



PATIENT INFORMATION

Name

Occupation

Street

Employer Name

City, State, and Zip

Employer Address

Male Female

Contact in case of emergency:

Date of Birth

Name

Cell Phone

Relationship to you

Other Phone (please specify)

Phone

Email

How would you prefer to be contacted for appointment reminders? email / phone

How did you hear about Balanced Health? *(if referred, please tell us by whom)*

I understand that Balanced Health Management, Inc. has a 24-hour cancellation policy. If I do not cancel my appointment by phone within 24 hours, I will be charged a \$50.00 No Show fee.

Signature and date



NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Balanced Health is very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health conditions.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your treatment and services.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your treatment and services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Balanced Health has a more detailed notice on file that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call at any time for a copy of our privacy notices.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. If we do agree, we will comply with your request unless the information is needed to provide your emergency treatment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must in writing. We will not be able to honor revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read this notice and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Signature of Patient or Authorized Personal Representative

Date

Printed Name



Patient Name _____

Date _____

HEALTH HISTORY QUESTIONNAIRE

All information is strictly confidential.

Have you ever been treated by Acupuncture or Oriental Medicine before? Yes No

Main Conditions you would like us to help you with, in order of significance:

- 1.
- 2.
- 3.

How long ago did these problem(s) begin? Please be specific:

To what extent do these problems affect your daily activities?

Type of activities	To what extent										
	Never										Significantly
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10

Please list all medications taken in the last 3 months (including drugs, vitamins and herbs):

Occupational Stress (chemical, physical, psychological, etc.):

Medical History:

Surgical History:

Do you have a regular exercise program? Y/N If yes, describe:

Are you on a restricted diet? Y/N If yes, describe:

Do you smoke? Y/N If yes, how many cigarettes per day?

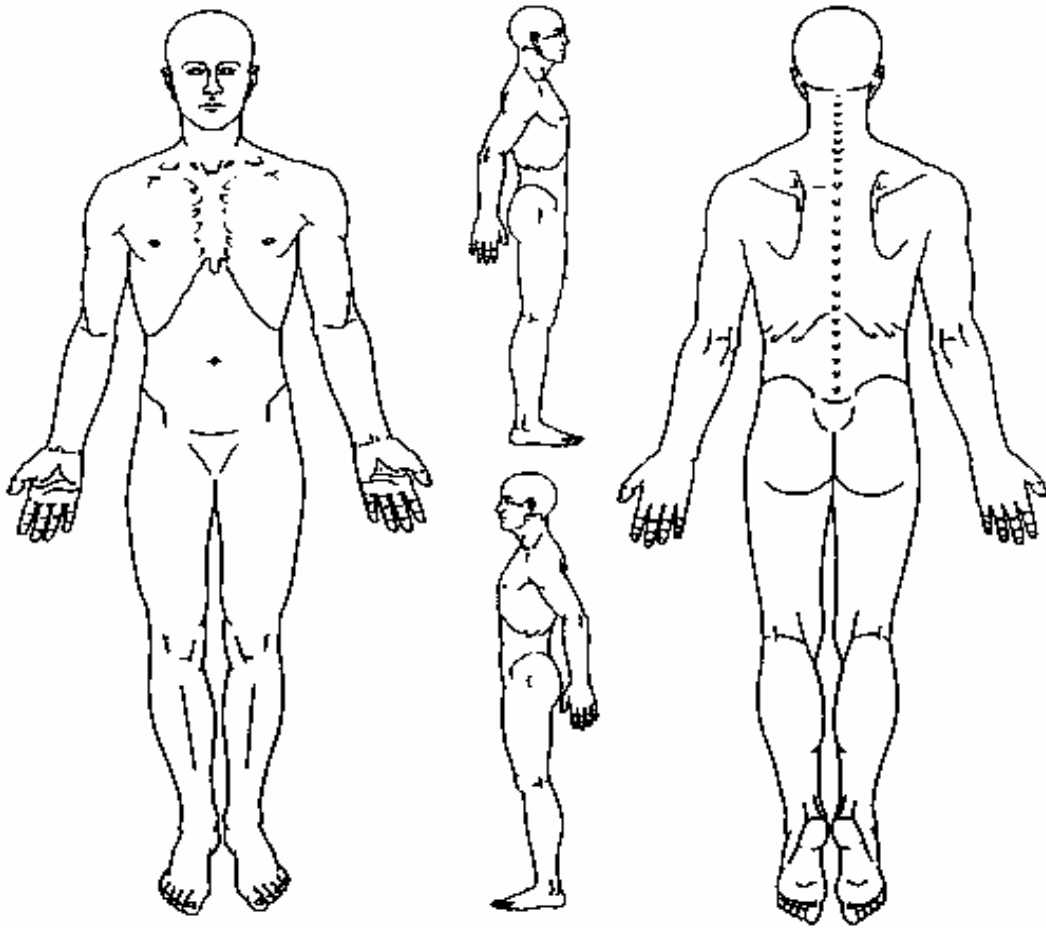
Do you drink alcohol? Y/N if yes, how much per week?

