PVA Neuroplasticity Coaching®

Name: _____ Date: _____

Home Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Phone: _____ SS#: _____

Occupation: _____

How do you like to be addressed: _____ Preferred Pronouns: _____

What is your Chief Complaint: (List all): _____

Please rate pain levels (1-5):

Sex: M ☐ F ☐ Height _____ Weight _____ Birthdate _____ Age _____

Marital Status Married ❑ Single ❑ Divorced ❑ Widowed ❑ Life Partner ❑

Have you received acupuncture before? Y ☐ N ☐ With whom: _____

PLEASE INDICATE ANY SIGNIFICANT MEDICAL HISTORY IN YOU OR A BLOOD RELATIVE:

	You	Relative	Date		You	Relative	Date
Cancer	❑	❑	❑	Diabetes	❑	❑	❑
Hepatitis	❑	❑	❑	Heart Disease	❑	❑	❑
Seizures	❑	❑	❑	High Blood Pressure	❑	❑	❑
Rheumatic Fever	❑	❑	❑	Emotional/Depression	❑	❑	❑
Infectious Diseases	❑	❑	❑	TB	❑	❑	❑

STDs: Gonorrhea ❑ Syphilis ❑ HIV/Aids ❑ HPV ❑ Herpes ❑

PLEASE LIST ANY MEDICATIONS/SUPPLEMENTS THAT YOU ARE TAKING (Continue on back if necessary):

Medicine	Dosage	Reason	How Long	Prescribed by	Date of last check-up

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Please indicate the use and frequency of the following:

	Yes	No	How Often		Yes	No	How Often
Coffee	❑	❑	_____	Tobacco	❑	❑	_____
Recreation Drugs	❑	❑	_____	Alcohol	❑	❑	_____
Soda Pop	❑	❑	_____	Water Intake	❑	❑	

For Women

Age of 1st period (menarche):	Are you pregnant?		# of pregnancies:
Age of last period (menopause):	# of live births:	# of abortions:	# of miscarriages:
Number of days between periods:	Date of last GYN exam:		Pap smear:
Number of days of flow:	Mammogram:		Bone density scan:
Color of flow:	Results:		
Clots?			

Average number of pads you use per day? 1st day____2nd day____3rd day____ 4th day____ +days____

Have you been diagnosed with: ❑ Fibroids ❑ Fibrocystic breasts ❑ Endometriosis ❑ Ovarian Cysts ❑ PID ❑ Other_____

Menstrual Pain and location:

Nature of pain:

☐ Cramping	☐ Aching	Hormonal Symptoms:	
☐ Burning	☐ Consistent	☐ Hot Flashes	☐ Weight Gain
☐ Dull	☐ Intermittent	☐ Irritability	☐ Bloating
☐ Bearing down sensation	☐ Stabbing		

For Men

☐ Prostate Issues	☐ Pelvic Pain
☐ Low Testosterone	☐ Testicular Pain
☐ Erectile Dysfunction	☐ Prostate Surgery
☐ Urinary Problems	☐ Vasectomy
☐ Hair Loss	☐ Hernia Repair
☐ Infertility	☐ Testicular Surgery

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General Symptoms

Digestive Symptoms

- ☐ Lack of appetite
- ☐ Excessive appetite
- ☐ Loose stool or diarrhea
- ☐ Digestive problems
- ☐ Indigestion
- ☐ Jaundice (yellowish eyes or skin)
- ☐ GB removal
- ☐ Vomiting
- ☐ Belching, burping
- ☐ Heartburn/reflux
- ☐ Feeling the retention of food in the stomach
- ☐ Nausea or vomiting
- ☐ Colitis or diverticulitis
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Blood in stool
- ☐ Black tarry stool
- ☐ Light-colored stool
- ☐ Loose stools or dumping syndrome
- ☐ _____

Urinary Symptoms

- ☐ Urinary problems
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Prostate Issues
- ☐ ED or Low T
- ☐ Decreased sex drive
- ☐ Increased or decreased libido
- ☐ Retention of urine
- ☐ Pain or coldness in the genital area
- ☐ Kidney stones

