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

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Acupuncture Informed Consent

I hereby consent to be treated with East Asian Medicine by a licensed acupuncturist at Balance Naturopathic & Acupuncture Clinic. I understand treatment may include, but not limited to, Acupuncture, Electro-Acupuncture, Chinese Herbal Medicine, Cupping, Tui Na, Gua Sha, Moxibustion, and Nutritional counseling.

Acupuncture: I have been informed that acupuncture is a generally safe method of treatment. I understand that acupuncture is performed by the insertion of sterile needles through the skin. I am aware it may have some side effects, including bruising, minor bleeding, minor pain or discomfort, dizziness or fainting, or numbness and tingling near the needling sites that may last a few days. Acupuncture is used to treat the underlying cause of the body's dysfunction or illness, to treat pain, and to treat the body's physiological functions. Acupuncture works with different systems of the body (e.g., nervous, musculoskeletal, cardiovascular, immune, gastrointestinal, etc.) to provide optimal function.

Moxibustion: The application of heat to the skin at certain points or area on the body.

- **Indirect Moxibustion:** the application of heat near the skin
- **Direct Moxibustion:** The application of heat directly to the skin. I am aware this is not intended to be a painful experience. I understand that if I receive direct moxibustion as part of therapy, there is risk of mild burning or scarring from its use.

Cupping: I understand that cupping is used to treat muscle pain. It is used to increase circulation and break up adhesion in muscle. I understand that cupping can cause bruising and mild bleeding.

Chinese Herbs/Nutrition: I understand that Chinese herbs may be recommended to me as part of the treatment. I understand that I am not required to take these substances. However, if I choose to take them, I understand that herbs prescribed need to be taken as recommended by my acupuncturist. I am aware that certain adverse side effects may result from taking these herbs and I will notify my acupuncturist of any unanticipated or unpleasant effects. These side effects may include, but not limited to: nausea, vomiting, abdominal pain or discomfort, headache, change in bowel movement, rashes, hives, tingling of the tongue, and possible aggravation of symptoms. I understand that some herbs and supplement are inappropriate for pregnancy and I will promptly notify my acupuncturist if I am pregnant.

Tui-Na/Acupressure: I understand I may also be given Tui-Na, which is a type of massage or acupressure as part of the treatment. I am aware that certain adverse side effects may result from this treatment: These include, but not limited to bruising, sore muscles or aches, and possible aggravation of symptoms.

Electro-Acupuncture: I understand that I may be asked to be treated with electro-acupuncture using a transcutaneous electrical nerve stimulations (TENs) machine that would be attached to the needles. Even though this method is generally painless, I am aware that certain adverse side effects may result. These may include, but not limited to pain or discomfort, electrical shock, and possible aggravation of symptoms.

By voluntarily signing below, I show that I have carefully read, or have had read to me, the above consent to treatment. I have been told abouts the risks and benefits of East Asian Medicine and understand all of the above information. I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent to the above procedures, 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 treatment for my present condition and for any future condition(s) for which I seek treatment.

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: ____________________