AcuBalance Wellness Center, LLC

ALL INFORMATION IS CONFIDENTIAL and is used in determining the best treatment plan for you. If you have any questions, please ask.

PATIENT INFORMATION

Name: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail: _____

q Single q Married q Divorced q Separated
qWidowed qPartnered

Occupation: _____ Date of Birth: _____

Height: _____ Weight: _____ Age: _____

Emergency Contact: _____

Home Phone: _____ Other Phone: _____

Relationship to You: _____

How did you hear of us? (please check all that apply)

___ Walking By ___ Referred By: _____
___ Newspaper ___ Local Presentation at: _____
___ Internet ___ Saw Flyer at: _____
___ Phonebook ___ Local Event: _____

Have you received acupuncture before? Yes _____ No _____

If yes, with whom? _____

For what condition? _____

What are your most important health concerns? Please list in order of importance:

1.		Date of Onset?	
2.		Date of Onset?	
3.		Date of Onset?	
4.		Date of Onset?	
5.		Date of Onset?	

What are your health goals? _____

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SYMPTOM SURVEY

Please review the following symptoms and mark an X in the appropriate column.

	Past	Present		Past	Present
cough			shortness of breath		
spontaneous sweating			catch colds easily		
nasal congestion/runny nose			allergies		
post-nasal drip			eczema or psoriasis		
enlarged lymph glands			acne or boils		
sinus congestion or infection			ringworm or fungus		
skin rashes or hives			dry nose, throat or skin		
asthma or wheezing			decreased sense of smell		
bleeding gums			hoarse or sore throat or voice		
low appetite			constipation		
loose stool or diarrhea			hemorrhoids		
acid reflux/heartburn			feelings of claustrophobia		
blood in the stool			excessive appetite		
fatigue after eating			gas or bloating after food		
obsession in work or relations			nausea or vomiting		
insomnia			palpitations		
tongue or mouth sores			anxiety		
sadness			vivid dreams or nightmares		
mental restlessness			excessive sweating		
chest pain			laughing for no reason		
irritability			hearing impairment		
bitter taste in the mouth			difficulty digesting oily foods		
muscle spasms or twitching			difficulty making decisions		
neck/shoulder tension			ringing in the ears		
low back pain			decreased sex drive		
sore, cold or weak knees			frequent urination		
hair loss			cold hands and feet		
urinary incontinence or urgency			body feels heavy		
dizziness/fainting			poor concentration		
floaters in field of vision			sticky taste/feeling in mouth		
hot hands and feet			foggy headed		
afternoon fevers			night sweats		
flushed cheeks			edema or ankle swelling		
headaches			cloudy urine		
heat or cold intolerance			bruise easily		
excessive thirst			muscle weakness		
change in weight			numbness/tingling		
nose bleeds			pain on urination		
ear aches or infections			athlete's foot		

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HEALTH HISTORY

Primary Physician: _____

Physician's Phone: _____ Date of last physical exam: _____

Please list any hospitalization and/or surgeries

Hospitalization / Surgery	Date	Reason

Please list any accidents and/or injuries:

Accident / Injury	Date	Relation to Health

Please list all prescription and over-the-counter medications you are currently taking:

Name	Dosage	Reason for Taking	Taking Since

About how many courses of antibiotics have you taken over the past 10 years? _____

List any allergies or food sensitivities: _____

_____

Please list all vitamins, minerals & supplements you are currently taking (include energy drinks, etc):

Name	Dosage	Reason for Taking	Taking Since

Do you have a pacemaker? Yes _____ No _____

Are there any issues of physical / sexual / emotional abuse
that you would like to discuss? Yes _____ No _____

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HEALTH HISTORY (continued)

Please indicate if you are taking any of the following:

q blood thinners (e.g. warfarin, Coumadin)
q pain relievers (e.g. Tylenol, aspirin.)
q sleeping aids
q thyroid medication
q laxatives
q lithium
q other tranquilizers/sedatives
q diet pills (e.g. diuretics, appetite suppressants)
q cortisone or other steroids
q antacids (e.g. Tums, Prevacid)

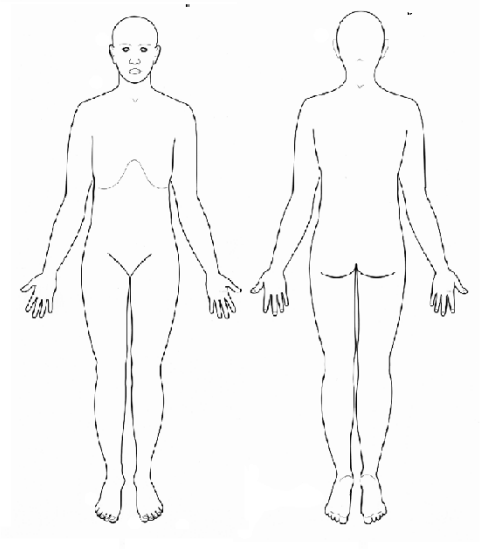
Do you have a bowel movement every day? Yes No _____