Hormonal & Endocrine Symptoms

- ☐ Type 2 Diabetes
- ☐ High cholesterol levels
- ☐ Fatty Liver Disease
- ☐ Difficulty digesting oily foods
- ☐ Gall stones
- ☐ Menopausal Symptoms
- ☐ Leaky Gut
- ☐ Autoimmune disease
- ☐ Food allergies or gluten sensitivity

Neurological & Mental Health Symptoms

- ☐ Insomnia, difficulty sleeping
- ☐ Nightmares
- ☐ Mentally restless
- ☐ Laughing for no apparent reason
- ☐ Easily angered or agitated
- ☐ Difficulty in making plans or decisions
- ☐ Dizziness
- ☐ Tendency to faint easily
- ☐ Shortness of breath
- ☐ Decreased sense of smell
- ☐ Feeling of claustrophobia
- ☐ Anxiety or nervousness
- ☐ Trauma
- ☐ Depression or sadness
- ☐ Stress
- ☐ Fatigue
- ☐ Spasms or twitching of muscles
- ☐ Childhood or Sexual abuse
- ☐ Headaches
- ☐ Difficulty in making plans or decisions

Cardiovascular Symptoms

- ☐ Heart palpitations
- ☐ Angina pains
- ☐ Chest pain
- ☐ Cold hands and feet
- ☐ Increased or decreased blood pressure

Skin & Appearance Symptoms

- ☐ Eczema
- ☐ Easily bruised
- ☐ Hair loss
- ☐ Skin Cancer

Musculoskeletal Symptoms

- ☐ Back pain
- ☐ Sciatic pain
- ☐ Knee problems
- ☐ Low back pain
- ☐ Muscle or joint pain

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Respiratory Symptoms	General & Miscellaneous Symptoms
☐ Cough	☐ Easily bruised
☐ Asthma	☐ Soft or brittle nails
☐ Hay fever	☐ Difficulty to stop bleeding
☐ Bronchitis	☐ Recent use of antibiotics
☐ Difficulty breathing	☐ Impotence
☐ Long COVID	☐ Cold hands and feet
	☐ Hearing impairment
	☐ Ear ringing

Lab results: You may include copies of lab results or authorize us to log into your medical records.

What are the main health problems for which you were seeking treatment (can add detail on the back):

What other forms of treatment have you sought?

List any other health problems you now have:

List any allergies, food sensitivities, or food cravings that you have:

List any accidents, surgeries, or hospitalizations, including dates:

I certify that my Personal Health History is complete and true to the best of my knowledge. I understand that my medical records are completely confidential, and my information is shredded after intake, locked at all times, and stored digitally in a manner compliant with personal health information guidelines under HIPAA. No personal information will be released to any other medical provider without my written permission.

Signature Date

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PVA Neuroplasticity Coaching Psychosocial and Bodywork History

Name: _____ Date: _____

Trauma and History

Do you know your ACE score? Yes / No / Unsure Score if known: _____

Please check any that apply to your history:

Physical trauma Emotional trauma Sexual trauma (CSA) Medical trauma (surgery, hospitalization, difficult birth, NICU) Concussion or TBI Memory loss or dissociative episodes

Please describe briefly if you are comfortable:

_____

Mental Health History

Have you seen a therapist or counselor? Yes / No

If yes, what type of therapy: _____

How long: _____ Are you currently seeing someone? Yes / No

Any psychiatric diagnosis: _____

Current psychiatric medications: _____

Any history of crisis, hospitalization, or self-harm: _____

Support and Context

Primary support system (who do you rely on):

_____

Do you feel safe at home? Yes / No / Prefer not to say

Faith or spiritual affiliation if any: _____

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Bodywork and Complementary Care History

Check all that apply and note whether it was helpful and whether you are currently seeing that provider:

- ☐ Acupuncture: Helpful? Y / N
- ☐ Craniosacral therapy: Helpful? Y / N
- ☐ Massage: Helpful? Y / N
- ☐ Physical therapy: Helpful? Y / N
- ☐ Chiropractic: Helpful? Y / N
- ☐ Naturopathic care: Helpful? Y / N
- ☐ Energy work (Reiki etc): Helpful? Y / N
- ☐ Somatic or trauma informed bodywork (SE, TRE, Feldenkrais etc): Helpful? Y / N
- ☐ Other: _____ Helpful? Y / N
- ☐

