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:_____

Cell:_____ Contact by text: yes____ No___

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 _____

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
__Excess thirst
__Appetite is ___ good ___poor
__Rapid weight gain/loss
__Stools are __ loose __soft __well-formed __constipated.
__Bowel movements ___ times daily
__Blood in stools
__Frequent Urination
__Menopausal
__Post Menopause
__Painful Menstruation
__PMS
__Pregnant, _____months
__Spontaneous sweating
__Night sweats
__Prostate problems
__Blood disorder
__Headaches at forehead, Temples, Top of head
__Irritability, frequent moodiness, anger
__Depression, mental restlessness
__Frequent over-thinking, constant worrying
__Sudden dizziness or vertigo
__High pitched ringing in ears
__Sudden hearing loss
__Blurred vision, eye floaters, poor night vision
__Twitching muscles or eyelids
__Numbness of limbs
__Tremors
__Palpitations (can feel heart beating in chest)
__Insomnia, difficulty falling asleep
__Insomnia, difficulty staying asleep
__Easily startled
__Dream disturbed sleep
__Feeling of lump in throat, difficult swallowing
__Poor memory-short term
__Long term memory decreased/forgetfulness
__Respiratory problems
__Sinus congestion, allergies
__Cold feet/hands all the time
__Fatigue

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	_____
Liver Disease	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_____

Covid Virus: Approximate date_____ Covid vaccine/injection Y N

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

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, and organ puncture.

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 essential 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..

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 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:

