Inner Balance Acupuncture

Acupuncture *Energy Work *Herbal Medicine
www.annahurtado.com

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New Patient Information

Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

Patient Name______________________________________ Date of Birth______________ Age_________

Address (street)_____________________________(city) ________________(state)______(zip)________

Phone______________________ Email ___________________________________ Gender: M ❑ F ❑

Emergency Contact ____________________________________ Phone ____________________________

Occupation___________________________ Referred By____

Have you ever received Acupuncture before: Yes ❑ No ❑

Have you ever used Chinese Herbal Medicine before: Yes ❑ No ❑

What is the primary reason for this visit:____

Diagnosis:______________________________ How long have you had this condition:_______________

Have you tried any other treatments: ____

What makes it better: _______________________ What makes it worse: __________________________

Is there anything else you would like to address: ____

____

Height________ Weight________ Are you pregnant: Yes ❑ No ❑ Do you have a pacemaker: Yes ❑ No ❑

Are you taking blood thinners: Yes ❑ No ❑ Please list any allergies: ___________________________

Hospitalizations/Surgeries:____

Injuries (type/date): ____

Patient Medical History

Please indicate whether YOU have had any of the following:

❑ AIDS/HIV	❑ Diabetes	❑ High Blood Pressure	❑ MS	❑ Stress
❑ Alcoholism	❑ Epilepsy	❑ High Cholesterol	❑ Mumps	❑ Stroke
❑ Addiction	❑ Eating Disorder	❑ IBS	❑ Obesity	❑ Trauma
❑ Allergies	❑ Emotional Eating	❑ Jaundice	❑ Pneumonia	❑ Thyroid Dz
❑ Asthma	❑ Glaucoma	❑ Kidney Disease	❑ Seizures	❑ Trauma
❑ Cancer	❑ Heart Disease	❑ Meningitis	❑ STDs	❑ Vascular Dz
❑ Colitis	❑ Hepatitis	❑ Migraines	❑ Psychological/Emotional Dz.	

Family Medical History

Please indicate whether a BLOOD RELATIVE has had any of the following:

❑ Alcoholism	❑ Asthma	❑ Heart Disease	❑ Seizures	❑ ____________________
❑ Allergies	❑ Cancer	❑ High Blood Pressure	❑ Stoke	❑ ____________________

Dietary Information

Please indicate what you eat on a regular basis:

❑ Fruit	❑ Vegetables	❑ Meat	❑ Sweets
❑ Grains	❑ Soy	❑ Fish	❑ Fast Food
❑ Bread/Pasta	❑ Nuts	❑ Dairy	❑ Junk Food
❑ Potatoes	❑ Seaweed	❑ Eggs	❑ Fried Foods

Medications/Vitamins/Herbs

Medication/Supplement	Reason for Taking	Dosage	Notes

Informed Consent

I hereby request and consent to the performance of acupuncture treatments and other procedures by ANNA HURTADO, L.Ac. I understand that treatments may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, tui-na, herbal medicine, and nutritional counseling. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. By voluntarily signing below, I show that I have read the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

PATIENT SIGNATURE: **DATE:**

Consent to Treatment of Minor

By my signature below, I hereby authorize ANNA HURTADO, L.Ac., to perform acupuncture to my child or dependent as she deems necessary.

SIGNATURE OF PARENT/GUARDIAN: **DATE:**

Review of Systems

General:

❏ Fatigue	❏ Runs warm	❏ Sweating	❏ Can't fall asleep	❏ Disturbing dreams
❏ Hyperactive	❏ Runs cold	❏ Body Odor	❏ Can't stay asleep	❏ Hard to wake up

Skin/Hair/Nails:

❏ Hives	❏ Acne	❏ Facial redness	❏ Excess hair growth	❏ Fungal infection
❏ Eczema	❏ Dry skin	❏ Paleness	❏ Hair loss	❏ Sores
❏ Psoriasis	❏ Oily skin	❏ Redness	❏ Dandruff	❏ Itchy Skin

Head/Eyes/Ears/Nose/Throat/Respiratory:

❏ Eye disease	❏ Allergies	❏ Sensitive teeth	❏ Frequent colds	❏ Ringing in the ears
❏ Eye pain	❏ Migraines	❏ Grinding teeth	❏ Shortness of breath	❏ Ear infections
❏ Eye strain	❏ Headaches	❏ Bleeding gums	❏ Chronic cough	❏ Ear discharge
❏ Red eyes	❏ Sinus pain	❏ Toothache	❏ Phlegm	❏ Hearing loss
❏ Itchy eyes	❏ Nasal congestion	❏ Dry throat/mouth	❏ Wheezing/Asthma	❏ Shallow breathing
❏ Watery eyes	❏ Sneezing	❏ Itchy/sore throat	❏ Dizziness	❏ Rapid breathing
❏ Poor vision	❏ Runny nose	❏ Dry/cracked lips	❏ Vertigo	❏ Painful breathing
❏ Floaters	❏ Nose bleeds	❏ Cold sores/ulcers	❏ Lightheaded	❏ Sleep apnea

Cardiovascular:

❏ Chest pain	❏ Irregular heart beat	❏ HBP	❏ Cardiomyopathy	❏ Edema/swelling
❏ Varicose veins	❏ Palpitations	❏ Low Blood Pressure	❏ Atherosclerosis	❏ Cold hands/feet

Gastrointestinal:

				Bowel Movements:
❏ Nausea	❏ Foul breath	❏ Gurgling sounds	❏ Foul odor stool	Frequency: ___________
❏ Vomiting	❏ Hiccups/burping	❏ Stomachache	❏ Bloody stool	❏ Well-formed
❏ Diarrhea	❏ Heartburn	❏ Intestinal pain	❏ Black/tarry stool	❏ Sticky
❏ Constipation	❏ Excessive appetite	❏ Rectal pain	❏ Mucus in stool	❏ Loose stool
❏ Gas/bloating	❏ Low appetite	❏ Hemorrhoids	❏ Watery stool	❏ Dry/hard to pass

Genitourinary:

❏ Urgent urination	❏ Burning urination	❏ Blood in urine	❏ Kidney stones	❏ Excessive libido
❏ Freq. urination	❏ Painful urination	❏ Cloudy urine	❏ UTI's	❏ Low libido
❏ Scanty urination	❏ Incomplete urin.	❏ Dark urine	❏ Genital Itching	❏ Painful intercourse
❏ Excessive urination	❏ Wake up to urinate	❏ Clear urine	❏ Impotence	❏ STDs
❏ Incontinence	❏ Discharge	❏ Bedwetting	❏ Low sperm count	

Musculoskeletal:

❏ Neck pain	❏ Arm/hand pain	❏ Muscle spasm	❏ Difficulty walking	❏ Frozen shoulder
❏ Shoulder pain	❏ Sciatica	❏ Sore muscles	❏ Arthritis	❏ Plantar fasciitis
❏ Up/mid back pain	❏ Fibromyalgia	❏ Body aches	❏ Muscle weakness	❏ Carpal tunnel
❏ Low back pain	❏ Swelling	❏ Heavy limbs	❏ Muscle cramps	❏ Pins & needles
❏ Leg/foot pain	❏ Joint pain	❏ Tendonitis	❏ Rib pain	❏ Shooting pain

Neurological:

❏ Numbness/tingling	❏ Tremors	❏ Brain injury	❏ Drooped eye	❏ Loss of coordination
❏ Paralysis	❏ Loss of balance	❏ Tics	❏ Bell's palsy	❏ Chronic fatigue
❏ Sensory problems	❏ Epilepsy/seizures	❏ Slurred speech	❏ Neuralgia	❏ Narcolepsy

Psychological:

❏ Depression	❏ Worry/anxiety	❏ Stress	❏ Forgetfulness	❏ Low self-esteem
❏ Sadness/grief	❏ Anger/frustration	❏ Irritability	❏ Fear/phobia	❏ Lack of support

Gynecology:

Age first period_________	# of pregnancies_______	❏ Irregular periods	❏ Clots	❏ Vaginal discharge
Days of flow____________	# of live births_________	❏ Painful periods	❏ Fibroids	❏ Vaginal odor
Length of cycle_________	# of miscarriages_______	❏ Heavy flow	❏ Breast lumps	❏ Vaginal dryness
Date of last period______	# of abortions__________	❏ Light flow	❏ Breast swelling	❏ Birth control
Menopause age_________		❏ Spotting	❏ Yeast infections	❏ HRT