For Practitioners Only

Modality and years in practice: _____

Do you currently have your own therapist or supervisor? Yes / No

Have you received any body based or somatic work on yourself? Yes / No

If yes, what kind and when: _____

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PVA Neuroplasticity Coaching Financial Agreement

Neuroplasticity coaching is a private pay service. Coaching is not medical treatment and is not covered by health insurance. We do not submit insurance claims or provide superbills.

All sessions are time based. The clock begins at the start of the appointment and includes consultation, review, and coaching time.

HSA and FSA

Some clients may be able to use HSA or FSA funds for coaching. This depends entirely on your individual plan. Please check with your plan administrator before assuming this applies. We make no guarantee that your plan will approve it.

Rates

Initial Consultation (75 minutes): $250. Includes up medical record review, training, exercise plan, nutritional assessment, and OTC supplement recommendations. Additional record review beyond 15 minutes is billed at $50 per 15 minutes. A written summary and personalized plan are available for an additional fee of $50 per 15 minutes.

Mommy and Me Sessions (90 minutes): $250 to $300. Available for established clients only. In person only for California residents. Remote sessions available via Zoom or FaceTime for clients outside California.

Cancellation Policy

Appointments cancelled with less than 24 hours notice will be charged the full session fee. Exceptions are at the sole discretion of Dr. Moffitt. Remote clients may need to reserve their first session with a major credit card or Venmo.

By signing below, I acknowledge and accept the terms of this agreement.

Client Name (Print): _____

Signature: _____

Date: _____

Email Address: _____

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Informed Consent Agreement for Coaching Services with Jennifer Moffitt

> Welcome. This agreement is here to make sure you feel fully informed about what coaching with me involves, what it is, and what it is not. Please read it carefully. I am happy to answer any questions before you sign.

> **IMPORTANT NOTICE**
> This is an agreement for coaching services only. Coaching is not therapy, counseling, or medical treatment, and it is not a substitute for professional clinical care. Signing this agreement does not create a clinical, therapeutic, or medical provider-client relationship of any kind.

1. About These Services

Neuroplasticity and neurosomatic coaching at Polyvagal Acupuncture® focuses on personal growth, lifestyle habits, wellness education, and goal achievement through conversation, guided exercises, nutrition, mindfulness and educational information.

The terms neurosomatic and neuroplasticity as used here refer to educational models and self-awareness tools. They do not constitute neurological, somatic, psychological, or medical treatment of any kind.

2. What Coaching Includes and Does Not Include

Coaching includes:

- Goal setting, values clarification, and accountability support
- Mindset, belief, and habit exploration
- Somatic awareness exercises as educational self-regulation tools
- Neuroplasticity-informed learning and habit formation strategies
- General wellness and lifestyle guidance including movement, sleep, and nutrition
- Life and values-based coaching conversations

Coaching does not include:

- Diagnosis or treatment of any medical or mental health condition
- Psychotherapy, counseling, or any clinical intervention
- Prescription or recommendation of medications
- Crisis intervention or emergency mental health support

> *If you are ever in a mental health crisis, please contact the 988 Suicide and Crisis Lifeline by calling or texting 988, call 911, or go to your nearest emergency room. Coaching is not an emergency resource.*

3. Coaching is Not Medical Treatment

Any wellness and lifestyle information shared in sessions, including general information about nutrition, movement, sleep, and supplements, is educational in nature. It is not medical advice and is not intended to address, treat, or influence any diagnosed medical condition.

You are responsible for your own decisions and actions. I am a thinking partner, not a decision-maker for your health or your life. If your medical or mental health situation changes in a way that requires professional clinical support, please let me know and seek appropriate care.

4. Scope, Licensing, and the Right to Decline

Because I am a licensed medical professional in my state, I hold a clear and firm boundary between coaching services and any form of telehealth or clinical care. These are entirely separate. Remote coaching across state lines does not constitute telehealth and I do not provide clinical services through this coaching relationship under any circumstances.

