ACUPUNCTURE/DRY-NEEDLING

NATUROPATHIC MEDICINE

New Patient Intake

Name (last, first, m) _____Nickname_____
Date of Birth_____ Age _____
Address_____
City_____ State_____ Zip Code_____
Cell Phone_____ Confidential Voicemail? ☐ Yes ☐ No
Work Phone_____ Cell-Phone Network Provider_____
Email_____
Appointment Reminder: ☐ Text ☐ Email

What is your birth sex: ☐ Male ☐ Female ☐ Unknown ☐ Others_____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced
Occupation_____ Employer _____
Emergency Contact_____ Relationship _____
Phone_____
Do you authorize Balance Naturopathic & Acupuncture to release information to this person?
____Yes _____No (If no, we cannot disclose any information)

I certify the above information is true and correct to the best of my knowledge. I acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I am subject to all terms on the financial consent form.

Patient/Guardian Signature_____ Date_____

Current Health Concern

What is the main reason or goal for your visit today? _____

Date of last physical exam _____

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc...)

Doctor's Name: _____Specialty: _____

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Allergies: Do you have a severe allergy to any of the following?

☐ Sulfa ☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Latex ☐ Sulfites ☐ Cats

☐ Dogs ☐ Mold ☐ Dust ☐ Bees ☐ Pollen ☐ Wheat ☐ Shellfish

☐ Peanuts ☐ Eggs ☐ Milk ☐ Soy Others: _____

Medical Conditions: Do you currently have or have a history of the following? Check all that apply

Adrenal Disorder	Anemia	Anxiety	Arthritis/Joint Disorder
Asthma	Cancer	COPD	Depression
Diabetes Mellitus	Digestive Problem	Heart Disease	Hyperlipidemia
Hypertension	Inflammatory Bowel Disease		Irritable Bowel Syndrome
Kidney Disease	Liver Disease	Stroke	Thyroid Disease

Other: _____

Social History:

Tobacco Use: ☐ Never Smoker ☐ Former Smoker ☐ Passive Smoke Exposure (Second Hand)
☐ Current Smoker

Type of tobacco used:

☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Vape Other: _____

Start Date: _____ End Date: _____
Packs/Day: _____ Years: _____

If you are a current tobacco user: Are you ready to quit? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No
Drinks/Week: Glasses of Wine_____ Cans of Beer_____ Shots of Liquor _____

Medications: What medications/supplements are you currently taking? List for what conditions, dosage and frequency

Medications/Supplements	Dose	Frequency	Conditions

Family History: Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had the following conditions.

Relative	Living? If no, cause of death and age	Diabetes Mellitus	Hypertension	Cancer	Thyroid disorders	Other
Mother						
Father						
Brother						
Sister						
Maternal GFather						
Maternal GMother						
Paternal GFather						
Paternal GMother						

Review of System: Please circle if you experience any of the following in the last 6 months

Constitutional

Fatigue	Fever	Undesired weight gain
General weakness	Chills	Undesired weight loss
Catches cold easily	Night sweats	Poor Appetite
Cold hands or feet	Sweat easily	
Slow wound healing	Feeling hot/flushed	

Eyes

Changes in vision	Watery, red, itchy eyes	Glaucoma
Eye pain	Dry eyes	Cataracts
Double vision	Poor night vision	Floaters

Ears

Changes in hearing	Ear discharge	Ringing in the ear
Ear pain	Ear infection	

Nose

Nose bleeds	Congestion	Decrease sense of smell
Nasal discharge	Nasal Polyps	

Mouth/Throat

Sore throat	Hoarseness	Bleeding gum
Ulcer of mouth or lips	Lump in throat	Difficulty swallowing
Swollen glands	Excessive mucus production	

Cardiovascular

Chest pain/tightness	Irregular heartbeat	Leg swelling
Blood clots	Varicose/spider vein	

Respiratory

Snoring	Cough	Wheezing
Shortness of breath		

Musculoskeletal

Painful joints	Joints swelling	Muscle cramp/spasm
Muscle pain	Muscle weakness	

Neurological

Headache	Numbness/tingling	Tremors
Dizziness	Fainting	Seizures
Difficulty concentrating	Speech difficulty	Facial asymmetry
Poor memory	Loss of balance	

Endocrine

Cold intolerance/sensitivity	Excessive thirst	Large volume/amount of urine
Heat intolerance/sensitivity	Excessive hunger	

Gastrointestinal

Abdominal pain	Nausea	Constipation
Gas/bloating	Vomiting	Diarrhea
Acid Reflux	Belching/hiccups	Blood in stool
Poor digestion	Ulcers	Loss of bowel control

Genitourinary

Difficulty/painful urination	Urinary retention	Pain in your side
Increase/urgency in urination	Nighttime urination	Pain with sex
Blood in urine	Dribbling urination	Pelvic pain
Urine incontinence/leakage	Bedwetting	Genital sores

Psychiatric

Depression, sadness	Stress	Hallucinations
Anxiety/panic attacks	Fear	Hyperactivity
Irritability/anger	OCD	Suicidal ideation
Post-partum	Apathy, lack of interest	

