AcuBalance
Acupuncture & Integrative Medicine

Dr. Colby & Andrea Helton
502.742.8613
306 Middletown Park Pl, Ste C
Louisville, KY 40243
info@acubalanceky.com
www.acubalanceky.com

Name:_____ DOB:_____ Age:_____ Sex/Gender/Pronouns_____

Ht: _____ Wt: _____ Occupation: _____ Marital Status:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Who may we thank for the referral? _____Have you received acupuncture? Y N

What are the main health issues that bring you here? _____

Medical History

Mark the box if any of the following are true <u>today</u>:

☐ Concussion or loss of consciousness ☐ Current/possible fracture ☐ Recent stroke

☐ Severe acute pain _____ ☐ Drastic weight change ☐ Current/possible infection

☐ Acute respiratory distress ☐ Psychiatric _____ ☐ Cancer (type): _____

☐ Heart Condition _____ ☐ Diabetes (Type 1) (Type 2) ☐ Seizures or Epilepsy

Do you have a pacemaker? Y N

Is there any possibility you could be pregnant? _____

Please indicate any diagnoses given by a qualified physician _____

Allergies (seasonal, food, medicine etc)? _____

History of serious illness, injuries, surgeries etc _____

Current medicines and supplements _____

_____

General Health

Please indicate below any symptoms, concerns, or issues you have with the following areas.

Ear/Eyes/Nose/Throat: _____

Respiratory/Immunity/Allergy: _____

Appetite & Thirst: _____

Digestion & Bowels: _____

Urination: _____

OB/GYN: _____

Date of Last Menstrual Period: _____

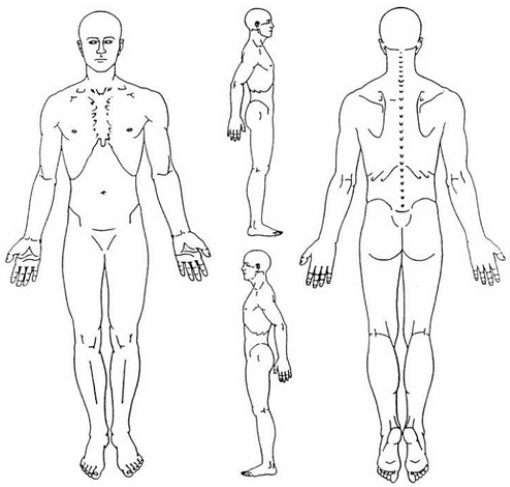
Sleep & Energy: _____

Emotions & Stress: _____

PAIN (Please use the body diagram →)

☐Headache ☐Pain ☐Injury

☐Arthritis ☐Stiffness ☐Numbness/Tingling



Informed Consent for Acupuncture Treatment

You have the right as a patient to be informed about your condition and any treatment you may receive that's within the scope of practice of the AcuBalance Practitioners, including the risks and benefits of treatments. This is so you may make an informed decision regarding your consent to receive or withhold treatment.

I hereby consent that the *AcuBalance Practitioners* may provide acupuncture, herbal medicine, and any other treatments within their scope of practice. I have had the opportunity to discuss my diagnosis, the nature, and purpose of acupuncture and other procedures and alternatives.

Complications from **acupuncture & auxillary treatments** are very rare, but risks may include:

- Minor pain with needle insertion and manipulation, with or without electrical stimulation
- Minor bleeding or bruising after needle withdrawal, cupping, or gua sha treatment
- Minor burns after moxibustion treatment
- Lightheadedness, dizziness, fainting after needle insertion

Complications from **herbal medicine** are very rare, but risks may include:

- Indigestion or other digestive discomfort
- Allergic reactions
  - I have disclosed any known allergens to the *AcuBalance Practitioners* x_____
- Herb-Drug Interactions
  - I have disclosed all medications (prescribed and over-the-counter), supplements, herbs, and vitamins I am taking to the *AcuBalance Practitioners* x_____

I understand that the *AcuBalance Practitioners* will take the appropriate steps to control the above risks, or will contact emergency medical authorities in the case of an emergency. I do not expect the *AcuBalance Practitioners* to be able to anticipate all risks and complications. I consent that they may exercise their medical judgment during the course of my treatment, and trust that their judgment is in my best interest.

I also recognize that the *AcuBalance Practitioners* are not prescribing me herbal medicine, but rather offering recommendations based on their clinical impressions. I recognize that the *AcuBalance Practitioners* are recommending herbs to maximize my health and are not claiming to cure any disease or imbalance. I also recognize that I need to disclose the use of recommended herbs to other physicians whose care I am under. I also recognize that the *AcuBalance Practitioners* are not claiming that herbal medicine can be a replacement for any of my prescribed medications and that any changes to my medications need to be discussed with my physician.

I understand that herbs need to be prepared, consumed and/or applied according to instructions provide by the *AcuBalance Practitioners*. I understand that if my condition were to change, I should stop taking the recommended herbs and contact the *AcuBalance Practitioners* to schedule another appointment for consultation and reassessment. I will immediately notify a member of the clinic staff of any unanticipated or unpleasant effects associated with the consumption of herbs.

MEDICAL REFERRALS: I understand I may be referred to a medical provider in the case of a medical condition that is outside the scope of practice of the acupuncture providers. In such circumstances, they will arrange a consultation, emergency transfer, and/or a referral to appropriate healthcare facilities or to an appropriate health-care practitioner. The acupuncture providers will provide me with a written notification form that I have received the referral information, that they will be contacting the referred medical provider, and that I will take the appropriate steps to contact the referred medical provider for a consultation.

I have read, or have had read to me, the above consent. I have had the opportunity to ask any and all my questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to receive treatment from the acupuncture providers. 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.

To be completed by the patient and/or patient's legal representative:

_____	_____	_____
Patient or Representative Signature	Print Patient Name	Date