _____ Reason: _____

Are you vegetarian or vegan? YES/ NO
Are you on any specific diet? YES/ NO If yes, please describe: _____
Do you smoke cigarettes? YES/ NO If yes, how many per day? _____
Do you drink alcohol? YES/ NO If yes, how many drinks per week? _____
Are you pregnant or have any reason to believe you may be pregnant? YES/ NO

Overall, the state of your health is: Excellent Good Average Fair Poor
How much are you willing to change your life overall to reach your healthcare goals?
None Some Moderate Complete

1. **In your opinion, what has happened to your health?**

2. **When was the last time in your life that you felt 100% with your healthcare?**

3. **What are your top 3 healthcare goals in the next year?**