Balanced Wellbeing Acupuncture

Health History Intake form

Today's Date: _____/_____/_____

First Name:_____

Last Name:_____

Address:_____

City:_____State_____Zip_____

Date of Birth:_____/_____/_____ Age:_____ Weight: _____lbs

Gender: M/F Marital Status: S M D W

Occupation:_____

Home Phone:_____ Work:_____

Emergency Contact Name:_____ phone:_____

E-mail address _____

Who can we thank for referring you?_____

Main Reason for Visit

Please identify your major health concerns that brought you to *Balanced Wellbeing Acupuncture*

1. _____

How long have you had this condition?_____

What treatments have you received?_____

What seems to make it better? _____

What seems to make it worse? _____

Have you seen a physician for this condition?_____ Date_____

2._____
How long have you had this condition?_____

What treatments have you received?_____

What seems to make it better? _____

What seems to make it worse? _____

Have you seen a physician for this condition?_____ Date_____

3. _____

How long have you had this condition?_____

What treatments have you received?_____

What seems to make it better? _____

What seems to make it worse? _____

Have you seen a physician for this condition?_____ Date _____

Have you had any recent X-rays, MRI, CT or lab work for above conditions Y N

Please answer the following questions if you are having PAIN.

Describe the location
_____
_____

Quality of pain (circle) dull sharp stabbing sore cramping throbbing burning
constant radiating fixed moves about severe moderate

Pain radiates to _____

What helps the pain (circle) ice heat rest movement dampness dry other_____

What aggravates the pain (circle) ice heat rest movement dampness dry other _____

How does exercise affect your pain _____

Do any medications help your pain _____

What treatments have you had for pain _____

For Men

Date of last prostate check up_____
Frequency of urination: daytime_____ Nighttime____ Color of urine _____
Symptoms related to prostate (circle)

Prostate problems	Delayed stream	Dribbling	Incontinence
Retention of urine	Rectal dysfunction	Increased libido	Decreased libido
Premature ejaculation	Impotence	Back pain	Groin pain
Testicular pain	Other_____		

For Women

Age of 1st period (menarche)_____ Are you Pregnant Y or N # of pregnancies _____

Age of last period (menopause)_____

Date of last: gynecological exam_____ Pap smear _____ Mammogram _____ Bone scan _____

# of Days between periods _____ # of days of flow _____ Color of flow _____

Average # of pads/tampons used per day: 1st day___ 2nd day ___ 3rd day ___ 4th day ___ +days ___

Have you been diagnosed with (circle) Fibroids Fibrocystic breasts Endometriosis Ovarian cysts PID

Other_____

Location of pain (circle) Lower abdomen Lower back Thighs Other _____

Nature of Pain (please indicate before, during or after menses)

Cramping_____	Stabbing_____
Burning _____	Aching _____
Dull _____	Bloating _____
Consistent _____	Intermittent _____
Bearing down sensation _____	

Other symptoms related to menses (circle)

Discharge	Vaginal dryness	Headache
Nausea	Constipation	Diarrhea
Swollen breasts	Mood swings	Insomnia
Ravenous appetite	Poor appetite	Increased libido
Hot flashes	Night sweats	Decreased libido

Symptom List (for everyone)

Check mark or circle the symptoms from the below list that you have experienced in the last three to six months.

__Indigestion, gas, bloating, heartburn, reflux
__Stomach distension or pain
__Nausea
__Appetite is ___ good ___poor
__Stools are __ Loose __soft __well formed
__Bowel movements ___ times daily
__Blood in stools
__Constipation often
__Frequent over-thinking, constant worrying
__Weakness of arms and legs –Heavy sensation
__Chronic hemorrhoids
__Cold sensation in abdomen-prefer warm foods
__Thirsty without desire to drink/ or no thirst
__Phlegm or mucous in nose, ears (wax)
__Lots of thin, clear mucous
__Yellow or green phlegm
__Frequent gurgling sounds in stomach
__Undigested food in Stools
__Sweet taste in mouth
__Craving for sweets
__Dry, cracked lips
__Mouth sores or Bleeding gums
__Toothaches
__Headaches at forehead
__Dry Heaves or Hiccups

__Irritability, frequent moodiness, anger
__Depression, mental restlessness
__Tight feeling in chest or side of trunk, breasts
__Frequent sighing or need to take deep breath
__Burping, belching, frequent hiccups
__Stools hard like little pebbles or long & thin
__Eye redness or pain
__Frequent headaches on temples or top of head
__Sudden dizziness or vertigo
__High pitched ringing in ears
__Blurred vision, eye floaters, poor night vision
__Dizziness when getting up or after exertion
__Brittle nails or dry skin
__Twitching muscles or eyelids
__Numbness of limbs
__Tremors, convulsions
__Sudden hearing loss, ear pain
__Genital itching, swelling or pain
__Easily startled
__Dream disturbed sleep
__Bitter taste in mouth
__Feeling of lump in throat, difficult swallowing

Acupuncturist Notes

__Respiratory problems (sob)/frequent colds
__Fevers, colds & flu, sore throat
__Cough-mild-harsh
__Phlegm is ___ clear ___yellow
__Phlegm is ___ thick ___watery
__Sinus congestion, allergies
__Spontaneous sweating
__Chronic asthma
__Fatigue and dislike of talking
__Facial edema or swelling
__Aversion to wind
__Asthma, harder to exhale than inhale

