Inner Balancing Touch Center for Self Healing

Date_____

New Patient Intake Form

(Please Print)

Patient's Name _____
(Last) (First) (MI)

Address _____ City _____ State _____ Zip _____

Mailing Address (if different) _____

Home Phone (___) _____ Age _____ Date of Birth _____

Cell Phone (___) _____ Height _____ Weight _____ Sex _____

Marital Status _____ Married _____ Divorced _____ Separated _____ Widowed

E-mail Address _____ ☐Newsletter ☐Appointment Confirmation

Social Security # _____ Employer's Name _____

Employer's Address _____ City _____ State ____ Zip _____

Business Phone (___) _____ Occupation _____

Spouse's Name _____ Spouse's Employer _____

Employer's Address _____ City _____ State ____ Zip _____

Business Phone (___) _____ Occupation _____

Person to Notify in Case of Emergency _____ Phone _____

Referred By _____

Health Insurance Co _____ Phone _____ Policy# _____

Physician _____ Phone _____ Copy to Physician? ☐Yes ☐No

Please List Past Surgeries _____

Medications 1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Supplements 1) _____ 2) _____ 3) _____

Allergies 1) _____ 2) _____ 3) _____

Is This Related to an Auto Accident? _____ Date of Accident _____ Claim# _____

Is This Related to a Personal Injury? _____ Date of Injury _____ Claim# _____

Attourney _____ Phone _____

Insurance Co _____ Adjuster _____ Phone _____

Do you drink ☐Coffee ☐ Black Tea How Much _____

Do you use alcohol? ☐Yes ☐No How Much _____

Do you smoke cigarettes? ☐ Yes ☐ No How many per day? _____ Cigarettes _____ Packs

Do you Exercise? ☐ Yes ☐ No How many days per week? _____

Major Complaint(s):

Please rate each complaint on a scale of 1-10. (#1 is virtually symptom-free and #10 is unbearable)

1. **Major Complaint:** _____ Rate:_____
2. Secondary Complaint: _____ Rate:_____
3. Other Complaint:

_____ Rate:_____

Overall Energy (Lung, Kidney function):

- ☐ Shortness of Breath
- ☐ Difficulty keeping eyes open in the day
- ☐ Overall Weakness
- ☐ Easily catch colds
- ☐ Low Energy
- ☐ Feel worse after exercise

Heart function:

- ☐ Palpitations
- ☐ Anxiety
- ☐ Sores on the tip of the tongue
- ☐ Lack of Taste
- ☐ Mental confusion
- ☐ Chest pain traveling to shoulder
- ☐ Frequent dreams
- ☐ Wake up tired
- ☐ Insomnia
- ☐ Mental sluggishness
- ☐ Mental fogginess

Spleen function:

- ☐ Low appetite
- ☐ Abrupt weight loss
- ☐ Abdominal bloating
- ☐ Abdominal gas
- ☐ Gurgling noise in the stomach
- ☐ Fatigue after eating
- ☐ Prolapsed organs (organ?: _____)
- ☐ Easily bruised
- ☐ Hemorrhoids
- ☐ Over-thinking
- ☐ Worry

Lung function:

- ☐ Nasal Discharge (Color: _____)
- ☐ Cough
- ☐ Nose Bleeds
- ☐ Sinus Congestion
- ☐ Dry Mouth
- ☐ Dry Throat
- ☐ Dry Nose
- ☐ Dry Skin
- ☐ Allergies (To What? _____)
- ☐ Alternating chills and fever
- ☐ Sneezing
- ☐ Headache (Location: _____)
- ☐ Overall achy feeling in body
- ☐ Stiff Neck/Stiff Shoulders
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Sadness
- ☐ Melancholy
- ☐ **Smoke cigarettes (# per day: _____)**

Blood (Liver, Spleen, Heart functions):

- ☐ Dizziness
- ☐ See floating spots
- ☐ Poor Memory
- ☐ Pale Skin

Spleen, Stomach, Large Intestine, Small Intestine function:

- ☐ Loose
- ☐ Constipated
- ☐ Incomplete
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Mucous in stools
- ☐ Undigested food in stools

Dampness:

- ☐ Heavy sensation in body
- ☐ Mental heaviness
- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Swollen joints
- ☐ Chest congestion
- ☐ Nausea
- ☐ Snoring

Eyes (Liver function)

- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry vision
- ☐ Decreased night vision
- ☐ Near-sighted
- ☐ Far-sighted

Kidney, Bladder function:

