

# BALANCE POINT HEALTH

90 MADISON STREET, SUITE 402  
DENVER, CO 80206

WWW.BALANCEPOINTDENVER.COM  
303-668-1229

## NEW PATIENT INTAKE FORM

**General Information**

<b>Name</b> (First, Middle, Last)		<b>Date</b>
<b>Address</b> (Street No., City, State, Zip)		<b>Date of Birth</b> (mm/dd/yyyy)
<b>Phone</b> (Home)	<b>Phone</b> (Work)	<b>Age</b> <b>Phone</b> (Cell)
<b>Email</b>	<b>Marital Status</b> (Single, Married, Divorced, Widowed)	<b>Number &amp; Ages of Children</b>
<b>Gender</b> (Male / Female)	<b>Height</b> _____ <b>Weight</b> _____	<b>Occupation/Employer</b>
<b>Student</b> <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<b>Would you like to receive our email newsletter?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Emergency Contact** (Please indicate who to notify in case of emergency)

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Who is your medical doctor? \_\_\_\_\_ Date of last visit \_\_\_\_\_ Reason \_\_\_\_\_  
 Have you received acupuncture/Chinese herbs in the past?  Acupuncture  Herbs  
 Name of acupuncturist \_\_\_\_\_ Date of last visit \_\_\_\_\_ Reason \_\_\_\_\_  
 List any health care practitioners you are seeing (including alternative such as Naturopath, Chiropractor, etc.) and the condition for which you are being treated \_\_\_\_\_  
 Who should we thank for referring you? \_\_\_\_\_

**Major Complaint**

What is your primary health concern for this visit?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Have you ever received treatment for this condition? If yes, when and by whom? \_\_\_\_\_  
 \_\_\_\_\_  
 What was the diagnosis? \_\_\_\_\_  
 Did the treatment help?  Not at all  Somewhat  Very effective  Not sure  Other \_\_\_\_\_  
 How long have you had this condition? \_\_\_\_\_ Is it getting worse? \_\_\_\_\_  
 What do you think caused it? Is the cause still present? \_\_\_\_\_  
 Does this condition bother you:  Sleep  Eating  Work  Other (specify) \_\_\_\_\_  
 Did your symptoms develop  Gradually  Suddenly  How long do symptoms last? \_\_\_\_\_  
 What causes your symptoms? \_\_\_\_\_  
 What makes them worse? \_\_\_\_\_  
 What makes them better? \_\_\_\_\_

**Severity:** (Please mark the scales below)

How severe is your problem **right now**?

No problem	Moderate	Worst Imaginable

What's the most severe level you have endured **within the last week**?

No problem	Moderate	Worst Imaginable

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## Affecting your Life: (Please mark the scales below)

How does this affect your ability to **work (employment & volunteer)?**

\_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_  
No problem Moderate Worst Imaginable

How much does this affect your **lifestyle (family, fun activities, hobbies, eating, sleeping, etc.)?**

\_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_  
No problem Moderate Worst Imaginable

Do you have specific questions you would like to discuss today? \_\_\_\_\_  
\_\_\_\_\_

## Personal Medical History

List current health conditions (Diabetes, lupus, IBS, Chronic Fatigue, etc.) \_\_\_\_\_  
\_\_\_\_\_

List any surgeries, traumas (auto accidents, falls, etc.) serious illnesses, hospitalizations, broken bones, scars, etc. \_\_\_\_\_  
\_\_\_\_\_

Dates of surgeries, hospital stays, etc. \_\_\_\_\_  
\_\_\_\_\_

Do you have any reason to believe you may be pregnant? Yes No If so, how far along are you? \_\_\_\_\_

Do you have any infectious (contagious) diseases? HIV+ AIDS Hepatitis A,B,C Venereal Disease Herpes Other \_\_\_\_\_

Do you have any of the following?: Severe Bleeding Disorder Pacemaker Metal Implants Electrical Implants Other \_\_\_\_\_

**Allergies:** Are you allergic or hypersensitive to any of the following? What is your reaction level: Mild Moderate Severe Anaphylaxis

