Acupuncture Intake Form

Name: _____ Date of Birth: ___/____/____Height: _____ Weight:_____

Referring Doctor:_____ Primary Care Physician_____

What is your reason for seeking care? _____

How did you find Balance Chicago? _____

When did the problem begin? _____

Have you seen a doctor or been hospitalized for your condition in the past year? □ Yes □ No

Have you had any surgeries? □ Yes □ No If yes, what & when? _____

Is your injury the result of a fall? □ Yes □ No Have you fallen in the last 12 months? □ **Yes** □ **No**
If yes, how many falls?_____

Do you have pain? □ Yes □ No
Where is the pain located? _____
What makes it better? _____
What makes it worse? _____

On a scale of 1-10 please describe your stress level (1 = none, 10 = extreme) Work: _____ Personal: _____

On a scale of poor, good, excellent, describe your: Diet: _____ Exercise: _____ Sleep: _____ Health: _____

Energy Level: very low- 1 2 3 4 5 6 7 8 9 10 - maximum

Consent For Traditional Mode of Treatment

I hereby authorize the acupuncturist of Balance Chicago, to perform the following specific procedures:

Acupuncture - The insertion of special sterilized needles through the skin into the underlying tissues at specific points on the surface of the body.
Cupping - A technique to relieve symptoms with cups made of glass, bamboo, or other materials put on the skin with a vacuum created by using heat or other devices.
Gua Sha - A rubbing of an area of the body with a blunt, round instrument.
Moxa - The indirect burning of an acupoint using a stick, string, or ball moxa to relieve symptoms.
Tuina - An ancient massage technique used to treat a wide variety of common disharmonies.

I recognize the potential risks and benefits of this procedure as described below:

Potential Risks - Discomfort, pain, infection and blistering at the site of procedure, temporary discoloration of skin and even aggravation of existing symptoms.
Potential Benefits - Drugless relief of presenting symptoms and improved balance of bodily energies which may lead to prevention and elimination of presenting problems.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Balance Chicago or any of its personnel regarding cure or improvement of my condition.
I hereby release Dr. Christopher Haslett from any and all liabilities which may occur in connection with the above procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in this procedure at any time.

Patient's Signature: _____ **Date:** _____

BALANCE CHICAGO

To Be Completed by Acupuncturist

Headache, Dizziness
_____

Temperature (Hot / Cold; Fever / Chills; Thirst):
_____

Perspiration:
_____

Appetite (Lack / Excess Appetite; Unusual Taste):
_____

Digestion (Heartburn, Belching, Gas, Bloating):
_____

Bowel Movements (Hard / Unformed; Dry / Watery):
_____

Urination:
_____

Eyes: _____ Nose:
_____

Ears: _____ Mouth, Lips, Throat:
_____

Chest / Abdomen:
_____

Sleep: # of Hours _____ Dream-Disturbed: _____

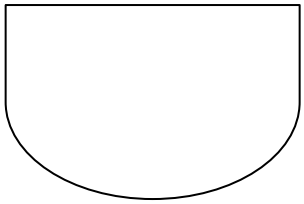
Sexual Function: _____

Menstruation: Irregular: _____ Clots: _____ Breast Distention: _____ Length of Cycle: _____

Emotions: _____ Others: _____

Observation:

Facial Color: _____ Tongue:
_____



Posture: _____
_____

Palpation: _____ Underside Veins _____

BALANCE CHICAGO

Pulse: R - _____ L - _____ Points: _____

Others: _____

DIAGNOSIS:

_____

TX PRINCIPLE:

_____

POINTS:

_____

Supplements:

_____

_____

_____

_____

ACUPUNCTURIST SIGNATURE (Dr. Christopher Haslett):_____