BALANCED function
Acupuncture, LLC

Patient Information & Health History

All information provided on this form is confidential. Although some items may not seem pertinent, it is very important the information given is complete and accurate to best facilitate proper diagnosis, treatment, and to support you in your healing process. By providing your email, you will receive appointment reminders and occasional updates and news from Balanced Function Acupuncture.

Today's Date:_____

First Name:_____ Last Name:_____

Date of Birth:_____ Age:_____ Gender: M F

Address:_____ City/State/Zip:_____

Email:_____ Phone:_____ cell / home / work

Marital Status:_____ Occupation:_____

Emergency Contact/Relationship:_____ Phone:_____

Have you had acupuncture before?_____ How did you find us?_____

What are your top 3 reasons for seeking care? (diagnosis, symptoms, include approximate date of onset)

1. _____

2. _____

3. _____

What other treatments have you received for any of these conditions?_____

_____

What makes your symptoms better? (activity, rest, heat, cold, pressure, massage, etc) _____

_____

What makes your symptoms worse? (stress, fatigue, certain foods, time of day, heat, cold, etc) _____

_____

What are your goals for your acupuncture visits?_____

Please rate your commitment to feeling better: 1 2 3 4 5 6 7 8 9 10

Allergies • Do you have any known allergies or hypersensitivities? (food, medication, smoke, environmental)_____

_____

_____

Medications & Supplements • What medications (Rx or OTC), herbs, vitamins, or supplements are you currently taking?

_____

_____

_____

_____

_____

Trauma • Please list any significant traumas (physical or emotional), hospitalization, surgery, x-rays/MRIs_____

_____

_____

Occupational Stress • How many hours do you work/week?_____# vacation days you take/year_____

Describe any physical or psychological stress at your work:_____

_____

Energy & Exercise • Energy level? (1 exhausted → 10 high) _____ Does your energy fluctuate?_____

How many days a week do you exercise?_____Length of workouts_____

Activities_____

How does exercise make you feel?_____

Sleep • How long do you normally sleep?_____hours/night Do you wake feeling rested?_____

I have difficulties with (check all that apply): falling asleep_____ staying asleep _____ dream disturbed sleep_____

restless / light sleep_____ waking mid-sleep cycle_____ hypersomnia / difficulty waking_____ nightmares_____

Typical Food Intake • # of meals/day_____# of snacks/day_____Do you skip meals?_____

What foods do typically you eat?_____

_____

Are there foods that you avoid?_____

_____

Do you follow a special diet?_____Food Cravings?_____

Do you prefer your food & drinks warm, cold, or temperature appropriate?_____

Typical breakfast?_____

Typical lunch?_____

Typical dinner?_____

Typical snacks?_____

Water intake per day:_____Caffeine_____Alcohol_____

How does food make you feel? (energized, tired, bloated, etc)_____

_____

Body Temperature • Normal_____ Entire body cold_____ Cold hands and/or feet_____
Hot all day_____ Hot only in afternoon_____ Hot only in night_____

Muscles, Joints & Bones • Location/area(s) of pain, injury, or musculoskeletal dysfunction?_____

_____

_____

Is your pain: an acute injury_____ a chronic condition_____ overuse/repetitive strain_____ unknown_____

When did the pain begin?_____ Pain Scale (1 almost none →10 unbearable) _____

How does the pain affect or impair your daily activities?_____

The pain is (check all that describe your pain): ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Shooting/stabbing
☐ Burning ☐ Numb ☐ Tingling ☐ Superficial pain ☐ Deep pain ☐ Constant ☐ Intermittent

☐ Pain Is Fixed ☐ Pain Moves Around ☐ Pain Refers to Other Areas ☐ Worse in a.m. ☐ Worse in p.m.