Woman's Health

Painful menses	Vaginal sores	Endometriosis
Pain between menses	Vaginal dryness	PCOS
Irregular menses	Facial hair growth	Ovarian cysts
Nipple discharge	Breast lump	Uterine fibroids
Low libido	Painful, swollen, or fibrocystic breast	Infertility

Date of last period_____ Normal? ☐ Yes☐ No

Date of last mammogram_____ Date of last pap smear_____

Are you now or could you be pregnant? ☐ Yes ☐ No

Men's Health

Pain or difficulty obtaining or maintaining erection	Pain or difficulty with ejaculation	Prostate disease
Pain or mass in testicle	Premature ejaculation	Low libido

Sleep

Trouble falling asleep	Nightmares	Typical bedtime: _____
Trouble staying asleep	Sleep talking/walking	Typical wake time: _____
Excessive dreaming	Tired upon waking	Hours/night: _____

Additional Information

_____

_____

_____

_____

Informed Consent

I hereby consent Dr. Meng Xiong, ND, LAc at Balance Naturopathic & Acupuncture Clinic to provide me with recommendations for my health conditions. I understand that these recommendations may include, but not limited to diet and lifestyle, clinical nutrition, supplements, physical medicine, mind-body medicine, homeopathic, and botanical medicine.

Clinical Nutrition and Supplements: Food is the best medicine, and it is the foundation of Naturopathic practice. NDs use the following, but not limited to, nutrition and supplements to treat many medical conditions with fewer complications and side effects.

Mind-Body Medicine: Emotional states and mental attitudes can influence or even cause physical illness. Mind-body medicine focuses on nutrition, counseling, stress management, and other therapies to address mental well-being and help patients heal psychologically.

Physical Medicine: An integral modality in naturopathic medicine that focuses on treating disorders of somatic tissues using, but not limited to, manual therapy, physiotherapy, and hydrotherapy.

Botanical Medicine (Herbal Medicine): The use of plants or plant extracts to treat illnesses internally or topically. When administered properly, botanical medicine can address a variety of health conditions effectively with minimal side effects.

Homeopathy: Homeopathy is treating disease or symptoms using the principle of "like cures like." Homeopathy remedies, derived from natural substances (plants, animals, minerals, etc), are low dose and stimulate the body's innate healing ability

Hydrotherapy: The use of water to promote healing and maintain health. Warm/hot water expands blood vessels and increases blood flow, while cold water contracts blood vessels to contract and decrease blood flow. The use of hot and cold water changes the temperature in an area and accelerates blood flow. The increase in blood flow brings in immune cells that are beneficial for healing. Hydrotherapy techniques include hot and cold compresses, steam bath, hyperthermia/peat bath, foot soak, and more.

I understand that the recommendations provided to me are not medical advice and are not the standard of care for my conditions and I do not have to follow the recommendations provided to me by Dr. Meng Xiong. I understand that it is recommended to have a licensed medical practitioner as part of my team care to evaluate any signs or symptoms. If an emergency arises, I will seek emergency services.

I understand that while Naturopathic Medicine is accepted as primary care medicine in many states, the State of North Carolina does not regulate Naturopathic Medicine and that Dr. Meng Xiong, ND, LAc, is not a licensed practitioner in the state of North Carolina. However, he is a licensed Naturopathic Physician and Acupuncturist in Washington state and has met all of the requirements as a Primary Care Physician.

By voluntarily signing below, I show that I have carefully read, or have had read to me, the above informed consent. I understand the risks and benefits of the recommendations given to me by Dr. Meng Xiong. I understand that I may ask questions regarding my recommendations before signing this form and that I am free to withdraw my consent to the above recommendations, realizing no guarantees have been given to me by Balance Naturopathic & Acupuncture regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. I hereby acknowledge that I am financially responsible for services rendered and consent to recommendation for my present condition and for any future condition(s) for which I seek recommendations.

Patient/Guardian Signature: _____ Date: _____

Notice of Privacy Policy

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a written Notice of Privacy Policy.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following describes how information about you may be used in this office:

- **Treatment Services:** We may use or disclose your health information to all of our staff members, your physicians, and/or other health care providers taking care of you.
- **Payment and Health Care Operations:** We may use or disclose your health information to obtain payment for services we provide to you, to participate in quality assurance, disease management, training, licensing, and certification programs. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, text messages, emails, postcards, or letters.
- **Legal Requirements:** We may use or disclose your health information when required to do so by law.
- **Abuse or Neglect:** If abuse or neglect is reasonably suspected, we may use or disclose your health information to the appropriate governmental authorities.
- **National Security:** When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal offices when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may be provided to correctional institutes.
- **Family Members, Friends, and Others Involved in Care:** At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services.
- **Public Health Activities:** We may use or disclose your health information for public health activities, to include the following: to prevent or control disease, injury, or disability; to report reactions with medications or problems with products, to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease of condition; to notify the proper government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (when required by law).
- **Other Authorizations:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
- **Breach Notification:** We will notify you any time your PHI may have been compromised through unauthorized acquisition, use or disclosure.

Patient/Guardian Signature: _____ Date: _____