Number of bowel movements per day? _____

Are your bowel movements (check all that apply):

qWell formed
qSoft
qRibbon-like
qLoose
qContaining undigested food
qContaining blood
qBad smelling
qBurning
qBurning/heaviness in rectum
qIncomplete
qHard to clean up after
qA struggle

Using the appropriate letters, note any areas of pain on the diagram:



D = Dull
S = Sharp
N = Numbness
T = Tingling
B = Burning
R = Radiating
A = Ache
X = other: _____

FAMILY HISTORY

Please indicate any significant illness you or a blood relative (grandparent, parent, sibling) have had:
_____ I am adopted

	You	Which Relative?		You	Which Relative?
Cancer			Diabetes		
Emotional Disorders			Heart Disease		
High Blood Pressure			Seizures		
Rheumatic Fever			Hepatitis		
Arthritis			Tuberculosis		

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LIFESTYLE HISTORY

Please indicate the use and frequency of the following:

	Now	Past	How Much		Now	Past	How Much
Water				Recreational Drugs			
Soda Pop				Alcohol			
Coffee/Black Tea				Tobacco			

Do you exercise? _____ How many times a week? _____

What type of exercise? _____

Please describe your typical diet:

Breakfast:	
Lunch:	
Dinner:	
Snacks:	

meals per day: _____ Do you eat at regular times each day? _____

snacks per day: _____ How often do you eat out (or order in)? _____

I eat the following diet (please circle) vegetarian vegan kosher

Are there other restrictions to your diet? _____

What is your average stress level (*1 is lowest, 10 is highest*)? _____

What is your average energy level (*1 is lowest, 10 is highest*)? _____

At what time of day is your energy typically at its best? _____ At its worst? _____

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad
Significant Other	q	q	q	q	q
Family Relations	q	q	q	q	q
Friendships	q	q	q	q	q
Self Image	q	q	q	q	q
Sex	q	q	q	q	q
Work	q	q	q	q	q
Exercise	q	q	q	q	q
Spirituality	q	q	q	q	q

How much change are you willing to/able to make at this time to improve your health? (Please circle)

Minimal Some Complete

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FOR WOMEN

Date of last OB/GYN exam:: _____ Are you pregnant now? Yes No

Age of first period: _____ Age of last period (post menopause): _____

Number of days between periods: _____ Number of days of bleeding: _____

The bleeding is: qHeavy qModerate qLight qSpotting Only

Menstrual Blood Color (check all that apply): q Pale Pink / Red qRed q Bright Red
q Dark Red q Dark Red / Brown q Black q Dark Purple

Number of pads/tampons used: ___ day 1 ___ day 2 ___ day 3 ___ day 4 ___ day 5 ___ day 6+

How often do you change your pad/tampon? q Every hour or less q Every 2 hours
q Every 4 hours q I don't really need to change it, but I do for hygiene
Other:_____

On your heaviest day, which do you use? q Regular qSuper q Super Plus

Do you bleed between periods? Yes No

If yes, bleeding is: q Heavy q Moderate q Light q Spotting Only

Periods are painful: q Before Period q During Period q After Period q N/A

Pain severity: q Mild q Moderate q Severe q N/A

Location of pain: q Low Abdomen q Low Back q Thighs q Other:_____

The quality of the pain is (check all that apply): q Cramping q Stabbing q Aching q Dull
q Burning q Constant q Comes & Goes q Bearing Down

Do you pass clots during your period? (please circle) yes no

Clot Color: q Bright Red q Dark Red q Brownish q Black qDark Purple qSticky

On average, the clot size is: q Small & Stringy q Small & Round q Dime Sized
q Egg Yolk Sized q Larger Than an Egg Yolk

Do you feel pain when you pass the clots? (please circle) Yes No N/A

Do you feel better after passing the clots? (please circle) Yes No N/A

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FOR WOMEN (continued)

Please review the following symptoms related to your period and mark an X in the appropriate column.

