InBalance AcuPT
Balance Your Health

Patient Information

Name ______________________________ Date of Birth ____________ Age ______

Home Address ____
City State Zip Code

Phone # ____________________ ☐Home ☐Cell Gender: ☐Male ☐Female ☐Non Binary

E-mail Address ____

Emergency Contact ____________________ Best Phone # ____________________

How did you hear about InBalance AcuPT? ______________________________

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:

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Patient Medical History

Do you currently have or in the past 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
☐	☐	Concussion/Head Injury	☐	☐	Osteopenia / Osteoporosis
☐	☐	Depression/Mental Illness	☐	☐	Pacemaker
☐	☐	Diabetes	☐	☐	Pregnant, ☐ C-Section(s)
☐	☐	Ear/Vestibular/Vertigo/Tinnitus	☐	☐	Reproductive Issues ________
☐	☐	Fall History ________ x/month	☐	☐	Seizures/Epilepsy
☐	☐	Fatigue/Adrenal Fatigue	☐	☐	Skin Conditions ________
☐	☐	Fibromyalgia	☐	☐	Stroke/TIA
☐	☐	Frequently Catch Colds	☐	☐	Thyroid Problems
☐	☐	Gastrointestinal Disorders	☐	☐	Urinary/Kidney Disorder/UTI
☐	☐	Headaches / Migraines	☐	☐	Vision Problems
☐	☐	Heart Disease / Palpitations	☐	☐	Other____________
☐	☐	Hepatitis / Liver Disease	☐	☐	Other____________
☐	☐	Herpes / Shingles	☐	☐	Other____________

Are you currently taking any of the following?

☐ Allergy medication	☐ Contraceptive/Hormone rx	☐ Sleeping aids ________
☐ Antidepressants	☐ Insulin	☐ Steroids
☐ Blood Thinners	☐ Muscle Relaxants	☐ Vitamins ________
☐ Blood Pressure meds	☐ Neuropathic medication	☐ Supplements ________
☐ CBD/THC	☐ Pain relievers	☐ 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 ______

Menses: ☐Painful ☐Irregular ☐Post-menopause #Days Bleeding _____ ☐Heavy ☐Light ☐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 asian 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 withdraw from all treatment(s) at any time.

***SIGNATURE** of Patient* ______________________________ *Date* ____________

PRINT Patient Name ____

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If 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 and text messages, which may contain confidential information Privileged Patient Medical Records that are protected under federal and/or state law.

Late Policy: 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 arrive by 15 minutes after my designated appointment time, my appointment will be cancelled and considered a late cancellation.

Cancellation/No-Show Policy: I understand that the time reserved for me is my responsibility to attend all scheduled appointments. Cancellation notice needs to be at least 48 hours in advance of appointment time. If the length of appointment is greater than 1.5 hours, cancellation notice needs to be at least 72 hours in advance. These requirements allow the time needed for my appointment to be given to someone else. Except in emergency situations, late cancellations and not showing for an appointment without the correct amount of notice will be charged the full rate of the appointment.

General Fee Schedule: An initial 1-hr patient evaluation (comprehensive medical history taking, clinical exam, and treatment) is $170. Each standard 1-hr follow-up visit is $85. A package of 5 follow-up 1-hr treatment sessions is $400. Rates for longer treatment times available upon request. 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: Due to the specialized nature of services provided, InBalance AcuPT 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 for reimbursement to my health insurance company.

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

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