- ☐ Frequent cavities
- ☐ Easily broken bones
- ☐ Sore knees
- ☐ Weak knees
- ☐ Cold sensation in the knees
- ☐ Low back pain
- ☐ Memory problems
- ☐ Excessive hair loss
- ☐ Low pitched ringing in ears
- ☐ Kidney stones
- ☐ Bladder infections
- ☐ Wake during the night to urinate
  (How many times? _____)
- ☐ Lack of bladder control
- ☐ Fear
- ☐ Easily startled

Stomach function:

- ☐ Burning sensation after eating
- ☐ Very large appetite
- ☐ Bad breath
- ☐ Mouth (canker) sores
- ☐ Bleeding, swollen or painful gums
- ☐ Heartburn
- ☐ Acid regurgitation
- ☐ Ulcer (diagnosed)
- ☐ Belching
- ☐ Hiccups
- ☐ Stomach pain
- ☐ Vomiting

Overall Temperature (Kidney function):

- ☐ Cold hands
- ☐ Cold feet
- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Heat in the hands, feet or chest
- ☐ Hot flushes
- ☐ Cold body temperature (sensation)
- ☐ Lack of perspiration
- ☐ Perspire easily
- ☐ Thirsty
- ☐ Take water to bed Night sweats
- ☐ Hot body temperature (sensation)

Libido: ☐ Normal ☐ High ☐ Low

Liver, Gallbladder function:

- ☐ Irritability
- ☐ Frequent unable to adapt to stress
- ☐ Depression
- ☐ Skin rashes
- ☐ Headache at top of the head
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Muscle spasms
- ☐ Muscle twitching
- ☐ Muscle cramping
- ☐ Seizures
- ☐ Convulsions
- ☐ Lump in the throat
- ☐ Neck Tension
- ☐ Limited Range-of-Motion in shoulders
- ☐ Drink alcohol
- ☐ Recreation drugs?
  (Which? _____)
  (How much per week? _____)
- ☐ High-pitched ringing in ears
- ☐ Gall-stones
- ☐ Sexually transmitted disease
  (Which? _____)
- ☐ Frustration
- ☐ Alternating diarrhea and constipation
- ☐ Chest pain
- ☐ Tight sensation in the chest
- ☐ Bitter taste in the mouth
- ☐ Anger easily

Urination

- ☐ Normal color
- ☐ Dark yellow
- ☐ Clear
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong odor
- ☐ Burning
- ☐ Painful
- ☐ Difficult
- ☐ Urgent
- ☐ Frequent

Women only:

Age of first menstruation? _____ Reg menstrual cycle? ☐ Yes ☐ No Number of children? _____

Avg. number of days of flow: _____ Pregnant? ☐ Yes ☐ No Number of pregnancies: _____

Age of menopause: _____ Vaginal discharge: ☐ Severe ☐ Moderate ☐ Slight ☐ Normal

Bleeding between periods: ☐ Severe ☐ Moderate ☐ Slight ☐ Normal

Do you experience any of the following pre-menstrual syndromes?

___Nausea	___Food Cravings	__Depression	___Vomiting
___Irritability	___Migraines	___Anxiety	___ Water Retention
___Breast Swelling	___Breast Tenderness	___Headaches	

How do these conditions impair your daily activities? _____

_____

Please fill in the following menstrual chart:
(Put in a number and what color it is)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Mood							
Breast tenderness, soreness							

Men only:

☐ Swollen testes	___Severe	___Moderate	___Slight	___Normal
☐ Testicular pain	___Severe	___Moderate	___Slight	___Normal
☐ Impotence	___Severe	___Moderate	___Slight	___Normal
☐ Premature ejaculation	___ Severe	___Moderate	___Slight	___Normal
☐ Feeling of cold or numbness in external genitalia	___ Severe	___Moderate	___Slight	___Normal
☐ Other: _____				

Pain:

How did pain begin?: _____

When did pain begin?: _____

Does Pain limit your Range of Motion? _____ Does pain wake you at night? _____

Quality of the pain:

❒ **Sharp** ❒ **Burning** ❒ **Aching** ❒ **Cramping** ❒ **Dull** ❒ **Moving** ❒ **Fixed** ❒ **Other:** _____

Intensity of the pain:

0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate					Intense

Do any of the following ***Lessen*** the pain?

