



Find Your Balance Acupuncture

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80305

PATIENT INFORMATION *All Information Will Remain Confidential*

Name: _____	Phone: _____ (home)
Address: _____	_____ (work)
	_____ (mobile)
DOB: Mo _____ Day _____ Yr _____	Email: _____
Weight: _____ lbs	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male
Height: _____ ft _____ in	Age: _____
Occupation: _____	Referred By: _____
Have you ever been treated with: <input type="checkbox"/> Acupuncture <input type="checkbox"/> Herbs	
Primary Care Physician: _____	
Emergency Contact (relation): _____	Phone: _____

REASON FOR TREATMENT

Primary reason for seeking treatment? _____ _____
When did the problem begin? _____ Have you had this in the Past? <input type="checkbox"/> yes <input type="checkbox"/> no
What makes the problem better? _____
What makes the problem worse? _____
What diagnosis have you been given by a medical doctor? _____
What kinds of treatment (medications, etc.) have you tried and did they help? _____



Other conditions to address?

LIST OF PRESCRIPTION DRUGS, MEDICATIONS, HERBS OR SUPPLEMENTS

Drug	Reason you are taking this drug?
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	

MEDICAL HISTORY

How would you describe your health as a child? _____

Have you had any surgeries?

Date

Do you use tobacco? yes no

How much? _____

Are you interested in quitting smoking? yes no

Do you use caffeine? yes no

How much?

Do you drink alcohol? yes no

How much?



Do you have any allergies to medications or sensitivities?

MEDICAL HISTORY (CONTINUED)

Please check any illnesses or conditions you have or have had in the past and explain on next page:

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes (type?) | <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Bleeding Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Fever |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Endocrine Disorder | <input type="checkbox"/> Goiter | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Unexplained Rashes | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Herpes (type?) |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Whooping Cough | |
| <input type="checkbox"/> Chronic Childhood Illnesses | | |
| <input type="checkbox"/> Other _____ | | |



MEDICAL HISTORY (CONTINUED)

Explanation of Past Illness (include dates):

Empty box for medical history explanation with horizontal lines.

FAMILY MEDICAL HISTORY

Please check any illnesses or conditions that are present in your family history:

Table with 2 columns: Illness/Condition and Family Member(s). Rows include High/Low Blood Pressure, Asthma, Mental Illness, Alcoholism, Seizures, Allergies, Stroke, Cancer (type?), Diabetes (type?), Heart Disease, and Thyroid Disease.

I have answered the questions on this form to the best of my ability and consent to treatment.

Patient signature _____ Date _____

Consent to treat a minor (patient name) _____