☐ Worse with Heat ☐ Better with Heat ☐ Worse with Cold ☐ Better with Cold ☐ Worse with weather changes

☐ Worse with Pressure ☐ Better with Pressure ☐ Worse with Movement ☐ Better with Movement

☐ Other:_____

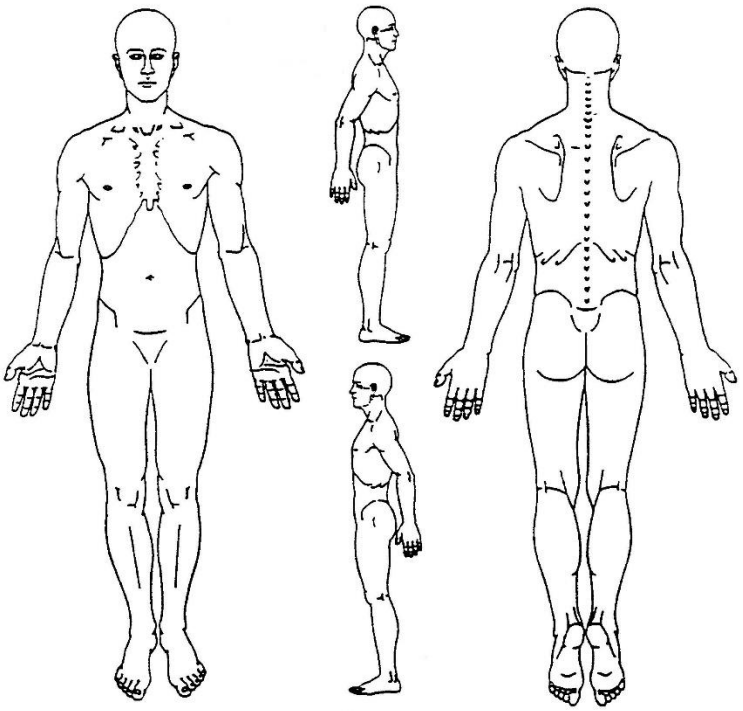
I have (check all that apply): ☐ Swollen joints ☐ Arthritis/Joint Pain ☐ Joint Stiffness/Immobility ☐ Bone Pain

☐ Muscle Tension ☐ Muscle Pain ☐ Muscle Twitching or Fasciculation ☐ Muscle Tightness/Inflexibility

☐ Muscle Spasms/Cramps ☐ Muscle Atrophy/Wasting ☐ Muscle Weakness

☐ Old fractures, surgeries, or significant injuries – where & when?_____

Pain Diagram • Please mark all areas of pain on the diagram below



Please check any symptoms/conditions you currently experience or have had in the past in the appropriate columns.

Now	Past	MAJOR MEDICAL
_____	_____	Asthma
_____	_____	Cancer
_____	_____	Clotting disorder
_____	_____	High cholesterol
_____	_____	Diabetes
_____	_____	Heart attack
_____	_____	Hepatitis
_____	_____	Pacemaker
_____	_____	Seizure disorder
_____	_____	Stroke

Other:_____

		GENERAL
_____	_____	Fatigue, exhaustion
_____	_____	Frequent colds or illness
_____	_____	Sweat too much
_____	_____	Don't sweat enough
_____	_____	Night sweats or hot flashes
_____	_____	Dizziness or fainting
_____	_____	Tendency to feel cold
_____	_____	Tendency to feel hot
_____	_____	Alternating sense of chills/heat
_____	_____	Sleep problems (too much, cannot get to sleep, wake during night, restless)
_____	_____	Weight gain or loss
_____	_____	High Stress
_____	_____	Recreational drug use
_____	_____	Drug or alcohol addiction
_____	_____	Eating disorder

		NEUROLOGIC, ENDOCRINE & IMMUNE
_____	_____	Seizures or tremors
_____	_____	Paralysis
_____	_____	Muscle weakness or fasciculation
_____	_____	Numbness or tingling
_____	_____	Vertigo or dizziness
_____	_____	Loss of balance or coordination
_____	_____	Parkinson's
_____	_____	Chronic Fatigue Syndrome
_____	_____	Fibromyalgia
_____	_____	Thyroid imbalance
_____	_____	Auto-immune disorder
_____	_____	Chronic infections
_____	_____	Chronic swollen glands
_____	_____	Slow wound healing

