FINE BALANCE
ACUPUNCTURE
Restoring Balance & Harmony for Optimal Health

Name:_____ Email: _____

Address:_____ City:_____State:_____ Zip: _____

Home Phone:_____Work Phone: _____ Cell Phone: _____

Birth Date:_____ Age:_____ Sex: F M SSN: _____

Marital Status:_____ Occupation: _____ Employer: _____

Emergency Contact:_____ Phone:_____

Primary Physician:_____ Physician's phone:_____

Referred by:_____ How did you hear about us?_____

Consent for Acupuncture

I, the undersigned, understand acupuncture treatment to involve the use of needles, acupressure, moxibustion and electrical stimulation etc. The risks, although limited, include: puncturing organs in the abdomen or chest cavities. Acupuncture may affect people on all levels: physical, emotional, mental and spiritual, because it works with the whole body to create balance. The duration of treatment varies from person to person depending on the specific illness and their constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.

_____ _____

Patient's signature (Parent or Guardian if under 18) Date

Reason you are seeking acupuncture:_____

How long ago did this problem begin?_____

Have you been given a diagnosis for this problem? If so, what? _____

What kinds of treatment have you tried?_____

Does anything improve your problem?_____

MEDICAL HISTORY (Please list illnesses & surgeries you have or have had and year diagnosed)

Illnesses:_____

_____

Surgeries:_____

_____

Significant Trauma (auto accident, falls etc):_____

Have you ever had any Infectious Diseases (HIV, TB etc)? □ Yes □ No If so, please describe:_____

Medicines (prescription and OTC, vitamins, herbs etc.) For what condition

_____ _____
_____ _____
_____ _____
_____ _____

Allergies:_____

FAMILY MEDICAL HISTORY (please check if any of the following applies to any family members)

□ AIDS
□ Alcoholism
□ Allergies
□ Asthma
□ Cancer
□ Diabetes
□ Heart disease
□ Hypertension
□ Seizures
□ Strokes
□ Pulmonary disease
□ Other

If mother, father or siblings are deceased, what was the cause?
_____

CURRENT SYMPTOMS (please check if any of the following applies)

WOOD
□ Irritability/Stressed
□ Depression
□ Headaches/migraines
□ Visual problems
□ Red eyes
□ Dry/itching eyes
□ Spots in front of eyes
□ Blurred vision
□ Feeling of lump in throat
□ Clenching of teeth at night
□ Muscle cramping
□ Muscle twitching
□ Joints feel tight/stiff
□ Soft/brittle nails
□ Craving or avoiding sour foods

WATER
□ Urinary problems
□ Frequent urination
□ Incontinence
□ Weakness/pain in lower back
□ Aching bones
□ Feel cold easily (hands/feet)
□ Low sexual energy
□ Excess sexual desire
□ Poor memory
□ Loss of hair
□ Hearing problems
□ Ringing in ears
□ Craving or avoiding salty foods