__Palpitations (can feel heart beating in chest)
__Insomnia, difficulty falling asleep
__Insomnia, difficulty staying asleep
__Long term memory decreased/forgetfulness
__Dry mouth and throat (Prefer cold drinks)
__Tongue sores
__Chest pain or stuffiness of chest
__Mild depression/easily saddened
__Skin rash that is red, burning or itching
__Burning urination

__Hearing loss
__Ear ringing, low hum or pitch/ dizziness
__Low Back pain
__Knee pain
__Cold feet all the time
__Feel cold easily
__Darkness under eyes
__Hair thinning or loss, early gray hair
__Frequent Urination, incontinence or dribbling
__Frequent night urination
__Color of urine is _ pale __ yellow __dark yellow
__Urine is ____clear____cloudy or turbid
__Asthma, harder to inhale than exhale
__Difficulty breathing when lying down
__Edema below waist-pitting
__Bone problems/teeth problems
__Early morning diarrhea or chronic diarrhea
__Prolonged physical or emotional stress
__History of blood loss
__Night sweats or hot flashes, flushed face
__Increased or reduced sex drive
__Low grade fever
__Frequent terror, fear or fright
__Poor memory-short term

Acupuncturist Notes

Please circle yes or no (leave blank if uncertain) any significant illnesses you or a blood relative (parent, grandparent or sibling) have had.

			Relationship				Relationship
Cancer	N	Y	_____	Diabetes	N	Y	_____
Hepatitis	N	Y	_____	Heart Disease	N	Y	_____
High blood pressure	N	Y	_____	Seizures	N	Y	_____
Rheumatic Fever	N	Y	_____	Tuberculosis	N	Y	_____
Emotional Disorders	N	Y	_____	High Cholesterol	N	Y	_____
Obesity	N	Y	_____	Migraines	N	Y	_____
Drug/Alcohol	N	Y	_____	Asthma	N	Y	_____
MRSA skin	N	Y	_____				

Infectious Diseases _____

Please list any other illnesses not listed._____

Surgeries_____

_____

Significant Trauma (auto accidents, falls, etc.) _____

_____

Please circle no or yes to the following statements

I have known allergies	N	Y
I am taking Coumadin/Warfarin (blood thinner)	N	Y
I have a pacemaker	N	Y

Please list any foods, drugs, or medications you are hypersensitive or allergic to (please indicate reaction)

_____

_____

_____

_____

List all medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking

Medication/Supplement	Reason for taking	How long

How do you feel about the following areas of your life?
Please mark the appropriate box and indicate any problems you may be experiencing

	Good	Fair	Bad	Your Comments
Significant other				
Family				
Diet				
Sex				
Self				
Work				
Exercise				

Current predominant Emotion_____

Please circle with a yes or no the use and frequency of the following:

			Amount				**Amount**
Coffee/Black Tea	Y	N	_____	Tobacco	Y	N	_____
Recreational drugs	Y	N	_____	Water Intake	Y	N	_____
Alcohol	Y	N	_____	Soda	Y	N	_____

Acupuncture Informed Consent to Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Angela B. Ratliff L.Ac. and other licensed Acupuncturist who now or in the future treat me while employed by , working or associated with or serving as back-up for Angela B. Ratliff L.Ac.

Acupuncture and Oriental Medicine treatments that may be administered but not limited to:

Acupuncture: This is a safe treatment involving the insertion of tiny sterile (and disposable) needles through the skin, which can produce a mild but temporary discomfort (usually achiness or soreness) at the acupuncture site. It can occasionally cause slight bleeding, and will rarely leave a bruise (not painful). Other possible risks from acupuncture include dizziness and fainting. I will report any dizziness or light-headedness that occurs during or after an acupuncture treatment. Rare potential risks of acupuncture (these have an extremely low incidence, especially when acupuncture is administered properly) include; nerve damage, organ puncture (pneumothorax), spontaneous miscarriage and infection.

Heat Treatment with a TDP Lamp: This is used to warm an area of the body. Every precaution is taken to prevent overwarming, but the rare possibility of mild burns exists.

Cupping: This involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction. Very rarely a slight burn or blister may appear due to the heat.

Gua Sha: Gua Sha is scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising at the treated area. The bruising, which is usually not painful, usually resolves in 3-7 days.

Electro-Acupuncture: A mild electric micro-current (similar to a TENS treatment) is used to stimulate the acupuncture points. A mild tingling or tapping sensation may be felt.

Tui Na: A form of massage based on Chinese medicine principles. It often includes the use of liniments, oils, or creams. There is a possibility of an allergic reaction to these and the practitioner will ask you before using them. Other risks with Tui na may include soreness post treatment, bruising, and/or increased pain.

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

I understand that no promise or guarantees can be made regarding the outcome of treatment and that reasonable efforts will be made to give information to me so that I might make educated decisions regarding the duration and appropriateness of continued care.

By voluntarily signing below, I show that I have read, or have had read to me, the above 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.

Patient Signature: **X**	Date:

For Patient Review Regarding Diagnostic Exam
Please sign one of the two options below

Option 1:

I have received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment.

Patient Signature Date

Option 2:

I have **NOT** received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment. Ohio law requires that a Licensed Acupuncturist recommend that you receive a diagnostic examination from a physician or chiropractor regarding the condition for which you are seeking treatment.

I understand this recommendation.

Patient Signature Date

Licensed Acupuncturist Signature Date

CC: Patient file

