Point of Balance
ACUPUNCTURE AND HERBAL MEDICINE

Today's Date:

Initial Intake Form

Thank you for taking the time to complete the following information that will help us assess your health needs. All information is confidential. We will be happy to answer any questions.

General Information

Name | Birthdate / / | Age | Identifying Gender

Address | City | State | Zip

Contact Phone | Marital Status

E-mail address

Would you like to receive our monthly e-newsletter with supportive health information? ☐ Yes ☐ No

Occupation | Hours per week

How did you hear about us?

Emergency Contact Information

Name | Phone | Relationship

Health History

Please describe your personal health history, including (but not limited to) allergies, arthritis, asthma, cancer, joint replacement, diabetes, epilepsy, Lyme's disease, substance abuse, stroke, thyroid disease, gender transition, etc.

Are you currently pregnant or trying to get pregnant? ☐ Y ☐ N

Are you currently under the care of any other health care provider (physician, physical therapist, etc.)? ☐ Y ☐ N

If yes, please provide the name and title of the practioner(s) and the condition being treated:

Please list all past medical conditions for which you were hospitalized and/or received surgery (and the dates):

Please list any medications, vitamins/supplements, herbs, etc. that you are currently taking. Please include condition being treated and dosage:

Name | Reason | Doseage

Current Health Concerns

Please list your health concerns in order of your priority:

1 4
2 5
3 6

What do you believe is causing your most important health concerns?

How long have you had this condition? How does it impact your quality of life?

Have you seen a physician or other health practitioner about this? ☐ Y ☐ N When?
What was the diagnosis (if any)? Describe any treatment you received and the results:

What aggravates this condition? What improves this condition?

Lifestyle Habits

Do you have a specialized diet? Check any/all that apply:

- ☐ No restrictions
- ☐ Paleo
- ☐ Keto
- ☐ Vegetarian
- ☐ Vegan
- ☐ Dairy Free
- ☐ Gluten Free
- ☐ Other

How strictly do you follow this diet?

☐ Very strict ☐ Moderate ☐ Not strict

How frequently do you consume the following substances?

Alcohol: Marijuana: Cigarettes Other

How many hours of sleep do you typically get each night?
How would you describe the quality of your sleep (difficulty falling asleep, vivid dreams, waking at night, not rested when waking, etc.)?

Do you have an exercise regimen? Please describe (what activities, frequency, intensity)

Pain and Stress

Please indicate where you experience pain and give some details:

Better with:

☐ Pressure ☐ Heat ☐ Cold ☐ Movement

Worse with:

☐ Pressure ☐ Heat ☐ Cold ☐ Movement

Pain quality:

☐ Sharp ☐ Dull ☐ Achy
☐ Fixed ☐ Comes and goes

On a scale of 1 - 10 how would you rate your typical stress level?

◉0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

No stress High stress

On a scale of 1 - 10 how would you rate your typical energy level?

◉0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Extremely low Extremely high

Symptoms

If you have had in the past, or currently experience, any of the following sympoms, please check the box:

Wood

- ☐ Depression/stress
- ☐ Headaches/migranes
- ☐ Red/dry/itchy eyes
- ☐ Vision problems/blurred vision
- ☐ Dizziness
- ☐ Gall stones
- ☐ Feeling lump in the throat
- ☐ Clenching teeth at night
- ☐ Muscle cramping/twitching
- ☐ Neck/shoulder pain/tightness
- ☐ Seizures/tremors
- ☐ Poor circulation
- ☐ Soft/brittle nails
- ☐ Bitter taste in mouth
- ☐ PMS/menstrual problems
- ☐ Tendonitis
- ☐ Pain below ribcage
- ☐ Cravings for: sour
- ☐ Tend to be irritable/angry

Water

- ☐ Urinary problems (i.e. at night)
- ☐ Bladder infection
- ☐ Incontinence
- ☐ Weakenss/pain in low back
- ☐ Osteoporosis
- ☐ Feel cold easily
- ☐ Feel hot easily
- ☐ Low or ☐ Excess sex drive
- ☐ Dark circles under eyes
- ☐ Thyroid problem
- ☐ Poor memory
- ☐ Hair loss/gray hair
- ☐ Hearing problems/Tinnitus
- ☐ Cavities
- ☐ Hot flashes/night sweats
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Cravings for: salty
- ☐ Fear

