Balanced Healing Acupuncture, LLC

Intake Form

NAME: Last_____ First: _____ GENDER: _____

Date of Birth ___/___/___ Age _____ Email Address _____

Address _____

City _____ State _____ Zip Code _____

Preferred Phone Number _____ Cell ___ Home ____ Work___

Preferred Method of Communication: Phone Call ____ Text Message ____ Email ____

In an Emergency Please Notify: Name _____

Phone Number _____ Relationship _____

1. Main problem you are seeking treatment for today _____
2. How long ago did this problem begin _____
3. Have you been given a diagnosis for this problem?_____
4. What treatment(s) have you received for this problem? _____

   _____

   _____
5. Name of Physician/Practitioner: _____
6. Is this Practitioner aware you are seeking Acupuncture for this condition? Y N

<u>Past Medical History</u>

Current Medical Condition: _____

_____

_____

Surgeries: _____

_____

_____

Significant Emotional and Physical Trauma(s):_____

_____

_____

Do you have or have you ever had any infectious diseases? Y N
If Yes please describe _____

Medications, including prescription, over the counter, vitamins and supplements, taken in the last three months _____
_____
_____

Allergies: _____
_____

Family Medical History: General Health
If deceased, please list age and cause of death

Mother: _____
Father: _____
Brother(s): _____
Sister(s): _____

Personal Medical History

Childhood Health Issues: _____
_____
_____

Current Emotional Health:

Rate on a scale of 1 (none) to 10 (significant amount)
Mood Swings _____ Nervousness _____ Mental Tension _____
Rate on a scale of 1 (poor) to 10 (good)
Family Life _____ Social Life _____ Work Life _____
Relationship Status: Single___ Married ___ Partnered ___Divorced ___ Widowed___
Quality of Significant Relationship _____

Predominant Current Emotion: _____

Occupation: _____

Work- related Stress Level (1-10) _____

Other Life Stressors: _____

_____

Hobbies and Recreational Habits: _____

_____

Do you have a regular exercise program, and if so what is it? Y N

_____

Smoker: No ___ Former, Quit date _____ Yes, amount/day _____

Alcohol use: None____ Former, Quit Date _____ Yes, amount/day _____

Have you ever been treated for emotional problems? Y N _____

_____

Have you ever considered suicide? Y N Have you ever attempted suicide? Y N

Do you experience a sudden drop in energy during the day? Y N Time? _____

Hours of sleep per night _____ Frequent waking? Y N

WOMEN ONLY

Age at First Menses _____ Days Between Menses _____ Duration of Menses _____

Check all that apply: Heavy Flow ____ Light Flow ____ Spotting Between Menses _____

Irregular Cycle ____ Clotting ____ Painful Periods ____ Difficulty Conceiving ____

PMS Symptoms ___ Breast Lumps ___ Nipple Discharge ___ Vaginal Discharge ___

Number of Pregnancies _____ Number of Births _____ Miscarriages ____ Abortions ____

Difficulties during pregnancy, labor and delivery _____

_____

Birth Control, type and duration of use: _____

Last Menstrual Period: ___/___/___ Last PAP Smear: ___/___/___

Please Check All That Apply

Lung/Large Intestine Meridians/Organ Network

___Difficulty Breathing ___Excess Phlegm ___Frequent Colds ___ Asthma
___Shortness of Breath ___Sinus/Rhinitis ___Wheezing ___ COPD
___Chest Congestion ___Cough ___Allergies ___Smoker
___Excessive Sweating ___Dry Skin ___Psoriasis ___Bronchitis
___Difficulty Concentrating ___Loose Stools ___Constipation ___Mucus in Stool
___Slow Healing Skin ___Unable to let go ___Timidity ___Sadness
___Boredom ___Apathy ___Low Energy ___Grieving

Heart/Small Intestine Meridians/Organ Network

___Dream Disturbed Sleep ___Palpitations ___Restlessness ___Dizziness
___Difficulty Falling Asleep ___Flushed Face ___Anxiety ___Vertigo
___Waking Still Feeling Tired ___Hot Flashes ___Nightmares ___Phobias
___Shortness of Breath ___Cardiac Pain ___Depression ___Anemia
___Mental Confusion ___Cold Hands ___Cold Feet ___Poor Circulation
___Bitter Taste in Mouth ___Speech Problems ___SIBO ___Excess Laughter
___Celiac Disease ___Forgetfulness ___Sores on the tip of the tongue

Spleen/Stomach Meridains/Organ Network

___Abrupt Weight Gain ___Excessive Appetite ___Low Appetite ___Heartburn
___Abrupt Weight Loss ___Acid Reflux ___Mouth Sores ___Belching
___Fatigue After Eating ___Bad Breath ___Nausea ___Vomiting
___Gurgling Stomach Noises ___Bloating ___Hiccups ___Gas
___Stomach Pain ___Hemorrhoids ___Indigestion ___Gastritis
___Irritable Bowel ___Diabetes ___Loose Stools ___Ulcers
___Crohn's Disease ___Vaginal Discharge ___Fatigue ___Organ Prolapse
___Weak Muscles ___Easily Bruised ___Headaches ___Over thinking
___Aching Heavy Limbs ___Worry ___Excess Phlegm ___Poor Memory
___Difficulty Focusing ___Feeling Insecure ___Restless Sleep ___Cold Knees

