PERSONAL BALANCE ACUPUNCTURE

Patient Intake Form

Personal Information

Name: _____ Sex: ☐ Male ☐Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: ____/____/_____ Age: _____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated/Divorced

Education Level: _____ SSN:_____

Height: _____ Weight: _____ Occupation: _____

Emergency Contact

Name: _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Medical Information

Physician Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Counselor/Psychologist Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Gynecologist Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Family History

Complete each column by placing an 'X' or the date in the appropriate box, as best you can, indicating any illnesses.

	Self (Date)	Mother	Father	Sibling	Spouse/Partner	Children
Adopted						
Good Health						
Cancer or Tumors						
Diabetes						
Thyroid Disorder						
Kidney Disorder						
High Blood Pressure/Heart disease/Stroke						
Blood or Bleeding disorders/anemia						
Seizures						
Allergies						
Alcohol or other drug use						
Depression or mental illness						
Hepatitis/other liver disorder						
Musculoskeletal disorder						
HIV/Aids						
Deceased (Age)	N/A					

Lifestyle Habits

For each item, please indicate how much, how many, or how often. Please note if this is current or the date you quit.

Cigarettes (packs per day) _____
Alcohol (drinks per week) _____
Drug Use (recreational) _____

Coffee/Tea (cups per day) _____
Soda (regular or diet) _____
Exercise ☐ Yes ☐ No Frequency _____
Type of Exercise _____

Medical

If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, list them below.

YEAR	OPERATION/ILLNESS	HOSPITAL OR TREATMENT LOCATION

Medicines

Please list all medications, vitamins, and/or food supplements you are currently taking.

Item Name	Dosage	Condition

Current and Past Conditions/Symptoms/Traumas

If you are currently experiencing any of the following, please mark with a 'C'; if you have experienced in the past, mark with a 'P'; if you have continuously experienced any, please mark with a 'P-C'.

General

_____ Insomnia
_____ Dreams/Nightmares
_____ Fatigue
_____ Poor Memory
_____ Strongly like cold drinks
_____ Strongly like hot drinks
_____ Recent weight gain/loss
_____ Cold hands & feet
_____ Chills
_____ Fever
_____ Bad breath
_____ Other (describe)
_____

Nose, Throat, Mouth

_____ Sinus Infection
_____ Hay fever/allergies
_____ Frequent sore throat
_____ Difficulty swallowing
_____ Mouth & tongue ulcers
_____ Frequent colds
_____ Nosebleed
_____ Dry Nose
_____ Nasal Congestion
_____ Loss of voice
_____ Thirst
_____ Excessive phlegm
_____ TMJ
_____ Facial pain
_____ Gum problems
_____ Dry mouth
_____ Other (describe)
_____

Cardiovascular

_____ High blood pressure
_____ Low blood pressure
_____ Chest pain or tightness
_____ Palpitation(s)
_____ Rapid heart beat
_____ Irregular heart beat
_____ Poor circulation
_____ Swollen ankles
_____ Phlebitis
_____ Anemia
_____ History of heart disease
_____ Heart murmur
_____ Night sweats
_____ Tendency to be cold
_____ Tendency to be warm
_____ Other (describe)
_____

Ears

_____ Ringing
_____ Hearing loss
_____ Hearing aids
_____ Infections
_____ Earache
_____ Vertigo
_____ Other (describe)
_____

Eyes

_____ Glasses/contacts
_____ Blurred vision
_____ Poor night vision
_____ Spots or floaters
_____ Eye inflammation
_____ Double vision
_____ Glaucoma
_____ Cataracts
_____ "Lazy" eye
_____ Other (describe)
_____

Neurological

_____ Seizures
_____ Tremors
_____ Numbness or tingling
_____ Pain (describe)
_____
_____
_____ Paralysis
_____ Poor coordination
_____ Other (describe)
_____

Head & Neck

_____ Headaches
_____ Migraines
_____ Stiff neck
_____ Dizziness
_____ Fainting
_____ Swollen glands
_____ Other (describe)
_____

Skin

_____ Hives
_____ Rashes
_____ Eczema/Psoriasis
_____ Night sweating
_____ Excess sweating
_____ Dry skin
_____ Easily bruised
_____ Changes in moles, lumps
_____ Itching
_____ Other (describe)
_____

Respiratory

_____ Difficulty breathing
_____ Difficult breathing w/ reclining
_____ Wheezing
_____ Asthma
_____ Chronic cough
_____ Wet cough
_____ Dry cough
_____ Coughing up phlegm
_____ Coughing up blood
_____ Shortness of breath
_____ Tight chest
_____ Pneumonia
_____ Other (describe)
_____

Male Genital

_____ Impotence
_____ Premature ejaculation
_____ Nocturnal emission
_____ Pain/itching
_____ Lumps in testicles
_____ Increased libido
_____ Decreased libido
_____ Breast checked
_____ Other (describe)
_____

Gastrointestinal

_____ Nausea
_____ Indigestion
_____ Stomach pain
_____ Diarrhea
_____ Constipation
_____ Poor appetite
_____ Excessive hunger
_____ Vomiting
_____ Gas
_____ Hiccups
_____ Acid regurgitation
_____ Bloating
_____ Laxative use
_____ Bloody stool
_____ Other (describe)
_____

Musculoskeletal

_____ Join pain/swelling
_____ Sore muscles
_____ Weak muscles
_____ Difficulty Walking
_____ Pain (describe
_____
_____
_____
_____ Limited range of motion
_____ Other (describe)
_____

Infection Screening

(circle self and/or partner)

_____ HIV risks: self / partner
_____ TB: self / household
_____ Hepatitis risks: self / partner
_____ History of STI: self / partner
Specify: _____
_____
_____ Other (describe)
_____

Mental / Emotional

_____ Depression
_____ Mood swings
_____ Irritability
_____ Difficulty relaxing
_____ Loneliness
_____ Sensitive
_____ Shyness
_____ Frequent crying
_____ Frequent worrying
_____ Compulsive behaviors
_____ Difficulty focusing
_____ Hopeless outlook
_____ Suicidal thoughts
_____ Loss of temper
_____ Frustration
_____ Other (describe)
_____

Gynecology

_____ Currently pregnant
_____ # of pregnancies
_____ # of live births
_____ # of miscarriages
_____ # of abortions
_____ Menopause
_____ Irregular periods
_____ Menstrual cramps
_____ Excessive blood flow
_____ Menstrual blood clots
_____ Breast tenderness
_____ Abnormal pap smear
_____ Vaginal infections
_____ Vaginal pain/itching
_____ Uterine fibroids
_____ Endometriosis
_____ Breast lumps, cysts
_____ Increased libido
_____ Decreased libido
_____ Other (describe)
_____

Urinary

_____ Pain during urination
_____ Frequent urination
_____ Urgent urination
_____ Blood in urine
_____ Incontinence
_____ Incomplete urination
_____ Bedwetting
_____ Wake to urinate
_____ History of UTI
_____ Kidney (specify)
_____
_____
_____ Other (describe)
_____

Traumas (list)

_____
_____
_____

* Personal Balance Acupuncture and Reiki Services accepts cash, personal checks, and credit cards.

Patient Signature

X_____ Date: _____