If during or after our consultation I determine that the level of support you need is beyond what I can legally provide as a remote coach, or that the severity of your situation is beyond the scope of remote coaching, I reserve the right to decline or discontinue and will make suggestions as to what might be helpful.

5. Your Medical Care

If you currently work with a medical or mental health provider, we encourage you to tell them you are also working with a coach. You do not have to. Because this is a coaching relationship and not medical care, I do not write medical letters, clinical summaries, or provider correspondence of any kind apart from the written summaries I provide after sessions.

6. Remote Services and Jurisdiction

Coaching sessions are conducted remotely by video or phone. This agreement is governed by the laws of [Your State]. Coaching is not a licensed profession, and there is no state licensing body that governs it. You are responsible for understanding whether receiving remote coaching services is subject to any regulation in your state.

- Sessions are conducted via [platform, e.g., Zoom, Google Meet]
- You are responsible for ensuring your own secure and private connection during sessions

7. Privacy and Confidentiality

Your personal information and session content are kept confidential and are not shared with third parties without your written consent. All client communications are conducted through encrypted channel. Although this is a coaching relationship, I hold a medical license in my state and remain bound by HIPAA obligations in that capacity.

Exceptions where disclosure may be required:

- You express intent to harm yourself or another person
- A valid court order or subpoena is received

I do not record sessions. You may not record sessions either, by any means including phone, video, or any other device. This is a condition of our coaching relationship.

7. Fees and Cancellations

I ask for 24 hours notice if you need to cancel or reschedule. Same day cancellations are charged the full session fee. Exceptions are at my sole discretion. I trust my clients and this policy exists only for the rare situation where it is needed.

8. Insurance, HSA, and FSA

Coaching services are not covered by health insurance. I do not submit insurance claims, provide superbills, or issue receipts formatted for insurance reimbursement.

Some clients may be able to use Health Savings Account (HSA) or Flexible Spending Account (FSA) funds for coaching. Whether this is permitted depends entirely on your individual plan. Please check

with your plan
administrator before assuming this applies. I make no guarantee that your plan will approve it.

9. Wellness Products

I may share general educational information about wellness products during sessions, including vitamins, supplements, and related items such as liposomal formulations and foundational nutritional support. All such information is educational and is not intended as medical advice or as a recommendation directed at any diagnosed condition. All products I may mention are available over the counter without a prescription.

> Transparency notice: Some products I mention may be available through my storefront at a discounted price, and I receive some compensation from purchases made there. You are never required to purchase through my storefront and are always free to source any product wherever you choose, including Amazon or your local health food store.

10. Complementary Modalities

As part of our work together I may suggest types of bodywork or complementary modalities that could support your goals, such as craniosacral therapy, chiropractic care, or similar approaches. These are general suggestions only, not endorsements of any specific provider or practice. I do not make formal referrals, but I can help you find the right licensed professional for your needs.

Any decision to explore these modalities is entirely yours, and all work with other practitioners is separate from and independent of our coaching relationship.

12. Your Rights

You have the right to:

- Ask questions about the coaching process at any time
- Decline any exercise or conversation topic
- End the coaching relationship at any time.
- Receive a copy of this agreement

13. Voluntary Participation

You enter this agreement freely and without pressure. Coaching is entirely voluntary and you may discontinue at any time.

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14. Limitation of Liability

Neuroplasticity and neurosomatic coaching are educational, and designed to support positive habit formation, mindset shifts, and cognitive routines. No guarantees of any kind are made regarding outcomes. The Client takes full responsibility for their own progress and results.

15. Your Acknowledgment

By signing below you confirm that you:

- Have read and understood this entire agreement
- Understand that coaching is not therapy, counseling, or medical treatment
- Understand that wellness and supplement information shared in sessions is educational and not directed at any diagnosed condition
- Are not using coaching as a substitute for mental health or medical treatment
- Voluntarily agree to the terms of this coaching relationship

Client

Full Name (Print)	*Date*
Signature	*Date*

Email Address: _____

Coach

Signature Dr. Jennifer Moffitt, CPRCS	*Date*

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