AcuBalance
Acupuncture & Integrative Medicine

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

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

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency Contact/Relation: _____ Phone: _____

Primary Care Physician (Name, 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 today:

☐ Concussion or loss of consciousness	☐ Current/possible fracture	☐ Recent stroke
☐ Severe acute pain _____	☐ Drastic weight change	☐ Current/possible infection
☐ Acute respiratory distress	☐ Current/possible pregnancy	☐ Psychiatric _____
☐ Cancer (type): _____	☐ Heart Condition _____	☐ Pacemaker
☐ Diabetes (Type 1) (Type 2)	☐ Seizures or Epilepsy	☐ Using Wafarin or similar drug

Do any of the above conditions run in your family? _____

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 _____

Dietary Habits (inc cigarettes, caffeine, alcohol, tobacco, sugar, salt, soda/pop etc.)_____

_____

How do you FEEL about the following areas in your life

Self _____	Family _____	Partner _____
Sex _____	Social Life _____	Work _____
Diet _____	Exercise _____	Spirituality _____

Please check the box if you currently have, or have a significant history of, any of the following conditions or symptoms:

General

☐Easily Stressed ☐Insomnia O Falling asleep O Staying asleep ☐Fatigue ☐Poor Immunity

☐Weight Change _____ ☐Changes in Appetite ☐Cravings _____ ☐Dizziness

☐Fever/Chills ☐Abnormal Sweat (night or spontaneous • whole body or O Simultaneous O Alternating O Whole Body O Specific Body part _____ ☐Cold Hands & Feet

Other_____

What is your predominate emotion when stressed (i.e. anxiety, irritability, depression) _____

Any Additional Remarks:_____

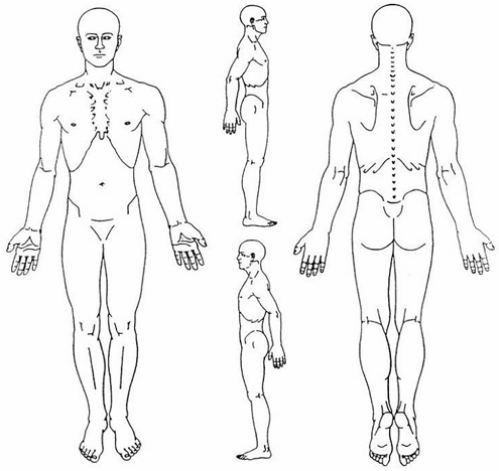
_____

Musculoskeletal

☐Headache ☐Pain ☐Injury

☐Arthritis ☐Stiffness ☐Numbness/Tingling

Please indicate on the diagram the locations, severity (1-10), and quality of pain you are experiencing (i.e. dull, achy, sharp, stabling, throbbing, burning, electric)



_____

_____

_____

_____

_____

_____

Skin, Hair, EENT

☐Acne/Pimples ☐Hair Loss/Gray ☐Change in hair, skin texture _____

☐Tumors or Lumps _____ ☐TMJ/Teeth Grinding ☐Toothache

☐Eye Strain/Pain ☐Red Eyes ☐Cataracts ☐Glaucoma ☐Dry Mouth/Throat

☐Ringing in Ears (Tinnitus) ☐Hearing Loss ☐Earaches ☐Sinusitis

☐Nosebleed ☐Runny Nose ☐Loss of Smell/Bad Smell_____

Additional Remarks _____

_____

Respiratory:

☐Asthma ☐Shortness of Breath ☐Cough ☐Cough Blood

If asthma or SOB, is inhaling or exhaling harder? _____

☐Bronchitis ☐Emphysema ☐Pneumonia ☐COPD

☐Tuberculosis Other: _____

Production of phlegm: Amt./Freq.: _____ Color: _____ Consistency: _____

Additional Remarks _____

_____

Cardiovascular & Blood:

☐High Blood Pressure ☐Low Blood Pressure ☐Chest Pain ☐Angina

☐Irregular Heart Beat ☐Palpitations ☐Swelling/Edema ☐Heart Attack

Type _____ Where_____

☐Heart Disease _____ ☐Anemia type _____ ☐Clotting Disorder

☐Bleeding Disorder ☐Bruise Easily

Type _____

Additional Remarks _____

_____

Digestive:

☐Nausea/Sensitivity ☐Indigestion/Heart Burn ☐Belching ☐Vomiting
☐Bad breath/taste ☐Bloating/Distension ☐Stomach Pain ☐Acid Reflux/GERD
☐Ulcer _____ ☐Constipation ☐Diarrhea ☐Jaundice
☐Irritable Bowel ☐Food Allergies _____ ☐Other _____
Bowel (Freq, Color, Odor, Pus/Blood, Pain) _____
Additional Remarks _____
_____

Neurological/Hormonal/Emotional:

☐Fainting ☐Tremors ☐Stroke/TIA ☐Poor Coordination
☐Parkinson's ☐Alzheimer's ☐Seizures ☐Addiction
☐Anxiety/Depression ☐Mood Swings ☐Poor Memory ☐Diabetes
☐Thyroid _____ ☐Hypoglycemia ☐Hot Flashes
Do you get Migraines or chronic headaches? Please Elaborate _____
In general, do you run hot or cold? _____
Additional Remarks _____
_____
_____

Uro-Genital:

☐Painful Urination ☐Urinary Urgency ☐Urinary Incontinence
☐UTI ☐Bladder Infection ☐Kidney Infection
☐Prostate Issue _____ ☐Erectile Dysfunction ☐Libido Change
☐Other: Urine: Frequency _____ Color: _____ Odor:_____
Additional Remarks _____
_____

OB/GYN:

Age of First Period _____ Cycle (How Often & Duration) _____ Menopause _____
Relevant Pregnancy & Birth History: _____
Last Menses _____ Last PAP (date/result) _____ Last Mammogram_____
Changes Prior to Menstruation (PMS): _____
Period Flow (Color, Consistency, Quantity, Pain) _____
_____
Birth Control (Type/Duration) _____
☐ Irregular Periods ☐ Painful Periods ☐ Vaginal Discharge ☐ Clots
☐ Breast Lump ☐ Ovarian Cyst/PCOS ☐ Uterine Fibroids Other _____

Anything else you'd like us to know about you? _____
_____
_____
_____
_____
_____

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