Drugs/Medicines/Herbs/Supplements \_\_\_\_\_

Foods \_\_\_\_\_

Environments/Seasons \_\_\_\_\_ Chemicals \_\_\_\_\_

Animal \_\_\_\_\_ Other \_\_\_\_\_

Please indicate any of the following conditions that apply to your health history:

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Antibiotic use                    | <input type="checkbox"/> Multiple Sclerosis                                      | <input type="checkbox"/> Allergies       |
| <input type="checkbox"/> Tuberculosis (TB)   | <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Emphysema                         | <input type="checkbox"/> Candida/Yeast infections                                | <input type="checkbox"/> Birth Trauma    |
| <input type="checkbox"/> Typhoid Fever       | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Kidney Disease                    | <input type="checkbox"/> Ulcers  | <input type="checkbox"/> Small Pox       |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Goiter           | <input type="checkbox"/> Pleurisy                          | <input type="checkbox"/> Venereal Disease/STD's                                  | <input type="checkbox"/> Malaria         |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Gout             | <input type="checkbox"/> Pneumonia                         | <input type="checkbox"/> Thyroid Disorder  | <input type="checkbox"/> Hepatitis       |
| <input type="checkbox"/> Mental Disorders    | <input type="checkbox"/> Whooping Cough   | <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Mumps           |
| <input type="checkbox"/> Polio               | <input type="checkbox"/> Major trauma     | <input type="checkbox"/> Measles                           | <input type="checkbox"/> Bruise easily   | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Drug addiction      | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Scarlet Fever                     | <input type="checkbox"/> Cancer  |  |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures         | <input type="checkbox"/> Chicken Pox                       | <input type="checkbox"/> Stroke  |  |
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Jaundice         | <input type="checkbox"/> Shingles                          | <input type="checkbox"/> Vascular Disease  |  |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Night sweats     | <input type="checkbox"/> Bleed easily                      | <input type="checkbox"/> Chronic colds/flu (Frequent viral/bacterial infections) |  |
| <input type="checkbox"/> Autoimmune Disease  | <input type="checkbox"/> Liver Disease    | <input type="checkbox"/> Eating Disorder                   | <input type="checkbox"/> Other (Specify) _____                                   |  |
| <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Unusual Childhood illnesses _____ |  |  |

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Please list any medications (prescribed and over-the-counter) you are currently taking and for the condition being treated:

1. \_\_\_\_\_ 4. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_  
3. \_\_\_\_\_ 6. \_\_\_\_\_

Please list any herbs, vitamins, supplements and homeopathic remedies you are currently taking:

1. \_\_\_\_\_ 4. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_  
3. \_\_\_\_\_ 6. \_\_\_\_\_

Check the immunizations you have received:

Chicken Pox                       Measles/Mumps/Rubella                       Hepatitis A, B                       Polio                       Foreign travel  
 Diphtheria/Pertussis/Tetanus                       Influenza                       Tetanus only                       Hib                       Other

List the Date and Results of last medical test:

Date	Test	Result	Date	Test	Result
	Cholesterol			Pap Smear	
	Hepatitis			Physical	
	HIV test			PSA (prostate)	
	Mammography			Stool	
	Other:			Other:	

X-Rays/CAT Scans/MRI's/Ultrasonounds/Special Studies:

Date:		Reason:	
Date:		Reason:	
Date:		Reason:	

## Family Medical History

Allergies                       High Cholesterol                       Cancer                       Kidney Disease                       Migraines  
 Diabetes                       Seizures                       Asthma                       Heart Disease                       Glaucoma  
 Stroke                       Alcoholism                       Drug addiction                       Liver Disease                       Arthritis  
 Mental Disorders                       Tuberculosis (TB)                       High / Low Blood Pressure                       Spinal problems                       Thyroid Disorder  
 Ulcers                       Sinus problems                       Eye Disease                       Respiratory Disease                       Gall Stones  
 Epilepsy                       Bleed easily                       Arteriosclerosis                       Autoimmune Disease \_\_\_\_\_

**Father**                       Living – Age \_\_\_\_\_ Health Status \_\_\_\_\_  
    Deceased – Age at death \_\_\_\_\_ Cause \_\_\_\_\_