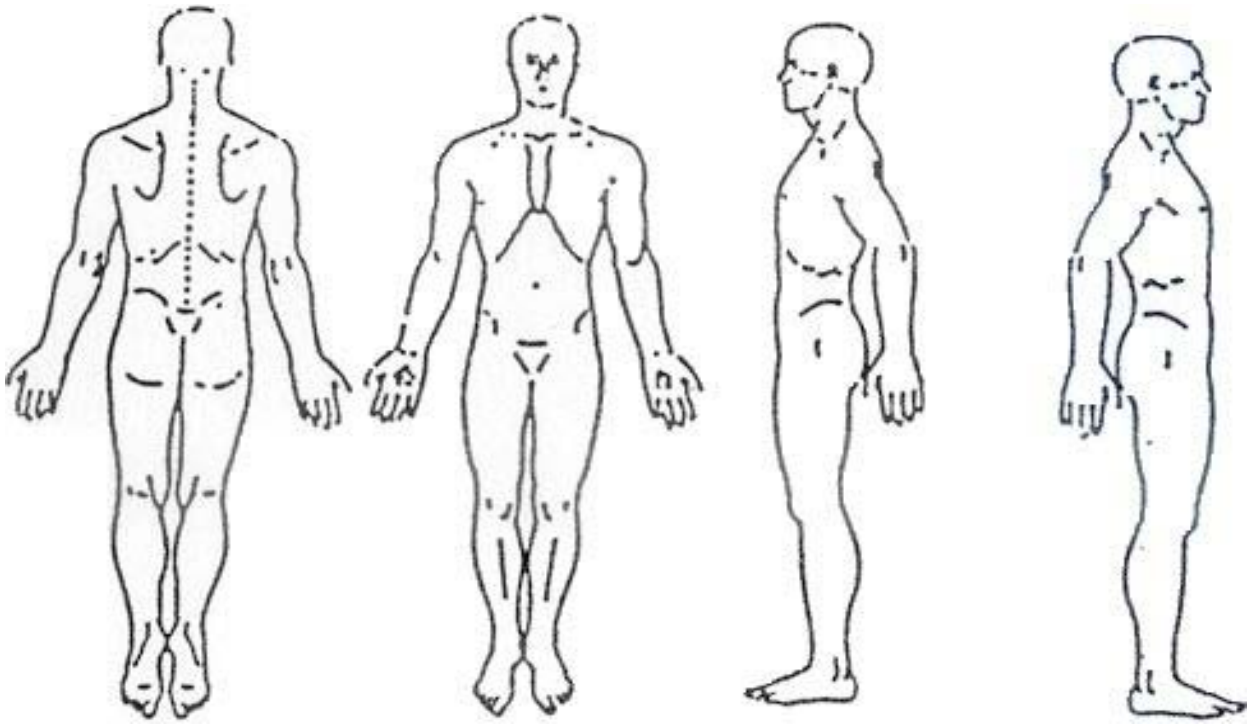
FIRE
□ Heart palpitations
□ Chest pain
□ Dizziness
□ Insomnia
□ Easily startled
□ Restlessness/agitation
□ Anxiety
□ Breathlessness
□ Vivid dreams
□ Dreams are bothersome
□ Lack of joy in life
□ Laughing for no reason
□ Craving or avoiding bitter foods

METAL
□ Dry cough
□ Cough with sputum
□ Nasal discharge
□ Poor sense of smell
□ Nose bleeds
□ Itchy, red or painful throat
□ Dry mouth
□ Skin rashes
□ Itchy skin
□ Grief, sadness
□ Shortness of breath
□ Allergies
□ Low resistance to colds or flu
□ Low physical stamina
□ Mild fever comes and goes
□ Craving or avoiding spicy foods

EARTH
□ Heaviness anywhere in body
□ Fatigue
□ Hard to get up in the morning
□ Edema (swelling)
□ Muscles feel tired often
□ Easy bruising and bleeding
□ Bad breath
□ Low appetite
□ Snacking often
□ Hypoglycemia/low blood sugar
□ Difficulty digesting oily foods
□ Nausea
□ Vomiting
□ Gas/belching
□ Bloating
□ Hemorrhoids
□ Constipation
□ Diarrhea
□ Abdominal pain
□ Indigestion/heartburn
□ Over-thinking
□ Obsessive tendencies
□ Craving or avoiding sweets

OTHER
□ _____
□ _____
□ _____
□ _____

Please circle areas of pain or injury



FEMALES

Age at First Menses:_____ Age stopped:_____ Period between Menses:_____ Duration of Menses:_____

Number of Pregnancies:_____ Number of Births:_____ Miscarriages:_____ Abortions:_____

Last period:_____ Last PAP smear:_____ Pregnant: □Y □N Form of birth control:_____

□ Menstrual pain □ Low backache □ Irregular menses □ Painful breast □ Clots □ Fertility problems

□ Mood changes □ Hot flashes □ Vaginal dryness □ Vaginal discharge □ Heavy bleeding

MALES

□ Erectile dysfunction □ Premature ejaculation □ Nocturnal emission □ Pain/itching of genitalia

□ Lumps in testicles □ Increased libido □ Decreased libido □ Other:_____

PERSONAL HABITS

□ Coffee # per day_____ □ Alcohol # drinks per week_____
□ Tobacco # per day_____ □ Former tobacco use # years quit _____
□ Recreational drugs # per day_____ □ Former alcohol use # years quit _____

Do you have a regular exercise program?_____ If so, please describe:_____

DIET (Please describe your typical daily diet)

Breakfast: _____ Morning Snack:_____

Lunch: _____ Afternoon Snack:_____

Dinner:_____ Dinner Snack:_____