Earth

- ☐ Body heaviness
- ☐ Difficulty getting up in the AM
- ☐ Muscles feel tired
- ☐ Edema ☐ Hands ☐ Feet
- ☐ Easily bruised/bleeding
- ☐ Bad breath
- ☐ Sweetish taste in mouth
- ☐ Lack of taste
- ☐ Excess or ☐ Low appetite
- ☐ Excess or ☐ Lack of thirst
- ☐ Nausea/vomiting
- ☐ Gas/belching
- ☐ Organ prolapse (i.e. uterus)
- ☐ Chronic loose stool
- ☐ Abdominal pain
- ☐ Indigestion/heartburn
- ☐ Foggy brain
- ☐ Mouth ulcers
- ☐ Tendency to gain weight
- ☐ Cravings for: sweet
- ☐ Over-thinking/worry

Fire

- ☐ Heart palpitations
- ☐ Rapid or irregular heatbeat
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Insomnia/trouble sleeping
- ☐ Vivid dreams/nightmares
- ☐ Easily startled
- ☐ Dark urine
- ☐ Red complexion
- ☐ Cravings for: bitter
- ☐ Anxiety/nervous
- ☐ Restlessness

Metal

- ☐ Bloody cough
- ☐ Dry cough
- ☐ Chronic cough
- ☐ Nasal discharge ☐ White ☐ Yellow ☐ Green
- ☐ Post-nasal drip
- ☐ Sinus infection/congestion
- ☐ Itchy, red, or painful throat
- ☐ Dry mouth/nose/throat
- ☐ Skin rashes/hives
- ☐ Snoring
- ☐ Shortness of breath
- ☐ Allergies/asthma
- ☐ Low immunity
- ☐ Catches colds easily
- ☐ Bronchitis
- ☐ Black or bloody stool
- ☐ Constipation
- ☐ IBS
- ☐ Diarrhea
- ☐ Colitis/spastic colon
- ☐ Cravings for: pungent/spicy
- ☐ Grief/sadness

Mandatory Disclosure Form

Education and Experience

Natalie Franciose earned her Master of Science Degree in Traditional Chinese Medicine degree from Colorado School of Traditional Chinese Medicine in August 2015. This three-year program consists of 2,850 hours of education including 1,000 hours of clinical practice. Natalie's training includes adjunctive therapies such as moxibustion, tui na (physiotherapy/therapeutic massage), acupressure, cupping, auriculotherapy, qi gong/tai qi, internal medicine (Chinese herbal medicine), nutritional dietary and lifestyle recommendations. Natalie's undergraduate Bachelor of Science degree was earned in 2008 from Radford University, majoring in Biology with a minor in Chemistry.

Natalie is certified as a Diplomat in Acupuncture and Traditional Chinese Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in August 2015. This includes certification in Clean Needle Technique and Chinese Herbology. She is a licensed acupuncturist in Colorado. None of these licenses, certificates, or registrations has ever been suspended or revoked.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule

Intake Consultation and Treatment	$125 (90m) + cost of herbs
Follow-Up Treatment	$100 (90m) or $75 (60m) + cost of herbs
Herbal or Dietary Consultation Only	$60

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202; (303) 894-7800.

I have read and understand this document.

Patient Full Name

Patient Signature Date

Informed Consent & Disclosure

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, herbal medicine, acupuncture, moxibustion, cupping, electrical stimulation, medical qigong, massage, gua sha, heat therapy, ear seeds, dietary advice, and lifestyle counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping, and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Very unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential but unlikely risks of moxibustion are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I also understand that certain social habits and medications may decrease the beneficial effects of Chinese medical treatment. These include the use and abuse of alcohol, painkillers, steroids, narcotics, tobacco, anti-depressants, and drugs.

Chinese medicine is a natural form of healthcare that works with the body's ability to heal itself, but is not a substitute for conventional medical diagnosis and treatment. The results of herbal medicine and acupuncture are not always noticeable immediately, especially with chronic conditions. Frequent, regular treatment is what gives Chinese medicine the best results.

I will notify the practitioner should I become pregnant or if I am in the process of trying to get 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 process.

I understand that herbal and nutritional supplements prescribed to me by my practitioner are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my practitioner as soon as I experience any discomfort or adverse reactions.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment, and healthcare operations received, incurred, or carried out at this practice. I also certify that I have informed my practitioner of all known physical, mental, and medical conditions and medications, and I will keep him or her updated on any changes.

Patient Signature Date