BALANCE POINT HEALTH

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NEW PATIENT INTAKE FORM

General Information

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

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:

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

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
❑Diptheria/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/Ultrasounds/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: _____

Lifestyle

❑ Exercise	❑ Energy drinks	❑ Salty food	❑ Marijuana
❑ Sedentary	❑ Coffee	❑ Sugar	❑ Recreational drugs
❑ Fad dieting	❑ Black Tea	❑ Artificial sweeteners	❑ Pharmaceutical dependency
❑ Fast food	❑ Green Tea	❑ Alcohol	❑ Stress
❑ Soft drinks	❑ Caffeine	❑ Cigarettes/Nicotine/Tobacco	❑ Occupational hazards
❑ Chips/Crackers	❑ Cookies/Sweets	❑Addictions_____	❑ 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:

❑Running	❑Organized sports	❑Computer work	❑Sitting	❑Driving
❑Skiing	❑Weight training	❑Lifting/Bending	❑Standing for long periods	❑Phone
❑Martial Arts	❑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 ❑Parnoia
❑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

❑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 brinks ❑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 _____

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? _____
_____

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 _____