Kidney/Urinary Bladder Meridians/Organ Network

___Dental Problems ___Kidney Stones ___Infertility ___Impotence
___Easily Broken Bones ___Low Back Pain ___Knee Pain ___Osteoarthritis
___Lack of Perspiration ___Night Sweats ___Hearing Problems ___Fear
___Excessive Perspiration ___Excessive Thirst ___Hot Feet ___Fatigue
___Cold Body Temperature ___Cold Hands ___Cold Feet ___Depression
___Hot Body Temperature ___Sciatica ___Easily Startled ___Hair Loss
___Memory Problems ___Panic Attacks ___Tinnitus ___Feel Overwhelmed
___Premature Gray Hair ___Decreased Will Power ___Low Libido
___Lack of Bladder Control ___Frequent Night Urination ___Dark Under Eye Circles

Liver/Gall Bladder Meridains/Organ Network

___One Sided Headache ___Migraines ___Easily Angered ___Frustrated
___Stiff Neck and Shoulders ___Depression ___Irritable ___TMJD
___Difficulty Staying Asleep ___Frequent Sighing ___Vertigo ___Tinnitus
___Bitter Taste in Mouth ___Acid Reflux ___Irritable Bowel ___Nausea
___Tightness in Chest ___ Vision Problems ___Belching ___Bloating
___Churning Stomach ___Numbness ___Twitching ___Restless Legs
___Tendonitis ___Muscle Spasms ___PMS ___Fibromyalgia
___Menstrual Cramps ___Brittle Hair ___Brittle Nails ___Impatience
___Unable to Plan ___Nervousness ___Indecision __Unable to Organize

Body Pain

On a scale of 1 (none) to 10 (worst pain possible), how is your pain today? _____

Does the pain impair your ability to (circle all that apply)
Work Exercise Sleep Climb Stairs Drive Walk Concentrate Participate in Hobby
Activities of Daily Living (list)_____

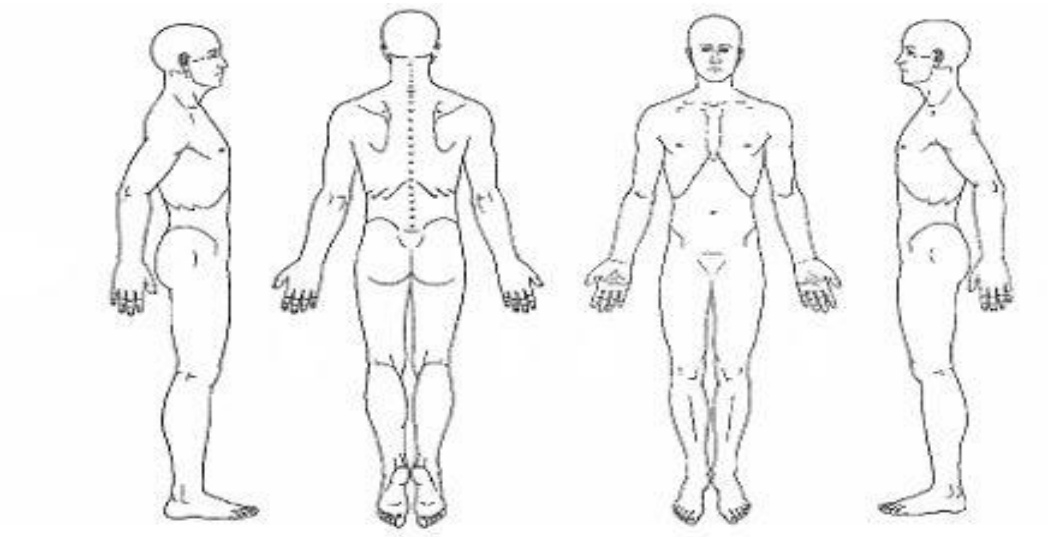
What makes the pain worse? Sitting Standing Heat Cold Stress Fatigue Activity _____

What makes the pain better? Rest Heat Cold Massage Activity_____ Other_____

Nature of the pain (circle all that apply)

Dull Distending Heavy Sharp Ache Stabbing Pulling Throbbing Deep Superficial Radiating Hot Numb Tingling Moves Around Local/Fixed

Please mark areas of pain on the chart below with an X



Please Sign One of the Two Options Below

Option #1

I have received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment.

Patient Signature _____ Date_____

Option #2

I have NOT received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment. Ohio law requires that a Licensed Acupuncturist recommend that you receive a diagnostic exam from a physician or chiropractor. I understand this recommendation.

Patient Signature_____ Date _____

Licensed Acupuncturist Signature _____