Patient Information

Name _____ Date of Birth _____ Age ____ ☐Male ☐Female

Home Address _____
City State Zip Code

Phone # _____ ☐Home ☐Cell Appt reminders via ☐Text ☐Email ☐None

E-mail Address _____

To stay green, we largely communicate digitally, which may contain personal information. To opt out, check here ☐

Emergency Contact _____Best Phone # _____

How did you hear about InBalance AcuPT? _____

Referring or Primary Physician _____

Employment Information

Employment Status ☐ Full-Time ☐ Part-Time ☐ Partial Duty ☐ Disability ☐ Retired

Occupation _____ Employer _____ Work Phone # _____

Patient Health Information

Please identify your major symptom or concern _____

How long have you had this problem? _____ Is your condition worsening? ☐ Yes ☐ No

Please rate your pain (0 = no pain, 10 = severe): at WORST _____ at BEST _____

What makes it worse? _____

What makes it better? _____

Have you had diagnostic imaging of problem area? ☐ X-ray ☐ MRI ☐ CT-Scan Date: _____

Please list surgeries, major illnesses, motor vehicle accidents, traumas, falls and applicable dates:

_____

Patient Medical History

Do you <u>currently</u> have or in the <u>past</u> had any of the following?

Past	Present		Past	Present	
☐	☐	Abdominal pain	☐	☐	High blood pressure
☐	☐	Allergies _____	☐	☐	HIV/AIDS
☐	☐	Anxiety/Nervous disorder	☐	☐	Implants (IUD, stents, pins, etc)
☐	☐	Arthritis	☐	☐	Infectious Disease/Lyme
☐	☐	Asthma/COPD	☐	☐	Joint replacement
☐	☐	Autoimmune Disorder _____	☐	☐	Joint pain _____
☐	☐	Blood disorder _____	☐	☐	Low blood pressure
☐	☐	Cancer/tumor _____	☐	☐	Lower back pain
☐	☐	Chest pain	☐	☐	Neck pain/Whiplash
☐	☐	Concussion/Head Injury	☐	☐	Osteopenia/Osteoporosis
☐	☐	Depression/Mental illness	☐	☐	Pacemaker
☐	☐	Diabetes	☐	☐	Pregnant, ☐ C-Section
☐	☐	Ear/Vestibular/Vertigo/Tinnitus	☐	☐	Reproductive Issues _____
☐	☐	Fall history _____ x/mo	☐	☐	Seizures/Epilepsy
☐	☐	Fatigue	☐	☐	Skin Conditions _____
☐	☐	Fibromyalgia	☐	☐	Sprains/Strains/Spasms
☐	☐	Frequently catch colds	☐	☐	Stroke/TIA
☐	☐	Gastrointestinal disorders	☐	☐	Sexually transmitted disease
☐	☐	Headaches/Migraines	☐	☐	Thyroid problems
☐	☐	Heart disease/Palpitations	☐	☐	Urinary/Kidney disorder/UTI
☐	☐	Hepatitis/Liver disease	☐	☐	Vision problems
☐	☐	Herpes/Shingles	☐	☐	Other_____

Are you <u>currently</u> taking any of the following?

☐ Allergy medication	☐ CDB/THC	☐ Pain relievers
☐ Anti-seizure medication	☐ Contraceptives/Hormone	☐ Sleeping aids _____
☐ Antibiotics	☐ Insulin	☐ Steroids
☐ Antidepressants	☐ Laxatives	☐ Turmeric
☐ Blood thinners	☐ Muscle relaxants	☐ Vitamins _____
☐ Blood Pressure meds	☐ Neuropathic medication	☐ Other _____

How is your Daily Health?

Weight _____ Height _____ Tobacco: ☐ No ☐ Yes Alcohol: ☐ No ☐ Yes

<u>Sleep</u>: ☐ Great! ☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Nightmares ☐ Poor Quality

<u>Diet</u> includes: ☐ Coffee ☐ Dairy ☐ Soda ☐ Sweets ☐ Gluten Free ☐ Vegan ☐ Other _____

<u>Bowel Movements</u>: ☐ Daily solid B/M ☐ Constipation ☐ Diarrhea ☐ Loose ☐ Pebbles ☐ Other

Types of <u>Exercises</u> and Frequency of Exercises _____

What are your goals for treatment? _____

_____

Informed Consent to Receive Treatment and Care

I hereby voluntarily request and consent licensed medical practitioners in the State of California employed by InBalance Acupuncture PT ("InBalance AcuPT") to perform procedures within the scope of oriental medicine, acupuncture, therapeutic exercises, and manual therapy on me (or on the patient named below, for whom I am legally responsible) for my medical condition(s), as I described in the intake form and at initial consultation.

