Find Your Balance Acupuncture

303.915.1698
BalanceAcupuncture@yahoo.com
3393 Iris Ave Suite 109
Boulder, CO 80301

PATIENT INFORMATION *All Information Will Remain Confidential*

Name: _____ Phone: _____ (home)

Address: _____ _____ (work)

_____ _____ (mobile)

DOB: Mo _____ Day _____ Yr _____ Email: _____

Weight: _____ lbs Sex: ❒ Female ❒ Male

Height: _____ ft _____ in Age: _____

Occupation: _____ Referred By: _____

Have you ever been treated with: ❒ Acupuncture ❒ Herbs

Primary Care Physician: _____

Emergency Contact (relation): Phone:

REASON FOR TREATMENT

Primary reason for seeking treatment? _____

When did the problem begin? _____ Have you had this in the Past? ❒ yes ❒ no

What makes the problem better? _____

What makes the problem worse? _____

What diagnosis have you been given by a medical doctor? _____

What kinds of treatment (medications, etc.) have you tried and did they help? _____

Other conditions to address?

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LIST OF PRESCRIPTION DRUGS, MEDICATIONS, HERBS OR SUPPLEMENTS

Drug	Reason you are taking this drug?
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	

MEDICAL HISTORY

How would you describe your health as a child? _____

Have you had any surgeries? Date

Do you use tobacco? ❒ yes ❒ no How much? _____

Are you interested in quitting smoking? ❒ yes ❒ no

Do you use caffeine? ❒ yes ❒ no How much?

Do you drink alcohol? ❒ yes ❒ no How much?

Do you have any allergies to medications or sensitivities?

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MEDICAL HISTORY (CONTINUED)

Please check any illnesses or conditions you have or have had in the past and explain on next page:

❒ Allergies	❒ Cancer	❒ Heart Disease
❒ Alcoholism	❒ Diabetes (type?)	❒ Pace Maker
❒ Hepatitis	❒ Pneumonia	❒ Asthma
❒ HIV/AIDS	❒ Mental Disorder	❒ Panic Attacks
❒ Bleeding Easily	❒ Glaucoma	❒ High Fever
❒ Stroke	❒ Jaundice	❒ Kidney Disease
❒ Multiple Sclerosis	❒ Thyroid Disorder	❒ Tuberculosis
❒ Ulcers	❒ Vascular Disease	❒ Venereal Disease
❒ Hypertension	❒ Weight Loss	❒ Weight Gain
❒ Chronic Fatigue	❒ Epilepsy	❒ Chicken Pox
❒ Endocrine Disorder	❒ Goiter	❒ Gout
❒ Unexplained Rashes	❒ Arteriosclerosis	❒ Herpes (type?)
❒ Eczema	❒ High Blood Pressure	❒ Psoriasis
❒ Mumps	❒ Scarlet Fever	❒ Typhoid Fever
❒ Polio	❒ Pleurisy	❒ Rheumatic Fever
❒ Stomach Ulcers	❒ Whooping Cough	
❒ Chronic Childhood Illnesses		

❒ Other _____

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MEDICAL HISTORY (CONTINUED)

Explanation of Past Illness (include dates):

FAMILY MEDICAL HISTORY

Please check any illnesses or conditions that are present in your family history:

- ❒ High/Low Blood Pressure Family Member(s):
- ❒ Asthma Family Member(s):
- ❒ Mental Illness Family Member(s):
- ❒ Alcoholism Family Member(s):
- ❒ Seizures Family Member(s):
- ❒ Allergies Family Member(s):
- ❒ Stroke Family Member(s):
- ❒ Cancer (type?) Family Member(s):
- ❒ Diabetes (type?) Family Member(s):
- ❒ Heart Disease Family Member(s):
- ❒ Thyroid Disease Family Member(s):

I have answered the questions on this form to the best of my ability and consent to treatment.

Patient signature _____ Date _____

Consent to treat a minor (patient name) _____