❒ **Pressure** ❒ **Cold** ❒ **Heat** ❒ **Exercise** ❒ **Other:** _____

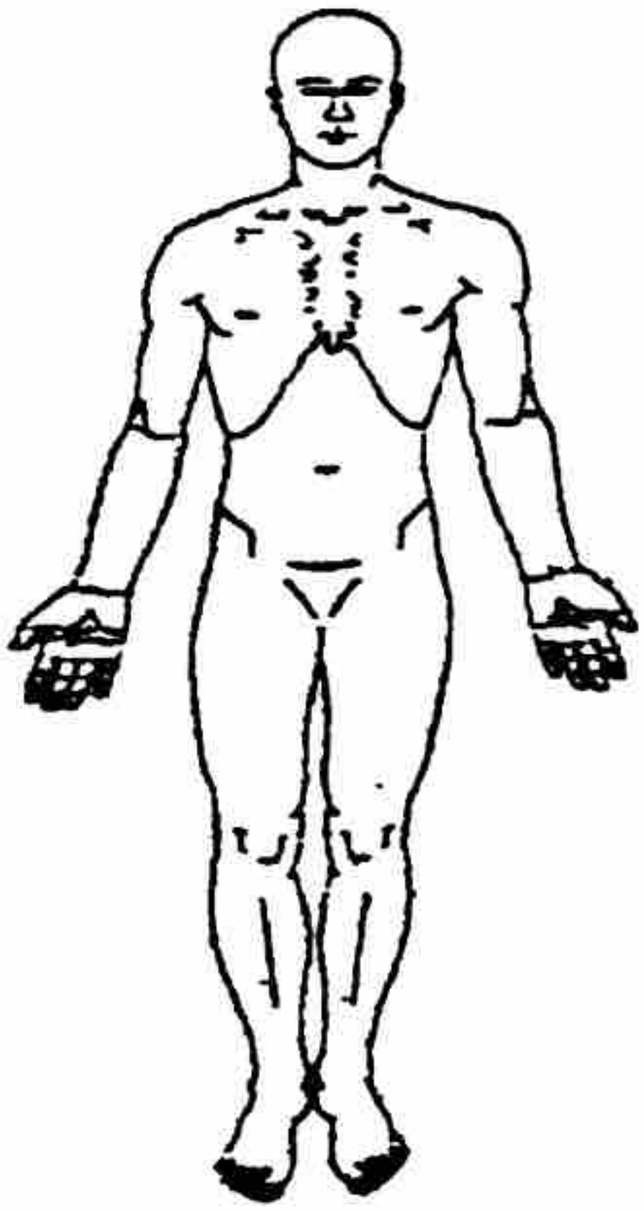
Do any of the following ***Worsen*** the pain?

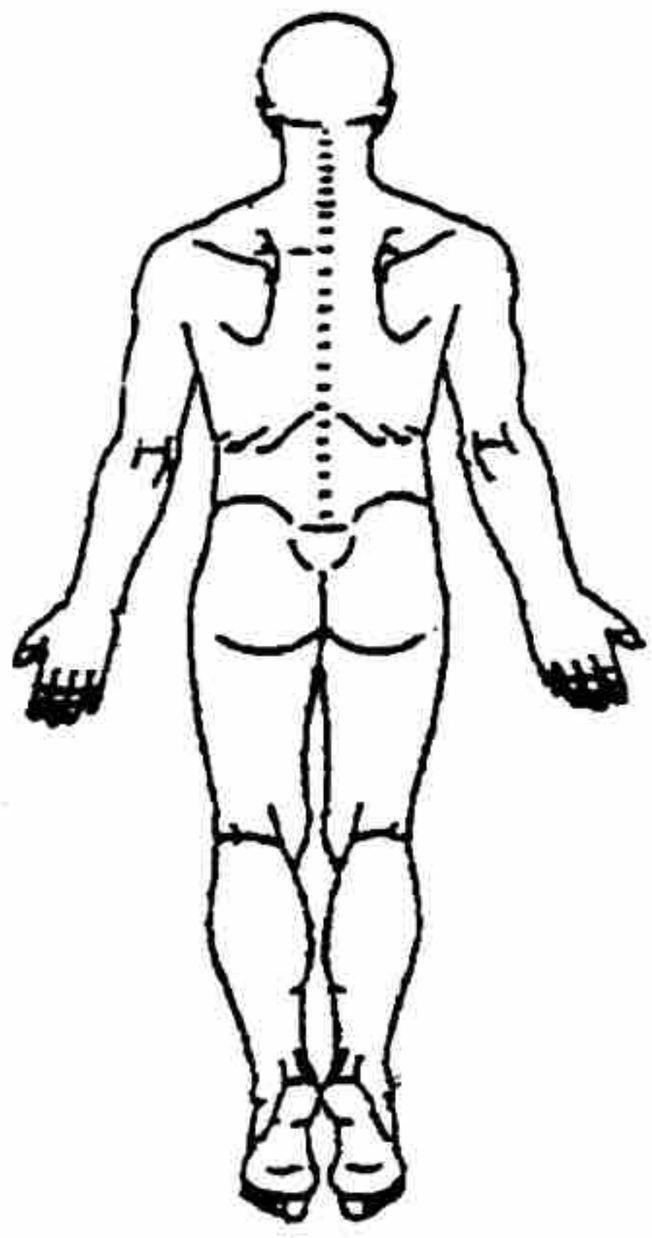
❒ **Pressure** ❒ **Cold** ❒ **Heat** ❒ **Exercise** ❒ **Other:** _____

