"Roots to Leaves Wellness" application form:

Please mail application in 1 week prior to first class to:

Samantha Parfrey

7510 288th Ave, Suite 2

Salem, WI 53168

Mission Statement

Roots to Leaves Wellness is a partnership between local organizations: JustLive, Inc., WildRoots Salon and Studio, and Turning Leaf Acupuncture. We believe that integrative therapies improve quality of life and are offering it to those in most need. Yoga and Acupuncture are paired in the program to facilitate mental and physical relief.

Roots to Leaves Wellness mission is to change the culture in the surrounding area by helping people overcome depression, anxiety, and other mental health illnesses. Our minds are the battlefield and Roots to Leaves Wellness intentions are to empower the renewal of thought patterns. Resembling the growth pattern of a plant, we need our "roots" to be nourished to sprout and grow new leaves.

General Questions

1. What is your quality of life on a scale form 0-10; 0 being the worst, 10 being best?

2. Why do you want to participate in the program?

3. Are you currently suffering from depression, anxiety, or other mental health issues?

4. Have you been diagnosed with a mental illness, if so, what? How long? Are you under MD or counselor care?

5. Are you under the age of 18? If so, please fill out the additional form with your parent or guardianship's signature.

6. Do you want to be contacted through phone or email? Provide phone number or email.

7. How many minutes a day do you take for yourself to make positive affirmations?

8. What are you currently doing to better your situation? (meditation, exercise, prayer, medication)

9. What would you like to see from this program? Number 1-7. 1 being the most important to 7 being the least important.

_____ Less stress/anxiety
_____ Balance emotions
_____ Increase energy
_____ Gain self worth
_____ Gain social support
_____ Improve body image
_____ Increase muscle strength

"Roots to Leaves Wellness "cannot diagnose an individual with mental illness but the GWB-D subscale and questions will be used to determine which patient is in most need of this program. Thank you for your continued effort in striving for a better and healthier you. We hope we can help you.!!

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10. How did you hear about the program?

"Roots to Leaves Wellness" program will be using the General Well-Being Schedule Depression (GWB-D) Subscale. This is a small scale using four questions that can be rated from 0 (the most negative response) to 5 (the most positive response) to assess depression symptoms over the past month. The questions are: (please circle a number).

Have you felt downhearted or blue?

0 1 2 3 4 5

How have you been feeling in general?

0 1 2 3 4 5

Have you felt so sad, discouraged, or hopeless that you wondered if anything was worthwhile?

0 1 2 3 4 5

How depressed or cheerful have you been?

0 1 2 3 4 5

General Information

Name____Date_______________

Address_____________________________City___________________State______Zip_______

Date of Birth ________________ Phone Number______________________________________

Emergency Contact _______________________ Phone Number__________________________

Have you had Acupuncture before? Yes No

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Acupuncture Informed Consent To Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of Traditional Chinese Medicine on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or servicing as back-up for the acupuncturist named above, 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, Tui-Na (Chinese Massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method 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 potential risks of moxibustion or cupping, or when treatment involves the use of a heat lamp. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 **X** ____________________________ DATE: ____/____/______

(Or Patient Representative)

(Indicate relationship if signing for patient)

<u>“Roots to Leaves Wellness”</u> application form:

HIPPAA CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME ____

BIRTHDATE ___________________

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

____

____

Patient:

X______________________________ ___________

Patient Signature or Legal Representative **Date**

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