How many caffeinated drinks do you drink per week (coffee, tea, soda)?

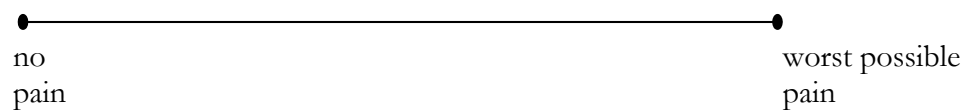
How much water do you drink daily?

Please indicate areas where you experience pain, using the body outlines below. Please mark the quality of the pain, using the suggested code letters, or other indicators you prefer.

A = ache
B = burning
N = numbness
P = pins and needles
S = sharp/stabbing
X = other



Please mark your level of pain anywhere on the line below:





Patient Name _____

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Please check the following that pertain to you:

Overall Temperature:

- Hot body temperature or sensation
- Cold hands
- Sweaty hands
- Afternoon flushes
- Cold body temperature or sensation
- Cold feet
- Sweaty feet
- Night sweats
- Heat in the hands, feet or chest
- Hot flashes at any time of the day
- Lack of perspiration
- Perspire easily
- Thirsty: for hot or cold drinks

Overall Energy:

- Difficulty keeping eyes open in the daytime
- Shortness of breath
- General weakness
- Easily catch colds
- Low energy
- Feel worse after exercise

Heart:

- Cardiovascular disease
- High blood pressure
- Low blood pressure
- Chest pain
- Fainting
- Palpitations
- Sores on tip of tongue
- Restlessness
- Anxiety
- Hard to fall asleep
- Wake unrefreshed
- Nightmares
- Restless sleep
- Mental confusion
- Restless dreaming
- Waking during the night
- Chest pain traveling to shoulders or down arms

Lung:

- Profuse nasal discharge: thin/clear/runny thick/white thick/yellow
- Cough: Wet or Dry
- Nose Bleeds
- Sinus Congestion
- Dry mouth
- Dry, itchy throat
- Sore throat
- Dry skin
- Allergies: to what?
- Sneezing
- Hives
- Stiff neck
- Stiff shoulders
- Bronchitis
- Rashes
- Itching
- Eczema
- Dandruff
- Sadness
- Melancholy
- Smoke cigarettes
- Alternating fever and chills
- Achy feeling in the body
- Difficulty inhale or exhale

Spleen/Stomach:

- Low appetite
- Changes in appetite
- Cravings, for what?
- Abrupt weight gain
- Abrupt weight loss
- Abdominal bloating
- Abdominal gas
- Stomach gurgling
- Fatigue after eating
- Easily bruised
- Hemorrhoids
- Pensive/Over-thinking
- Worry
- Prolapsed organs: which organ?
- Loose Stools
- Incomplete bowel movements
- Constipation
- Diarrhea
- Blood in Stools
- Undigested food in stools
- Mucous in stools
- Black or tarry stools
- Chronic use of laxatives: what type of laxative?
- General sensation of heaviness in body
- Mental heaviness
- Mental sluggishness
- Mental fogginess
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring
- Dizziness

- Snoring
- Phlegm production
- Burning sensation after eating
- Large appetite
- Bad breath
- Vomiting
- Sores on lips, tongue or mouth
- Ulcer (if diagnosed)
- Belching
- Acid regurgitation
- Cold sensation in stomach
- Hiccoughs/hiccups
- Stomach pain
- Heartburn
- Bleeding, swollen or painful gums