	Seldom	Frequent		Seldom	Frequent
Headaches			Swollen or Painful Breasts		
Cravings			Mood Swings		
Nausea			Increased Appetite		
Constipation			Decreased Appetite		
Diarrhea			Insomnia		

Have your periods changed since they started? Yes No

When? _____

Why? _____

Total Number of Pregnancies: _____ Number of Live Births: _____

Number of Miscarriages: _____ Number of Terminations: _____

Are You Sexually Active? Yes No

List any known STDs: _____

Current Type of Birth Control: _____ Used for How Long? _____

What other types of birth control have you used in the past? _____

Do you experience any sexual difficulties? (please describe) _____

Please mark an X in the appropriate column if you experience any of the following:

	Seldom	Frequent		Seldom	Frequent
Endometriosis			Fibrocystic Breasts		
Ovarian Cysts			Breast Cancer		
Uterine Fibroids			Breast Lumps		
Abnormal Pap Smear			Nipple Discharge		
Yeast Infections			Vaginal Discharge/Odor		
Urinary Tract Infections			Herpes		
Pain/Itching of Genitalia			HPV (Human Papilloma Virus)		
Genital Lesions/Discharge			Hysterectomy		
PID (Pelvic Inflammatory Disease)			Uterine Prolapse		

Is there anything else you would like us to know? _____

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FOR MEN

Date of last prostate exam: _____ PSA results: _____

Prostate exam results / diagnosis: _____

Frequency of urination -- Day Time: _____ Night Time: _____

Color of Urine (please circle): Colorless Light Yellow Dark Yellow Reddish

Urine is cloudy: Yes No Urine has an odor: No Yes like: _____

Please mark an X in the appropriate column if you experience any of the following:

	Seldom	Frequent		Seldom	Frequent
Delayed Urine Stream			Increased Libido		
Dribbling Urine			Decreased Libido		
Urinary Incontinence			Discharge/Sores		
Urinary Retention			Premature Ejaculation		
Testicular Masses			Inability to Ejaculate		
Testicular Pain			Difficulty Achieving Erection		
Groin Pain			Difficulty Sustaining Erection		
Hernia			Impaired Fertility		
Back Pain			Rectal Dysfunction		

Are You Sexually Active? Yes No

List any known STDs: _____

Is there anything else you would like us to know? _____

_____

_____

_____

AcuBalance Wellness Center, LLC

Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working with or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories of this form or not.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, gua sha, electrical stimulation, Tui Na (Chinese massage), Chinese or Western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping or gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a safe, clean environment. Burns and/or scarring are potential risks of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of the treatment, which the acupuncturist thinks at the time, based on the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have been read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

Print Name of Patient	Print Name of Acupuncturist
X	**X**
Signature of Patient (or Representative)	Signature of Acupuncturist
(Print Name of Patient Representative)	(Print Name of Witness / Translator)
X	**X**
Date Consent Completed	(Signature of Witness / Translator)

AcuBalance Wellness Center, LLC

Consent for Purposes of Treatment and Office Policies

I consent to the use or disclosure of my identifiable health information by AcuBalance Wellness Center for the purposes of diagnosis or providing treatment, obtaining payment for my health care bills or to conduct health care operations. I understand that my diagnosis or treatment at AcuBalance Wellness Center may be conditioned upon my consent as evidenced by my signature on this document.
My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan. If I believe health information at AcuBalance Wellness Center is incorrect or incomplete, I may ask to correct or complete the information. I have the right to request a correction as long as the information is kept by this office. I always have the right to my medical records and to obtain them I understand that I must make a written request.

Confidentiality

Patient confidentiality (as mandated by state and federal law) is maintained at all times.

Courtesy

Please do your best to keep your voice low and cell phone on a silent or quiet setting while in the office waiting and treatment rooms. This helps ensure that you and all other patients have a positive and uninterrupted treatment experience. Please also refrain from wearing strong fragrances or perfumes to your treatment, as many people have different reactions to strong scents.

Cancellations

Your appointment time is reserved solely for you. Consequently, a 24-hour cancellation policy applies to your appointment. If you are unable to cancel your appointment 24-hours in advance, a cancellation charge for the full treatment fee for the appointment will apply.

Appointments

You are expected to be on time for your appointments. If you find that you cannot be on time, please notify our office as soon as possible.

Payment

Payment in full is expected at the time of service. Cash, checks, debit cards and credit cards (Visa, Mastercard, Discover & American express) are accepted forms of payment. A $20.00 service charge applies for any returned checks. All herbs must be paid in full at time of purchase.
If we are not preferred providers for your health insurance company, we will be happy furnish you with the appropriate receipts so that you can file for reimbursement through your insurance carrier.

Return Policy

There will be no refunds given for any granular prescription, as this is a custom-made formula for you and it is not possible to separate the raw materials once they are mixed.

I understand I have the right to review AcuBalance Wellness Center's notice of privacy practices prior to signing this document.
AcuBalance Wellness Center reserves the right to change information contained in the notice of privacy practices at any time. I may obtain a revised notice of privacy practices and/or a copy of this consent by requesting the most current notice during any office visit.

_____ _____

Signature of Patient or Authorized Representative Date