Inner Balance Physical Therapy
Dry Needle Intake

Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone # (home): _____ (cell):_____ (work): _____
Email address: _____ Gender: Female ___Male ___

May we leave a message with phone numbers listed? Yes ___ No ___
Have you ever had acupuncture? Yes ___ No ___ Have you had adverse reactions to acupuncture: Yes ___ No ___

What are you seeking dry needling for?

_____
_____
_____
_____
_____

Do you have any allergies?

_____
_____

Do you take any medications?	Dose:	Purpose:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgeries/Invasive Procedures:	Year:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Diagnosis & Conditions: (Please check all that apply)

Anemia	___	Chest Pain	___	Pacemaker	___
Anxiety	___	Depression	___	Rosacea	___
Asthma	___	GERD	___	Seizures	___
Arthritis	___	Heart Attack	___	Smoker:	___
Blood Disorder	___	HIV/Hep B/C	___	Stroke	___
Breathing Problems	___	High BP	___	Vertigo	___
Cancer	___	Infection	___	Other:	_____
Site: _____		Site: _____		Other:	_____
Site: _____		Metal Allergy.	___		

Signature: _____ Date: _____