**Mother**                       Living – Age \_\_\_\_\_ Health Status \_\_\_\_\_  
    Deceased – Age at death \_\_\_\_\_ Cause \_\_\_\_\_

**Brother(s)**                       Health Status \_\_\_\_\_

**Sister(s)**                       Health Status \_\_\_\_\_

**Children**                       Boy(s) # \_\_\_\_\_  Girl(s) # \_\_\_\_\_ Health Status \_\_\_\_\_

## Patient Birth History (for pediatric patients only)

Prolonged labor                       Forceps delivery                       C-Section                       Other \_\_\_\_\_

Notes: \_\_\_\_\_

## Childhood and Teenage Health (for all patients)

Physical: \_\_\_\_\_

Emotional: \_\_\_\_\_

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## Lifestyle

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Exercise       | <input type="checkbox"/> Energy drinks  | <input type="checkbox"/> Salty food                  | <input type="checkbox"/> Marijuana                 |
| <input type="checkbox"/> Sedentary      | <input type="checkbox"/> Coffee         | <input type="checkbox"/> Sugar                       | <input type="checkbox"/> Recreational drugs        |
| <input type="checkbox"/> Fad dieting    | <input type="checkbox"/> Black Tea      | <input type="checkbox"/> Artificial sweeteners       | <input type="checkbox"/> Pharmaceutical dependency |
| <input type="checkbox"/> Fast food      | <input type="checkbox"/> Green Tea      | <input type="checkbox"/> Alcohol                     | <input type="checkbox"/> Stress                    |
| <input type="checkbox"/> Soft drinks    | <input type="checkbox"/> Caffeine       | <input type="checkbox"/> Cigarettes/Nicotine/Tobacco | <input type="checkbox"/> Occupational hazards      |
| <input type="checkbox"/> Chips/Crackers | <input type="checkbox"/> Cookies/Sweets | <input type="checkbox"/> Addictions _____            | <input type="checkbox"/> Other _____               |

## **Diet (typical foods):**

- Beef  Poultry  Fish  Pork  Tofu  Eggs  Cheese  Milk  Yogurt  Butter  Margarine  Grains  Bread  Soy  
 Vegetables  Salads  Energy Bars  Ice Cream  Sweets  Hot Spicy Food  Fried Food  Other \_\_\_\_\_  
 Eat three meals per day  Eat at regular time every day  Eat breakfast  Other eating habits: \_\_\_\_\_

## **Typical Food Intake:**

Breakfast: \_\_\_\_\_  
Lunch: \_\_\_\_\_  
Dinner: \_\_\_\_\_  
Snacks: \_\_\_\_\_  
Treats: \_\_\_\_\_

## **Appetite:**

- Good  Fair  Poor  Absent  Hungry a lot/Excessive  Up and down  Loss of taste  Cravings \_\_\_\_\_

## **Exercise:**

- Daily  5-7 times per week  2-4 times per week  Once per week  Less than once per week  Never  
Type of exercise: \_\_\_\_\_

## **Recreational/Work Activities:**

- |                                       |   |  |  |                                  |
|---------------------------------------|---|--|--|----------------------------------|
| <input type="checkbox"/> Running      | <input type="checkbox"/> Organized sports | <input type="checkbox"/> Computer work   | <input type="checkbox"/> Sitting                   | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Skiing       | <input type="checkbox"/> Weight training  | <input type="checkbox"/> Lifting/Bending | <input type="checkbox"/> Standing for long periods | <input type="checkbox"/> Phone   |
| <input type="checkbox"/> Martial Arts | <input type="checkbox"/> Rock climbing    |  |  |                                  |
- Interests/Hobbies: \_\_\_\_\_

## **Emotions:**

- Happy  Easily irritable  Difficulty making decisions  Angry  Cry easily  Easily Stressed  Hurry to do things  Depression  
 Restless  Nervousness  Mood swings  Sadness  "Head trash"  Anxiety  Bad temper  Loss of control  Paranoia  
 Violence potential  Abuse survivor  Attempted suicide  Seeing a therapist  History of treatment for emotional problems: \_\_\_\_\_

## **Stress:**

Please rate your typical stress level on a scale of 1 to 10, with 10 being the most stress: \_\_\_\_/10  
Types or sources of stress you experience:  
 Occupational  Academic  Home/Family  Relationships  Illness/Pain  
 Work-Life balance  Financial  Other: \_\_\_\_\_  
I deal with my stress by: \_\_\_\_\_  
Do you enjoy your work? Why or why not? \_\_\_\_\_

## **Body Systems** For the following, please CHECK any that you experience NOW and UNDERLINE any that you have experienced in the PAST.

