Balancing Point
ACUPUNCTURE LLC
The Point is Health...
Your Health

Linda L. Scott, LAc, Dipl OM
3048 E. Baseline, Suite 115
Mesa, AZ 85204 Ph480-204-5395
www.BalancingPointAcupuncture.com

Confidential Patient Information Sheet

Patient Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell _____

Email _____

Would you like to receive a free email newsletter? (your email information is held in complete confidence) ☐ Yes ☐ No

Height _____ Weight _____ Age _____ Sex: ☐ Male ☐ Female Date of birth _____

Marital Status: _____

Number of children: _____ Ages of children: _____ Number who live with you: _____

Occupation _____ Employer _____

In emergency notify (name): _____ Emergency phone number: _____

Primary Care Doctor _____ Last seen: _____

How did you hear about Balancing Point Acupuncture: ☐ Yellow Pages ☐ Article ☐ Brochure ☐ Business Card

☐ Web site ☐ A talk ☐ Referred by: _____

Medical History

Have you had acupuncture before? ◦ Yes ◦ No Name of Acupuncturist: _____

Reason for your visit here today: _____

_____

Are you being treated for this condition by anyone else: ☐ Yes ☐ No

If Yes, who? _____ Phone Number _____

Has this condition been diagnosed by a MD? ☐ Yes (Diagnosis: _____) ☐ No

Have these treatments helped? ☐ Yes ☐ Somewhat ☐ Not much ☐ Not at all

How does this condition affect you? _____

How long have you had this condition? _____

Do you currently have any infectious diseases? ☐ Yes ☐ No ☐ Possibly If Yes, please identify: ☐ HIV+ ☐ HepatitisB

☐ Hepatitis C ☐ Flu / Cold ☐ Streptococcus ☐ Mononucleosis ☐ Tuberculosis ☐ Other: _____

Known or suspected allergies: _____

Accidents / Hospitalizations / Surgeries in the past 10 years:

Reason Date / Year(s)

_____

_____

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Health Inventory

Cardiovascular
- Heart Disease
- A Pacemaker
- High Blood Pressure
- Low Blood Pressure
- Chest Pain
- Palpitations
- Stroke
- Varicose Veins
- Edema

Emotional / Mental:
- Clinical Depression
- Mild Depression
- ADD or ADHD
- Schizophrenia
- Mood Swings
- Panic Attacks
- Nervousness
- Anxiety
- Alzheimer's
- Dementia

Energy & Immunity:
- Chronic Fatigue Syndrome
- General Fatigue
- Slow Wound Healing
- Easy Bruising
- Chronic Infections
- Frequent Allergies

Respiratory:
- Pneumonia
- Asthma
- Frequent Common Colds
- Emphysema
- Persistent Cough
- Pleurisy
- Tuberculosis
- Shortness of Breath

Musculo-Skeletal:
- Neck / Shoulder Pain
- Muscle Spasms / Cramps
- Arm Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Leg Pain
- Osteoporosis
- Arthritis
- Joint Pain

Head, Eye, Ear, Nose & Throat:
- Impaired Vision
- Eye Pain/Strain
- Glaucoma
- Glasses / Contacts
- Tearing / Dryness
- Impaired Hearing
- Ear Ringing
- Earaches
- Ear Infections
- Headaches
- Sinus Problems
- Nose Bleeds
- Teeth Grinding
- Sore Throats
- TMJ / Jaw Problems
- Hay Fever

Genito-Urinary Tract:
- Kidney Disease
- Kidney Stones
- Painful Urination
- Dribbling Urination
- Frequent UTI
- Frequent Urination
- Blood in Urine
- Discharge
- Incontinence

Neurological:
- Vertigo / Dizziness
- Paralysis
- Numbness / Tingling
- Loss of Balance
- Seizures / Epilepsy
- Dyslexia

Gastrointestinal:
- Stomach Ulcers
- Changes in Appetite
- Nausea / Vomiting
- Epigastric / Abdominal Pain
- Passing Gas
- Heart Burn
- Belching
- Gall Bladder Disease
- Gall Bladder Stones
- Hemorrhoids
- Constipation
- Diarrhea

Endocrine:
- Hypothyroid
- Hyperthyroid
- Diabetes Type I
- Diabetes Type II
- Night Sweats
- Unusual Sweating
- Feeling Hot or Cold
- Cold Hands / Feet

Other:
- Cancer
- Fibromyalgia
- Lupus
- Candida
- Anemia
- Rashes
- Eczema / Hives
- Other _____

Liver Conditions:
- Hepatitis A
- Hepatitis B
- Hepatitis C

Men Only:
- Impotence
- Prostate problems
- Testicular Pain / Redness / Swelling
- Low libido
- Excessive libido
- Painful Intercourse
- Seminal emissions

Women Only:

Are you pregnant right now? ☐ Yes ☐ No ☐ Trying ☐ Maybe Method of Birth Control:_____

Age at first period: _____ Date of last menses: _____ Age at menopause: _____

Typical length of menses (days): _____ Typical length of cycle (from 1st day to 1st day of menses): _____

Number of: Pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____

Check all that apply: ☐ Low libido ☐ Excessive libido ☐ Painful Intercourse ☐ Clotting ☐ Painful Periods
☐ Heavy Flow ☐ Scanty Flow ☐ Bleeding Between Cycles ☐ Irregular Cycles ☐ Vaginal Discharge
☐ Breast Lumps / Tenderness ☐ Nipple Discharge ☐ Infertility ☐ Menopausal Symptoms ☐ Premenstrual Problems
☐ Endometriosous ☐ Fibroids ☐ Ovarian Cysts ☐ Abnormal Pap Smear