Liver and Gallbladder:

- Chest pains
- Tight sensation in chest
- Bitter taste in mouth
- Anger easily
- Frustration
- Depression

Balanced Health Management, Inc. – 30 Chauncy Street – Boston, MA 02111

617-542-8500

www.lifeneedsbalance.com



Patient Name _____

Date _____

- Irritability Skin rashes Tingling sensations
- Numbness Muscle spasms Muscle twitching
- Muscle cramping Seizures Convulsions
- Lump in throat Teeth grinding Alternating diarrhea and constipation
- Neck tension Shoulder tension Hip pain/sciatica
- Drink alcohol Recreational drugs (which, how much per week?)
- High pitch ringing in the ears Gallstones, history of or currently
- Sexually transmitted diseases (which) Genital sores
- Frequently unable to adapt to stress (what causes this stress?)
- Headaches: How often? Describe location:
- Migraines

Eyes:

- Itchy Red or bloodshot Hot Dry
- Watery Gritty or sandy feeling Blurry vision Decreased night vision
- Near-sighted Far-sighted Cataracts Visual Disturbances

Kidney:

- Frequent cavities Easily Broken Bones Poor hearing Earaches
- Painful knees Weak knees Cold in knees Low back pain
- Memory problems Excessive hair loss Pre-mature grey hair Low-pitch ringing in the ears
- Kidney stones Bladder infections Fear Easily startled
- Foot or ankle weakness or pain Lack bladder control Sneeze or jump incontinence

How many times per day do you urinate?

Do you wake during the night to urinate? How many times per night?

- Normal color urine Dark yellow Clear Reddish
- Cloudy Scanty Profuse Strong Odor
- Burning Painful Difficult Urgent

Libido:

- Normal High Low

Women only:

Do you practice birth control? What type and for how long?

Pregnant? _Y_ N Is there a chance you may be pregnant now?

Vaginal discharge: Frequent? Color? Odor?

Regular menstrual cycle? _Y_ N

Number of children: _____ Number of pregnancies: _____

Age of first menstruation: _____ Age of menopause (if applicable): _____

Average number of days of flow: _____ Average number of days of entire cycle: _____

Uterine bleeding/spotting between periods? _Y_ N How much and how often?

Do you experience any of the following pre-menstrual syndromes?

- Nausea Vomiting Water retention Breast swelling
- Food cravings Headaches Migraines Breast tenderness
- Depression Irritability Anxiety Other emotions: _____
- Dull pain, where? _____ Sharp pain, where? _____

Men only:

- Swollen testes Testicular pain Impotence Premature ejaculation
- Feeling of coldness or numbness in external genitalia Other _____

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I, _____, hereby do authorize Jessica Shaw, MAOM, Lic.Ac., or Susan Shaver, MAOM, Lic.Ac., of Balanced Health Management, Inc. to administer any style of Oriental Medicine relevant to my diagnosis and treatment, included but not limited to the following:

1. Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
2. Heat treatments including *Artemesia vulgaris* (moxibustion, or moxa) or a conventional heat lamp may be placed on or near any part of my body. For indirect moxibustion treatments, the moxa is placed on the head of the needle or on top of a barrier, such as a slice of ginger or slat, which rests on the skin. When direct moxa is used, the moxa is placed directly on the skin. The heat generated from moxa treatments may involve slight discomfort or leave a small blister or scar on the skin. With any type of heat, there is a risk of burn.
3. Electrical stimulation of the needles may be used, which produces a vibration-tapping sensation on the needles. Ion pumping cords may be attached to the needles.
4. Cupping and/or Gua Sha may be used to promote the circulation of Qi (energy) through the meridians. These therapies may produce red/purple marks on the area treated, which may remain for 1 to 5 days.
5. Micro-bleeding of acupoints, alone or in conjunction with cupping, may be used to improve the circulation in specific meridians. Pre-sterilized lancets are inserted into the skin and small amounts of blood are expressed at the puncture.

I have read this consent form. I have been informed that I have a right to refuse any form of treatment, have been informed of the risks and possible consequences involved with this treatment, and have been given an opportunity to ask questions pertaining to my treatment. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

Signature

Printed Name

Date