

Patient Information

Name _____	Date of Birth _____	Age _____	
Home Address _____	City _____	State _____	Zip Code _____
Phone # _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non Binary	
E-mail Address _____			
Emergency Contact _____	Best Phone # _____		
How did you hear about InBalance AcuPT? _____			
Primary Physician _____			

Employment Information

Employment Status	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time	<input type="checkbox"/> Partial Duty	<input type="checkbox"/> Disability	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> X-ray <input type="checkbox"/> MRI <input type="checkbox"/> CT-Scan Date: _____
Please list surgeries, major illnesses, motor vehicle accidents, traumas, falls and applicable dates: _____ _____ _____

Patient Medical History

Do you currently have or in the past had any of the following?

Past Present

Past Present

- | | | | | | |
|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies _____ | <input type="checkbox"/> | <input type="checkbox"/> | HIV / AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety/Nervous Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Implants (IUD, stents, pins, etc) |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Infectious Disease / Lyme |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma/COPD | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune Disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> | Joint Pain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor _____ | <input type="checkbox"/> | <input type="checkbox"/> | Lower Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | Neck pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Concussion/Head Injury | <input type="checkbox"/> | <input type="checkbox"/> | Osteopenia / Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression/Mental Illness | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant, <input type="checkbox"/> C-Section(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear/Vestibular/Vertigo/Tinnitus | <input type="checkbox"/> | <input type="checkbox"/> | Reproductive Issues _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Fall History _____ x/month | <input type="checkbox"/> | <input type="checkbox"/> | Seizures/Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue/Adrenal Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Skin Conditions _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> | Sprains/Strains/Spasms |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequently Catch Colds | <input type="checkbox"/> | <input type="checkbox"/> | Stroke/TIA |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches / Migraines | <input type="checkbox"/> | <input type="checkbox"/> | Urinary/Kidney Disorder/UTI |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease / Palpitations | <input type="checkbox"/> | <input type="checkbox"/> | Vision Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis / Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes / Shingles | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Are you currently taking any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergy medication | <input type="checkbox"/> Contraceptive/Hormone tx | <input type="checkbox"/> Sleeping aids _____ |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Insulin | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Turmeric |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Vitamins _____ |
| <input type="checkbox"/> Blood Pressure meds | <input type="checkbox"/> Neuropathic medication | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> CBD/THC | <input type="checkbox"/> Pain relievers | <input type="checkbox"/> Other _____ |

How is your Daily Health?

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

Sleep: Great! Difficulty falling asleep Difficulty staying asleep Nightmares Poor Quality

Diet includes: Coffee Sweets Gluten Free Vegan Vegetarian Other _____

Bowel Movements: Daily solid B/M Constipation Diarrhea Loose Pebbles Other _____

Types of Exercises 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 Inc. DBA 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 during each visit.

Proposed and Alternative Treatments: Treatments at InBalance AcuPT may include: manual therapy, acupuncture, retaining acupuncture needles outside of the clinic, cupping, fire cupping, electrical stimulation, electroacupuncture, Chinese herbal medicine, 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, fainting 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 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, opioids, 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, psychological, and medical conditions, symptoms, medications, 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 comply with the instructions given, during treatment visits, of proper care, removal and disposal of retained acupuncture needles. 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 _____

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/No-Show/Late Policy: I understand that the time reserved for me is my responsibility. For each visit, I am allowed a 15-minute grace period if I am going to be late. I will text or call to notify InBalance AcuPT. Arriving late for an appointment will cut the treatment session short. If I do not arrived by 15 minutes after my designated appointment time, my appointment will be cancelled and considered a late cancellation. Within a calendar year, if I miss an appointment or cancel with less than 24 hours notice more than 2 times, I will be financially responsible for the appointment: a flat fee of \$85 or a deduction of one visit from a pre-paid package.

General Fee Schedule: An initial 1-hr patient evaluation (comprehensive medical history taking, clinical exam, and treatment) is \$170. Each 1-hr follow-up visit is \$85. A package of 5 follow-up 1-hr treatment sessions is \$400. Pre-paid packages expire 365 days from the date of purchase. 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 with Medicare. 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 health 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 \$50 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