Proposed and Alternative Treatments*:* Treatments at InBalance AcuPT may include: manual therapy, acupuncture, indirect moxibustion (heat therapy with dried mugwort plant), cupping, fire cupping, electrical stimulation, electroacupuncture, ultrasound, gua sha (coining/scraping), heat therapy, ear seeds, Tui-Na (Chinese massage), soft tissue mobilization, taping, therapeutic exercises, and lifestyle counseling. I understand these treatments may require physical contact with my practitioner. He or she will verbally ask my permission before initiating any physical contact. Prior to the treatment(s), my practitioner and I have discussed the history, current symptoms, and prognosis of my medical issue(s). We also discussed the nature and purpose of the plan of care and proposed treatment(s). I was given opportunities to ask questions. My practitioner addressed all of my concerns to my satisfaction. Furthermore, we discussed the:

- Potential major benefits and risks of the proposed treatment(s)
- Nature, benefits, and risks of alternative treatments, regardless of the costs
- Other available medical procedures (if known and available), and potential consequences of choosing not to receive treatments

Potential Benefits: I understand I may experience relief of symptoms after any treatments, which may lead to the elimination of my medical problem(s). I understand there are no implied or stated guarantees of effectiveness of any treatment(s).

Potential Risks: I understand that there are potential, but uncommon risks associated with all treatments that include, but not limit to: bruising, numbness, tingling, spasms, swelling, infection, bleeding, soreness, and dizziness. These symptoms at or near the needling sites may last up to 14 days after acupuncture treatments. Burns, blistering, and scarring are uncommon risks of indirect moxibustion and heat therapy. Bruising and redness lasting a few days are risks of cupping, fire cupping, gua sha, and manual therapy. I understand very rare risks associated with all treatments include death, fainting, spontaneous miscarriage, nerve damage and organ puncture (for example, pneumothorax). I understand that certain social habits, lifestyle choices, and other treatments may decrease the beneficial effects of any treatments. These may include

alcoholism, sedentary lifestyle, unhealthy diets, pain-relieving medication, blood-thinning medication, steroids, narcotics, tobacco, anti-depressants, and other drugs. I understand minor risks may occur. I do not expect my practitioner to be able to explain all possible risks of any treatment(s).

My Responsibilities: I will inform my practitioner of all physical, mental, and medical conditions, symptoms, medication, surgeries, supplements, allergies, and changes prior to each treatment session. I will immediately notify my practitioner should I try to get pregnant. I agree to contact my practitioner **immediately** if I experience any complications after each treatment. If I experience a medical emergency, I understand I must seek immediate help at a hospital or urgent care facility.

By signing below, I have fully read, understand, and agree with the contents found in this document. My signature indicates I consent and authorize my practitioner to perform an evaluation and proposed treatment(s) on me. I intend this consent form to cover the entire course of treatment now and in the future. I will follow directives found in the "My Responsibilities" section of this document. I have received a copy of this consent form for my records. I understand I can withdrawal from all treatment(s) at any time.

***SIGNATURE** of Patient* _____ *Date* _____

PRINT Patient Name _____

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If you are under 18 years of age and/or incapacitated according to California law:
I am considered the parent or legal guardian of the patient pursuant to the State of California laws. I understand the legal consequences of signing this document. I consent and authorize the patient to receive evaluation and treatments at InBalance AcuPT. The practitioner and I have discussed the information found in each section of this document. I understand that I am responsible for the patient to follow directives found in the "My Responsibilities" section of this document.

By signing below, I have fully read, understand, and agree with contents found in this document.

Signature _____ *Date* _____

PRINT Name of Patient's **Parent/Legal Guardian** _____

Treatment Terms and Conditions

Privacy Practices: I acknowledge I have received, read, and understood the Privacy Practices. I also have access to a copy online at www.inbalanceacupt.com.

Electronic Correspondence: I agree to receive electronic mail, which may contain confidential information Privileged Patient Medical Records that are protected under federal and/or state law.

Cancellation Policy: I understand that the time reserved for me is my responsibility and if I miss an appointment or cancel with less than 24 hours notice, I will be financially responsible for the appointment, a flat fee of $70, after the second occurrence.

Late Policy: I will be given a 15-minute grace period if I am going to be late. I will text or call to notify InBalance AcuPT. If I do not arrived by 15 minutes after my designated appointment time, my appointment will be cancelled and I will be responsible for the full payment of the session, $70, after the second occurrence.

Fee Schedule: An initial patient evaluation (comprehensive medical history taking, clinical exam, and treatment) is $100. Each follow-up visit is $75. A package of 5-treatments is $350. Packages may be shared with family members. Returning patient appointment time may not be exchanged for a new patient appointment.

Patients with Medicare: InBalance AcuPT, including all its practitioners, is not enrolled in Medicare and Medicare does not pay for acupuncture services. By my signature, I agree that I will not seek reimbursement through Medicare for any services provided or expenses incurred at InBalance AcuPT.

Financial Responsibility: I understand that InBalance AcuPT is not responsible for insurance reimbursement. By my signature, I acknowledge that I assume full responsibility for each treatment fee at the time of service even if I submit claims to my health insurance company.

Returned Checks: I will be charged a Returned Check fee of $40 for each check returned for insufficient funds, in addition to the amount the check was for.

I, _____(*PRINT full name*), have fully read, understand, and agree with the policies and will abide by these terms.

_____

***SIGNATURE** of Patient (Legal Guardian)* *Date*