Inner Balance Acupuncture

274 Southland Drive, Suite 101, Lexington, KY 40503
859-595-2164
www.acupunctureky.com

Patient Information

Name:_____ Today's date:_____

Age:_____ □Male □Female Marital status:_____

Date of Birth: __ __ / __ __ / __ __ __ __

Social Security Number (VA Patients Only):_____

Occupation:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home phone:_____ Cell phone:_____

Work phone:_____ E-mail:_____

May we call you at either of the above phone numbers? □Yes □No
May we leave a message? □Yes □No

Emergency contact: (name)_____

(phone)_____

(relation)_____

Referred by:_____

Are you under the care of a physician now? □ Yes □ No

If yes, what for:_____

Physician's name: _____

Physician's phone number: _____

Reasons for today's visit:

Reason #1 _____

How long have you had this condition: _____

Are you receiving other treatments for this condition? (please specify): _____
_____

Reason #2 _____

How long have you had this condition: _____

Are you receiving other treatments for this condition? (please specify): _____
_____

Reason #3 _____

How long have you had this condition: _____

Are you receiving other treatments for this condition? (please specify): _____
_____

Have you had Acupuncture before? □ Yes □ No

Have you used Chinese Herbs before? □ Yes □ No

Is your condition getting □ worse? □ better?

What seemed to be the initial cause? _____

Please list current medications you are taking, including vitamins, herbs, etc.:

_____

_____

_____

Family Medical History:

□Heart Disease □Stroke □Diabetes □Asthma □Seizures
□Alcoholism □High Blood Pressure
□Cancer □other: _____

Your Past Medical History:

□HIV/AIDS	□Alcoholism	□Allergies	□Appendicitis
□Asthma	□Cancer	□Chicken Pox	□Diabetes
□Emphysema	□Epilepsy	□Goiter	□Heart Disease
□Hepatitis	□Hypertension	□Multiple Sclerosis	□Mumps
□Pacemaker	□Pneumonia	□Seizure	□Stroke
□Thyroid	□TB	□Typhoid Fever	□Ulcers

□other: _____

List any hospitalizations you've had during the past 5 years:

_____

_____

Surgeries:
(list)_____

Your Lifestyle:

□Alcohol □Marijuana □Stress □Tobacco □Drugs □Occupational Hazards

Regular Exercise: □Yes □No Type:_____

How Often: _____

General Symptoms:

□Poor Appetite	□Dream disturbed sleep	□Shortness of breath
□Excess Appetite	□Fatigue	□Fever
□Strongly like cold drinks	□Lack of Strength	□Chills
□Strongly like hot drinks	□Peculiar taste in mouth	□Night Sweats
□Recent weight loss	□Body feels heavy	□Sweat Easily
□Recent weight gain	□Cold feet	□Sleep too much
□Bleed or bruise easily	□Cold hands	□Muscle Cramps
□Poor sleep	□Poor circulation	□Vertigo or dizziness

Head, Eyes, Ears, Nose, Throat:

□Glasses	□Headaches	□Red Eyes	□Itchy Eyes
□Spots in Eyes	□Poor Vision	□Blurred Vision	□Dry Eyes
□Night Blindness	□Glaucoma	□Cataracts	□Teeth Problems
□Grinding Teeth	□TMJ	□Facial Pain	□Gum Problems
□Dry Mouth	□Excess Saliva	□Sinus Problems	□Swollen Glands
□Lumps in Throat	□Enlarged Thyroid	□Nose Bleeds	□Poor Hearing
□Ringing in Ears	□Sores on Lips/Tongue	□Recurrent Sore Throat	
□Excessive Phlegm	(color of phlegm:_____)		

Respiratory:

□Difficulty Breathing Lying Down	□Shortness of Breath	□Tight Chest
□Asthma/Wheezing	□Pneumonia	□Cough
□Cough up Blood		

Cardiovascular:

□High Blood Pressure	□Irregular Heart Beat	□Phlebitis
□Low Blood Pressure	□Blood Clots	□Palpitations
□Difficult Breathing	□Chest Pain	□Fainting

Are you taking blood thinners/aspirin: □Yes □No

Gastrointestinal:

□Nausea	□Vomiting	□Gas	□Acid Regurgitation
□Hiccups	□Bloating	□Bad Breath	□Diarrhea
□Constipation	□Use Laxatives	□Black Stools	□Bloody Stools
□Mucus in Stools	□Itchy Anus	□Burning Anus	□Rectal Pain
□Hemorrhoids	□Anal Fissures	□Intestinal Pain or Cramping	

Bowel Movements

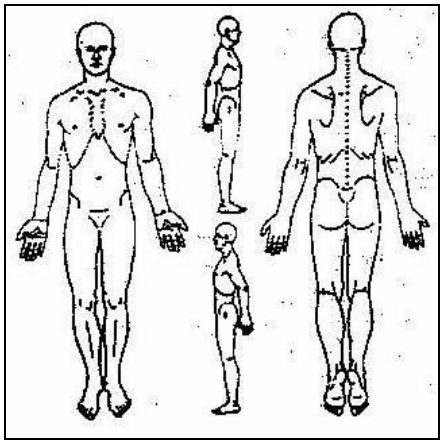
Frequency _____ Color _____

Formed or Loose _____ Strong odor: □Yes □No

Musculoskeletal

□Neck/Shoulder Pain □Upper Back Pain
□Joint Pain □Muscle Pain
□Low Back Pain □Rib Pain
□Limited Range of Motion □Sciatica
□Paralysis □Numbness

>> Mark areas of pain on the diagram >>



Skin and Hair

□Rashes □Eczema □Dandruff □Hives
□Ulcerations □Psoriasis □Itching □Acne
□Hair Loss □Fungal Infections □Change in Hair/Skin Texture
□Other: _____

Neuropsychological

□Seizures □Poor Memory □Irritability □Depression
□Easily Stressed □Anxiety □Tics □Abuse Survivor
□Seeing a Therapist □Considered or Attempted Suicide
□Other: _____

Genitourinary

□Pain on Urination □Blood in Urine □Venereal Disease □Increased Libido
□Frequent Urination □Incontinence □Bedwetting □Decreased Libido
□Urgent Urination □Kidney Stone □Wake to Urinate □Impotence
□Incomplete Urination □Other: _____

Gynecology

Age Menses Began: _____ Duration of Flow: _____

Length of Cycle: _____ Date Last Period Began: _____

Age of Menopause: _____ Date of Last PAP Exam: _____

□ Irregular Periods □ Vaginal Sores □ Breast Lumps
□ Painful Periods □ Vaginal Odors □ # pregnancies_____
□ Clots □ Vaginal Discharge □ # live births_____
□ PMS color_____ □ # abortions_____
□ Breast Self Exam □ # premature births_____
□ Other: _____

Is there anything else that you feel we should know relevant to your condition(s)?

_____
_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on myself (or on the patient named below, for whom I am legally responsible) by licensed acupuncturists who now or in the future treats me while employed by, working or associated with Robert N. Fueston or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to instructions provided orally and in writing.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling site that may last a few days. Bruising is a common side effect of cupping. Burns and/or scarring are a potential risk of moxibustion and cupping. The clinic uses sterile disposable needles and maintains a clean and safe environment. I understand while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain risks and complications of treatment, and I wish to rely on the clinical staff to exercise appropriate clinical judgement during the course of treatment. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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

(Date)

PATIENT SIGNATURE

(Or Patient Representative) (Indicate relationship if signing for patient)

Cancellation Policy

When an appointment is made, a certain amount of time is reserved for just you! We do what we can to be here when you need us, and we kindly ask that you be here when expected. Inner Balance Acupuncture has instituted a policy in order to reduce the number of no-show or missed appointments.

Since the clinic is normally booked two weeks in advance, **we require 24 hours notice for cancellation of any appointment** that you cannot attend. When patients cancel at the last minute or do not show up, another patient is denied the chance of treatment and the cost of clinical operations goes up.

We understand that things come up. If you have an emergency due to illness, car trouble, etc., we ask that you reschedule and show up for that treatment to avoid it being counted as a missed appointment.

The second cancelation of an appointment with less than 24 hours notice will result in a $15 cancelation fee being charged and donated to Lexington Public Library. After a third last minute cancelation, you will be asked to pre-pay for any future appointments.

If you are calling after hours, **please leave a message**. Our voicemail will document the time and day you called.

Thank you for understanding.

I have been made aware of the 24-hour notice cancellation policy.

_____

Patient's Signature

_____

Date