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Medications

Please list all prescription and over the counter medications you are currently taking:

Drug/Supplement	Reason for taking	For how long	Dose	Frequency

I am taking Coumadin/ Warfarin ☐ Yes ☐ No

I have a pacemaker ☐ Yes ☐ No

Lifestyle

(Daily amount used within the past 2 months)

Tobacco: ☐ Yes ☐ No Amount: _____ Alcohol: ☐ Yes ☐ No Amount: _____

Coffee: ☐ Yes ☐ No Amount: _____ Recreational Drugs: ☐ Yes ☐ No Amount: _____

Daily Water intake: _____ Daily Soda Intake: _____

Are you vegetarian or vegan? ☐ Yes ☐ No

Hours of sleep / night_____

How would you rate the following areas of your health in the past Month:

Energy: ☐ Great ☐ Good ☐ Fair ☐ Poor Comments:_____

Digestion: ☐ Great ☐ Good ☐ Fair ☐ Poor Comments:_____

Urination: ☐ Great ☐ Good ☐ Fair ☐ Poor Comments:_____

Sleep: ☐ Great ☐ Good ☐ Fair ☐ Poor Comments:_____

Appetite: ☐ Great ☐ Good ☐ Fair ☐ Poor Comments:_____

TypicalDay's Meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks / Other: _____

Food cravings: _____

Hobbies or other recreation: _____

Physical exercise you do regularly: _____

Hours of television watched per week: _____ Hours of work per week? _____

Highest level of education completed? ☐ High School ☐ Bachelors ☐ Masters ☐ Doctorate ☐ Other

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Emotions/Relationships

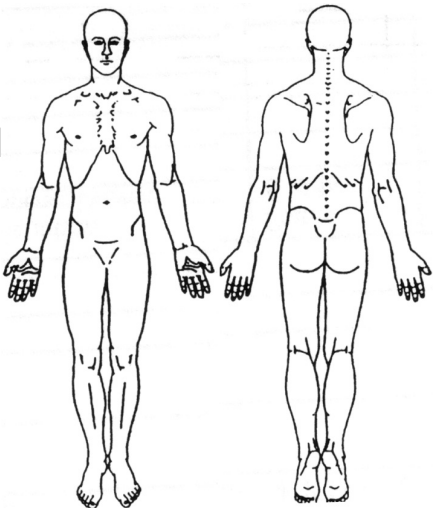
Number of biological Brothers: _____ Sisters: _____ Birth order sequence #_____Were you adopted? ☐ Yes ☐ No
Did you feel safe and nurtured as a child? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

What would you characterize as your predominate emotion right now? ☐ Anxiety / Worry ☐ Anger ☐ Grief
☐ Fear / Dread ☐ Depression ☐ Happiness ☐ Contentment ☐ Joy ☐ Numbness/Apathy ☐ Other:_____

How would you rate your current stress level? ☐ Extreme ☐ Very High ☐ High ☐ Moderate ☐ Low

Pain

Please answer the following questions if you have pain.
Indicate on the diagram on the left areas of pain:



Quality of pain: ☐ Dull ☐ Sharp ☐ Stabbing ☐ Sore ☐ Cramping ☐ Burning
☐ Constant ☐ Fixed ☐ Moves about

How strong is your pain? (please circle one number below)

☺ 1 2 3 4 5 6 7 8 9 10 ☹
Least Pain **Most Pain**

Does the pain radiate? ☐ Yes ☐ No Where?_____
What helps the pain? ☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Pressure
☐ Moisture ☐ Massage ☐ Nothing
What aggravates the pain? ☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Pressure
☐ Moisture ☐ Massage ☐ Nothing

Do any medications help your pain?_____
Other treatments you have had for your pain?_____
Describe the onset of your pain:_____
_____
Anything you wish to add:_____
_____

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Balancing Point Acupuncture 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

X Signed: _____ Date: _____

Parent / Guardian (if applicable) _____

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Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture, Chinese medicinal herbs and Oriental medicine by Linda Scott, a Licensed Acupuncturist at Balancing Point Acupuncture. I understand that acupuncturists practicing in the state of Arizona are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

***Initial here*_____ Acupuncture / Moxibustion:** I understand that acupuncture is performed by the insertion of single use sterile needles through the skin, application of low intensity laser light on the skin or by the application of heat to the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture and Moxibustion are typically safe methods of treatment, however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop the acupuncture treatment at any time.

***Initial here*_____ Pregnancy:** I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

Initial here*_____ Direct Moxibustion:** I understand that if I receive direct moxibustion as part of therapy, ***there will likely be burning or scarring the skin from its use. In fact, burning and scarring may even be a part of the therapeutic action, and may be intentional, on the part of the practitioner. I understand that I may refuse this therapy.

***Initial here*_____ Chinese Herbs:** I understand that Chinese medicinal herbs may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, nausea & vomiting, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call Balancing Point Acupuncture as soon as possible.

***Initial here*_____ Acupressure / Tui-Na:** I understand that I may also be given acupressure / tui-na as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

Initial here*_____ Cupping / Gua Sha:** I understand that I may also be given cupping (the application of glass cups with vacuum to the skin) and Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. ***I am aware that these treatments are intended to cause minor bruising and though unsightly are not normally painful. However certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

***Initial here*_____ Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I do not expect Linda Scott or Balancing Point Acupuncture, LLC staff to be able to anticipate and explain all possible risks and complications of treatment. I have carefully read and understand all the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent (unless in an emergency or by legal demand). I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____