Where is the pain? _____

*Please clearly mark areas of pain and any scars.

- Circle body part(s) that are in pain
  - Mark with an **X** all specific areas of pain
- Mark with an **S** areas of scar tissue





Patient Medical History:

How was your childhood health? _____

Hospital Visits/Stays: _____

Recent tests: (please indicate test results and date below)

❑ Physical ❑ Cholesterol ❑ Prostate ❑ Blood ❑ HIV/STD ❑ Pap Smear ❑ ❑ Mammography

❑ Other: _____

Test Results and Date: _____

_____

Check any you have had in the past:

___ Rheumatic Fever	___ Tuberculosis	_ Glaucoma	___ Diabetes _____
___ Heart Disease	___ CVA (stroke)	_ Mumps	___ Polio
___ Chicken Pox	___ Emphysema	_ Cancer _____	___ Allergies _____
___ Vein Condition	___ Bleeding Tendency	_ HIV	___ Mononucleosis
_ Multiple Sclerosis	___ Meningitis	___ Asthma	___ Nervous disorder
_ Thyroid disorder	___ Pneumonia	___ Measles	___ Gonorrhea
_ Syphilis	___ Jaundice	___ Epilepsy	_ Paralysis
_ High Blood Pressure	___ Hepatitis _____	___ Migraines	___ other liver illnesses
___ other stomach illnesses	___ other lung illnesses	___ other kidney illness	___ other heart illnesses
_ other spleen illnesses	___ other: _____		

Immunizations: _____

Surgeries (type and date): 1) _____ 2) _____
3) _____ 4) _____

Family History:

Where are you in the birth order? ❑ First ❑ Last ❑ Middle ❑ Only child

Check the following that have occurred in your blood relatives:

___ Diabetes	___ Cancer	___ Heart Disease	___ High Blood Pressure
___ Tuberculosis	___ Obesity	___ Alcoholism	___ Bleeding tendency
___ Kidney Disease	___ Allergies	___ Stroke	___ Mental Illness
___ Nervous Illness	___ Balding	___ Other _____	

IT IS THE RESPONSIBILITY OF THE PATIENT TO NOTIFY THIS OFFICE IF ANY OF THIS INFORMATION SHOULD CHANGE.

Informed Consent for Acupuncture Treatment

I _____ hereby agree and consent to the performance of acupuncture and other Oriental Medicine procedures. I understand that such procedures may include, but are not limited to acupuncture, moxibustion, cupping & gua-sha (dermal friction technique), infrared heat lamp, breathing techniques, exercise therapy, Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling based on traditional Chinese medical theory. Acupuncture is a technique utilizing fine stainless steel needles inserted at specific points in the body to correct various ailments.

Moxibustion is the application of indirect heat by burning a stick of compressed Folium Artemisiae vulgaris, commonly known as Mugwort, over acupuncture points.

Cupping utilizes round suction cups over a large muscular area (such as the back) to enhance blood circulation to the designated area.

Tui-na is a form of Chinese bodywork (massage) used in facilitating healing and pain management. Occasionally there may be increased soreness at the sites of treatment on the day of, or day following treatment.

I have been informed that in all acupuncture treatments only sterile, disposable needles are used according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment possible.

I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including bruising, numbness or tingling, dizziness or fainting, minor swelling, bleeding, hematoma may occur at the site of insertion and may last a few days. A sensation of lightheadedness may occur after acupuncture treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained, or removed.

I am relying on the TCM practitioner to exercise judgment during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interest. I understand that acupuncture and other Oriental Medicine procedures are not substitutes for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan

By voluntarily signing below I, _____, hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

Print Patient Name_____ Patient Signature_____

Date: _____