

BALANCE POINT HEALTH

90 MADISON STREET, SUITE 402
DENVER, CO 80206

WWW.BALANCEPOINTDENVER.COM
303-668-1229

NEW PATIENT INTAKE FORM

General Information

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

- | | | | | |
|---|--|---|--------------------------------|---|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles/Mumps/Rubella | <input type="checkbox"/> Hepatitis A, B | <input type="checkbox"/> Polio | <input type="checkbox"/> Foreign travel |
| <input type="checkbox"/> Diphtheria/Pertussis/Tetanus | <input type="checkbox"/> Influenza | <input type="checkbox"/> Tetanus only | <input type="checkbox"/> Hib | <input type="checkbox"/> 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

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Spinal problems | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Gall Stones |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Bleed easily | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> 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 _____

BALANCE POINT HEALTH, INC.

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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? _____