### **Weight:**

- Normal  Underweight  Overweight  Recent gain  Recent loss  Fluctuating loss and gain

### **Energy and Immunity:**

- Up and down  Low  Excess  Normal  Low after eating  Tired in afternoon  Sudden drops in energy  Lack of Strength

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- Tired at certain time of day  Sick often/Frequent colds  Autoimmune Disease  Slow wound-healing  Chronic infections  
 Chronic Fatigue Syndrome  Fatigue/Exhaustion: How often? \_\_\_\_\_  Other \_\_\_\_\_

## Body Temperature/Perspiration:

- Warm body temp  Cold body temp  Flushed face  Feel warmer late afternoon & night  Sweat easily  Night sweats  
 Profuse perspiration  Chills  Fevers  Alternate fever & chills  Cold hands & feet  Warm palms  Warm soles  Warm chest  
 Sweat for no reason  Sweat with exercise  Normal body temp  Trouble regulating body temp  Do you dislike any of the following?  
 Cold  Heat  Damp  Dry  Wind  Other \_\_\_\_\_

## Digestion/Gastrointestinal:

- Indigestion  Bloating  Heartburn/reflux  Nausea  Vomiting  Full feeling/distention  Belching  Bad breath  Gas  
 Hiccups  Ulcers  Antacid use  Nutritional deficiencies  Hypoglycemia  Irritable Bowel Syndrome (IBS)  Epigastric pain  
 Difficulty digesting fatty or oily foods  Bitter taste in mouth  Changes in appetite  Abdominal pain or cramping  Liver Disease  
 Gall Bladder Disease/Gallstones  Hepatitis B or C  Normal  Please list any digestive disturbances: \_\_\_\_\_

## Bowels/Stools:

- Loose stool  Bloody stool  Black stool  Mucous in stool  Undigested food in stool  Stools with unusual/strong odor  
 Frequent bowel movements  Diarrhea  Constipation (difficulty going)  Constipation (hard, dry stool)  Intestinal pain or cramps  
 Normal  Colon problems  Hemorrhoids  Anal fissures  Rectal pain  Itchy anus  Burning anus  
 Incomplete bowel movements  Laxative use: how often? \_\_\_\_\_  Number of bowel movements per day: \_\_\_\_\_  
 Texture/form: \_\_\_\_\_  Other \_\_\_\_\_

## Urination/Genito-Urinary Tract:

- Frequent  Burning  Urgency  Bloody  Bedwetting  Incontinence  Dribbling/Leaking  Retention/impaired  Incomplete  
 Decrease in flow  Heavy flow  Painful  Cloudy  Frequent UTI  Bladder infections  Kidney stones/infections  Normal  
 Kidney disease  Wake to urinate? How often? \_\_\_\_\_  Urine color: \_\_\_\_\_  Other \_\_\_\_\_

## Thirst:

- Strong thirst for hot drinks  Strong thirst for cold drinks  Less than normal  Excessive  Prefer cold drinks  Prefer hot drinks  
 Thirsty but do not drink  Normal  Glasses/ounces of water per day \_\_\_\_\_  Other \_\_\_\_\_

## Sleep:

- Poor sleep habits  Sleep disorder  Difficulty falling asleep  Awake easily  Difficulty going back to sleep  Lots of dreams  
 Nightmares  Restless  Restless leg syndrome  Sleep too much  Wake rested  Early riser  Night owl  Normal  
 Trouble waking up  Average # of hours a night \_\_\_\_\_  Other \_\_\_\_\_

## Neurological:

- Headaches  Migraines  Vertigo  Dizziness  Paralysis  Areas of Numbness/Tingling  Poor Balance  Lack of coordination  
 Weakness  Seizures/Epilepsy  Concussion  Tics  Tremors  Facial pain  Poor memory  Difficulty concentrating  
 ADD  Substance abuse  Motion sickness  Faint easily  Bend down, stand up and get dizzy  Other \_\_\_\_\_

## Skin:

- Dry  Hives  Itching/scratching  Oily  Acne/pimples  Eczema  Psoriasis  Rashes  Corns  Warts  Bruise easily  
 Edema/swelling  Ulcerations (open/oozing sores)  Non-healing rash/lesion  Wounds heal slowly  Fungal infections  Normal  
 Recent moles/changes  Changes in skin/hair \_\_\_\_\_  Other \_\_\_\_\_

## Hair:

- Dry  Oily  Dandruff  Itchy scalp  Hair loss  Brittle  Early grey  Normal  Other \_\_\_\_\_

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## Nails:

Soft  Spots  Ridges and lines  Break easily  Purple  Pale  Grow slowly  Grow fast  Normal  Other \_\_\_\_\_

## Eyes:

Impaired/poor vision  Blurred vision  Wear glasses/contacts  Poor night vision  Red  Dryness  Itchy  Tear easily/watery  
 Gritty  Discharge  Twitch  Eyelids swollen  Pain  Sensitive to light  Glaucoma  Cataracts  Color blindness  Normal  
 Eye strain  Spots in vision field/floaters  Blind fields  Other eye problems: \_\_\_\_\_

## Ears:

Impaired/poor hearing  Ringing (high pitch)  Ringing (low pitch)  Frequent infections  Earaches  Discharge  Normal  
 Cause of hearing loss (if known) \_\_\_\_\_  Other \_\_\_\_\_

## Nose:

Stuffy nose/congestion  Hay fever  Sneeze a lot  Environmental sensitivity  Mucous  Runny nose/drainage  Nose bleeds  
 Loss of smell  Peculiar smells  Normal  Blow nose a lot  Sinusitis  Rhinitis  Other \_\_\_\_\_

## Mouth & Throat:

Dry  Frequent colds  Frequent sore throat  Difficulty swallowing  Feel lump in throat  TMJ/jaw problems  Grind teeth  
 Broken teeth  Sensitive teeth  Numerous cavities  Bleeding gums  Gum problems  Excessive saliva  Enlarged thyroid  
 Thyroid problems  Hoarseness  Sores on lips/tongue  Peculiar tastes  Normal  Other \_\_\_\_\_

## Respiratory:

Shortness of breath  Difficulty inhaling  Difficulty exhaling  Difficulty breathing when lying down  Sigh a lot  Chest pain  
 Chest tightness  Cough with phlegm  Dry cough  Persistent cough  Cough with blood  Wheezing  Asthma  Emphysema  
 Pneumonia  Bronchitis  Tuberculosis  Pleurisy  Normal  Other Lung problems: \_\_\_\_\_

## Cardiovascular / Circulation:

Diagnosed heart problems  Palpitations/Fluttering  Murmur  Irregular heart beat  High blood pressure  Low blood pressure  
 Chest pain/discomfort  High cholesterol  Bleed easily  Bruise easily  Blood clots  Foot/Hand swelling  Bodily edema  
 Varicose veins  Stroke  Numbness in extremities  Cold hands/feet  Fainting  Difficulty breathing  Hardening arteries  
 Embolisms/Thrombosis/Aneurism  Normal  Other heart/blood vessel problems: \_\_\_\_\_

## Pain / Musculoskeletal:

Neck/Shoulder pain  Arm pain  Hand/Wrist pain  Upper Back pain  Mid Back pain  Low Back pain  Hip pain  Leg pain  
 Knee pain  Foot/Ankle pain  Rib/Flank pain  Joint pain (where?) \_\_\_\_\_  Muscle spasm/twitching  
 Muscle cramps  Muscle weakness  Damp weather  Sciatica  Arthritis  Bursitis/tendonitis  Nerve  Spine  Fractures  
 Pinched nerve  Herniated disc  Inflammation  Limited use/range of motion  Localized weakness  Other \_\_\_\_\_

