Inner Balance Acupuncture
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Patient Information

Name:_______________________________________ Today's date:____________

Age:_________ ☐Male ☐Female Marital status:____________

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

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

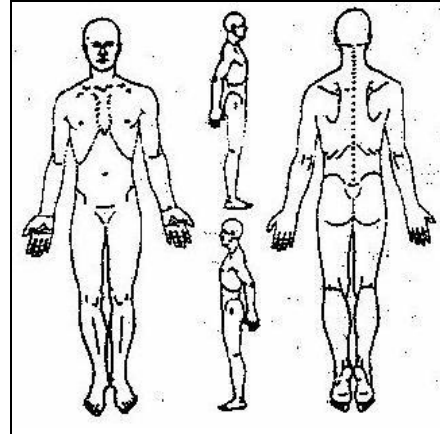
Frequency ____________________ Color ________________________

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)?
____
____