Healthy Balance

Acupuncture

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Patient Intake Form

Present Health Concerns: Please list your most important health concerns in order of their significance.

1. ____ Approx. Date of Onset:___________________________
Does it interfere with your: □Work □Sleep □Daily routine □Recreation
Other therapies tried: □Medications □Surgery □Chiropractic □Physical therapy □Other________________

2. ____ Approx. Date of Onset:___________________________
Does it interfere with your: □Work □Sleep □Daily routine □Recreation
Other therapies tried: □Medications □Surgery □Chiropractic □Physical therapy □Other________________

3. ____ Approx. Date of Onset:___________________________
Does it interfere with your: □Work □Sleep □Daily routine □Recreation
Other therapies tried: □Medications □Surgery □Chiropractic □Physical therapy □Other________________

Please lists all **medications** that you are currently taking (or have used in the past two months), w/ dosages:

1. ____ 4. _______________________________________
2. ____ 5. _______________________________________
3. ____ 6. _______________________________________

Please list any **vitamins, minerals, herbs, or homeopathic remedies** that you are presently taking:

1. ____ 4. _______________________________________
2. ____ 5. _______________________________________
3. ____ 6. _______________________________________

Please list **allergies** that you have to any of the following:

Drugs: ______________________________________ Foods: ____

Other (ie pollen, dust, paint, ect.): ____

Health History

Past Medical History: Please list past injuries, broken bones, surgeries and hospitalizations, w/ approx dates.

____
____
____

Family Information:

Do you have children? □Yes □No If Yes, how many? ________ Ages __________________

Are you, or could you be currently pregnant ? □Yes □No Due date___________________

Please check if you have had (in the **last three months**)

GENERAL

- ☐ Poor appetite
- ☐ Strong thirst
- ☐ Fever/Chills
- ☐ Weight loss/gain appetite
- ☐ Bleed/bruise easily
- ☐ Heavy sleeping
- ☐ Dizziness
- ☐ Heavy appetite
- ☐ Sweat easily
- ☐ Tremors
- ☐ Cravings
- ☐ Sudden energy drop (time?)
- ☐ Dream disturbed sleep
- ☐ Changes in appetite
- ☐ Localized weakness
- ☐ Poor sleeping
- ☐ Peculiar tastes
- ☐ Fatigue
- ☐ Night sweats

HEAD, EYES, EARS, NOSE, AND THROAT

- ☐ Concussions
- ☐ Glasses/Contacts
- ☐ Eye strain/pain
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Dry eyes
- ☐ Excessive tearing
- ☐ Poor/blurry vision
- ☐ Night blindness
- ☐ Cataracts/Glaucoma
- ☐ Spots in front of eyes
- ☐ Earaches/Infections
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Sinus problems
- ☐ Post nasal drip
- ☐ Excessive phlegm-Color?
- ☐ Nose bleeds
- ☐ Recurrent sore throat
- ☐ Concussions
- ☐ Swollen glands
- ☐ Sores on lips/tongue
- ☐ Dry mouth
- ☐ Excessive saliva
- ☐ Teeth problems
- ☐ Gum problems
- ☐ Headaches (location, triggers)
- ☐ Grinding teeth
- ☐ TMJ Disorder

SKIN AND HAIR

- ☐ Rashes/Hives
- ☐ Itching
- ☐ Dry skin
- ☐ Dandruff
- ☐ Ulcerations
- ☐ Eczema/Psoriasis
- ☐ Loss of hair
- ☐ Pimples/Acne
- ☐ Fungal infections/tinea
- ☐ Recent moles
- ☐ Change in hair or skin texture

Other hair or skin concerns:

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Palpitations
- ☐ Fainting
- ☐ Cold hands/feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Phlebitis

Other heart or blood vessel concerns:

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas/bloating
- ☐ Hiccups

History of chronic laxative use?

- ☐ Belching
- ☐ Bad breath
- ☐ Blood in stools
- ☐ Black stools
- ☐ Mucus in stools
- ☐ Acid regurgitation
- ☐ Abdominal pain
- ☐ Itchy anus
- ☐ Burning anus
- ☐ Hemorrhoids/fissures

Other concerns with your general digestion:

GENTIO-URINARY

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Decrease in flow

If you wake to urinate, how often?

- ☐ Kidney stones
- ☐ Unable to hold urine
- ☐ Decreased libido
- ☐ Increased libido
- ☐ Nocturnal emissions
- ☐ Sores on genitals
- ☐ Bed wetting
- ☐ Frequent urinary tract infections

Other concerns with genitals or urinary system:

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Upper back pain
- ☐ Lower back pain
- ☐ Hand/wrist pain
- ☐ Muscle pains
- ☐ Muscle weakness
- ☐ Cramps/spasms
- ☐ General joint pain/stiffness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Hip pain
- ☐ Joint with limited range of motion__________________

Other muscle, joint or bone concerns:

RESPIRATORY

- ☐ Cough
- ☐ Coughing blood
- ☐ Wheezing
- ☐ Asthma
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Pain w/ deep breath
- ☐ Shortness of breath
- ☐ Tight chest
- ☐ Production of phlegm- color?_________Is it thick or thin?

Other lung related concerns:

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Loss of balance
- ☐ Areas of numbness
- ☐ Tics
- ☐ Lack of coordination
- ☐ Memory loss
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability, anger
- ☐ Easily susceptible to stress
- ☐ Difficulty concentrating
- ☐ History of sexual/emotional or physical abuse

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Other neurological or psychological concerns:

Woman:

At what age did you start menstruating?_____________Number of days between cycles?_____________

Duration of flow___________Color___________Clots?__________Consistency of blood___________

Age of Menopause____________Any bleeding since?_________

(Peri) Menopausal Symptoms:____

Check any current symptoms:

- ☐ Irregular menses
- ☐ Heavy flow
- ☐ Light flow
- ☐ No flow
- ☐ Polycystic ovaries/cysts
- ☐ Spotting between menses
- ☐ Breast lumps
- ☐ Vaginal itching/burning
- ☐ Discomfort/pain *before* menses
- ☐ Discomfort/pain *during* menses
- ☐ Discomfort/pain *immediately following* menses
- ☐ Pelvic inflammatory disease
- ☐ Chronic yeast infections

PMS symptoms: ____

Any vaginal discharge? ☐ Yes ☐ No Amount_______ Color _________ Frequency_____ __________

Number of Pregnancies ________ Deliveries_________ Abortions/Miscarriage(s)_________________

Date of last PAP:_______________Results were: normal abnormal unsure

If you use birth control, what type & for how long?

Other gynecological concerns:

Men: check any current symptoms

- ☐ Impotence
- ☐ Prostatitis
- ☐ Lump in testicles
- ☐ Pain/itching of genitalia
- ☐ Premature ejaculation
- ☐ Penis blood/mucus discharge

FAMILY HISTORY

Please fill in the boxes for each condition that applies to one of your family members.

	YES	WHO	Comments
Addition (alcohol/drugs)			
Cancer			
Cardiac disorders (heart disease, high blood pressure, stroke			
Diabetes			
Digestive/Gastro-intestinal disorders			
Immune disorders (hepatitis, HIV, etc.)			
Mental illness			
Respiratory disorders (asthma, allergies, etc)			
Skin disorders (eczema, Psoriasis, ect.)			
Seizure disorders			
Other			

COMMENTS

Please let us know of any other concerns you would like to address: