Balance Point Health

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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) **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 Disease
❑Ulcers ❑Sinus problems ❑Eye Disease ❑Arthritis ❑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:

❑Prolonged labor ❑Forceps delivery ❑C-Section ❑Other______________________

Notes: ______________________

Childhood and Teenage Health:

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 ❑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
❑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 ____________________

Nails:
❑Soft ❑Spots ❑Ridges and lines ❑Break easily ❑Purple ❑Pale ❑Grow slowly ❑Grow fast ❑Normal ❑Other ________

 Patient Name: ______________________________ Date: ____________

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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? ______
______
______

Patient Name: ______ Date: ______