## Endocrine:

Hypothyroid  Hypoglycemia  Hyperthyroid  Diabetes Mellitus  Night Sweats  Feeling Hot or Cold

## Male Reproductive:

Diagnosed prostate problems  Testicular pain/swelling  Penile discharge  Impotence  Premature ejaculation  
 Sexual difficulties  Change in sex drive  Low sex drive  Excessive sex drive  Venereal disease/STD's  Sores on genitals

## What are your treatment goals?

- Temporary relief of symptoms/pain control
- Eliminate root or cause of problem (if possible)
- Maintenance care (periodic balancing/tune-up of stay in good health)

Anything else you feel might be important? Are there any other concerns you would like to discuss? \_\_\_\_\_

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## Females Only (If you are female, please continue filling out the remainder of this form.)

Are you or might you be pregnant? Yes No Maybe If yes, approximate date of conception \_\_\_\_\_  
Do you have regular pap exams? Yes No Last exam date/results: \_\_\_\_\_  
Do you have regular breast exams? Yes No Last exam date/results: \_\_\_\_\_  
Do you have facial hair or excess body hair? Yes No  
Are you experiencing a change in sex drive? Yes No Other difficulties? Please explain: \_\_\_\_\_

## Menstrual cycle: If you have entered menopause please answer the following for what occurred during your period.

Age started \_\_\_\_\_ Age stopped \_\_\_\_\_ My Cycle occurs(ed) every \_\_\_\_\_ days Bleeding lasts(ed) for \_\_\_\_\_ days  
Last menses start date \_\_\_\_\_

For the following, please CHECK any that you experience NOW and UNDERLINE any that you have experienced in the PAST. If you have entered menopause please answer the following for any symptoms that occurred during your period.

Irregular Painful Heavy flow Light flow Dark-colored flow Light-colored flow Clots Water retention Backache  
Abdominal bloating Painful or tender breasts Breast lumps Nipple discharge Spotting between periods Fatigue Cravings  
Lump in throat feeling Tightness in chest Constipation and/or diarrhea Sigh a lot Emotional changes/mood swings PMS  
Irritability Changes in body/psyche prior to menstruation Hormonal problems Difficulty conceiving Other \_\_\_\_\_

## Gynecological Conditions:

Uterine fibroids Fibroids in breasts Breast cancer Ovarian cancer PCOS Venereal disease/STD's Sores on genitals  
Post coital bleeding Yeast infections: Frequency \_\_\_\_\_ Vaginal Discharge: Yellow White Clear Bad/strong odor  
Endometriosis Other gynecological conditions: \_\_\_\_\_

## Fertility:

Number of IVF procedures \_\_\_\_\_ Number of IUI procedures \_\_\_\_\_ Have monitored Basal Body Temperature (BBT)  
Has a physician diagnosed difficulty in fertility due to: Female factor Male factor Undetermined  
Other fertility issues: \_\_\_\_\_

## Menopause

Perimenopausal Menopausal Post menopausal Age menopause started \_\_\_\_\_ Hot flashes Night sweats Osteoporosis  
Urinary incontinence Vaginal atrophy Facial hair Thinning scalp Cardiovascular disease Changes in psyche Insomnia  
Changes in body Change in sex drive Reduced sex drive Increased sex drive Taking hormone replacement (HRT)  
Other \_\_\_\_\_

## Pregnancy:

Total number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_ Number of premature births \_\_\_\_\_  
Number of miscarriages \_\_\_\_\_ Number of medical abortions \_\_\_\_\_ Pregnancy or childbirth complications: \_\_\_\_\_

Morning sickness Breech Induction Insufficient lactation Uterine prolapse Postpartum depression Retention of lochia

## Gynecological history / Operations:

Ovaries \_\_\_\_\_  
Uterus \_\_\_\_\_  
Fallopian tubes \_\_\_\_\_  
Vagina \_\_\_\_\_  
Breasts \_\_\_\_\_  
Other \_\_\_\_\_

## Birth Control:

Current method of birth control \_\_\_\_\_  
Birth control used in past \_\_\_\_\_

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