Other:_____

Now	Past	HEAD, NOSE & THROAT
_____	_____	Headaches
_____	_____	Migraines
_____	_____	Jaw pain / TMJ disorder
_____	_____	Teeth grinding
_____	_____	Canker sores / Cold Sores / Oral herpes
_____	_____	Hay fever / Sinusitis
_____	_____	Sinus infections
_____	_____	Runny nose
_____	_____	Nose bleeds
_____	_____	Dry mouth, nose or throat
_____	_____	Sore throat
_____	_____	Feeling of lump in the throat
_____	_____	Bad breath
_____	_____	Metallic, bitter, or sour taste in mouth
_____	_____	Cavities or missing teeth
_____	_____	Gums bleed easily

Other:_____

		EYES & EARS
_____	_____	Nearsighted / Farsighted
_____	_____	Poor night vision
_____	_____	Blurry vision
_____	_____	Cataracts / Glaucoma / Macular degeneration
_____	_____	Dry eyes / Itchy eyes / Watery eyes
_____	_____	Spots in front of eyes, ocular floaters
_____	_____	Red eyes / Swollen eyes / Painful eyes
_____	_____	Difficulty hearing
_____	_____	Ringing in ears
_____	_____	Earaches; ear infections

Other:_____

		RESPIRATORY
_____	_____	Cough frequently; wet or dry?
_____	_____	Phlegm…what color?
_____	_____	Allergies
_____	_____	Bronchitis
_____	_____	Pneumonia
_____	_____	Asthma
_____	_____	Chest congestion
_____	_____	Chest tightness, fullness, or heaviness
_____	_____	Shortness of breath
_____	_____	Wheezing
_____	_____	Difficulty breathing: at rest, after exercise, laying down, at night, triggered by emotion
_____	_____	Smoker (cigarettes, cigars, marijuana)

Other:_____

Now	Past	CIRCULATION & HEART
_____	_____	Chest pain
_____	_____	Irregular heart beat
_____	_____	Palpitations, fluttering
_____	_____	Swelling of hands or feet
_____	_____	Dizziness on standing up
_____	_____	Cold hands or feet
_____	_____	Varicose veins, phlebitis
_____	_____	Low blood pressure
_____	_____	High blood pressure
_____	_____	Easy bleeding or bruising
_____	_____	Anemia

Other:_____

		GASTROINTESTINAL & DIGESTION
_____	_____	Poor appetite / Loss of appetite
_____	_____	Trouble swallowing
_____	_____	Heartburn, reflux
_____	_____	Ulcer – gastric or duodenal
_____	_____	Nausea
_____	_____	Vomiting
_____	_____	Belching
_____	_____	Gas / Bloating
_____	_____	Abdominal pain / cramping
_____	_____	Gallbladder inflammation / stones
_____	_____	Constipation
_____	_____	Diarrhea
_____	_____	Alternating consistency of stools
_____	_____	Mucus in stools
_____	_____	Blood in stools
_____	_____	Undigested food in stools
_____	_____	Feeling of incomplete evacuation
_____	_____	Foul odor to stool or gas
_____	_____	Hemorrhoids
_____	_____	Anal itching or bleeding
_____	_____	Irritable Bowel Syndrome
_____	_____	Crohns or Inflammatory Bowel Disease

How often do you have a bowel movement:_____

Other:_____

Now	Past	MUSCLE, JOINT & BONE
_____	_____	Neck Pain
_____	_____	Shoulder Pain
_____	_____	Arm / Elbow / Wrist Pain
_____	_____	Hip Pain
_____	_____	Knee Pain
_____	_____	Leg Pain
_____	_____	Calf / Ankle / Foot Pain
_____	_____	Back Pain – Upper / Middle / Lower
_____	_____	Arthritis
_____	_____	Sciatica
_____	_____	Restless Leg Syndrome
_____	_____	Osteoporosis
_____	_____	Heaviness of limbs
_____	_____	Muscle pain / tightness / inflexibility
_____	_____	Muscle spasms / cramping
_____	_____	Muscle twitching / fasciculation
_____	_____	Joint stiffness / immobility
_____	_____	Areas of numbness or tingling
_____	_____	Loss of strength, muscle weakness
_____	_____	Bone fractures (list on page 3)

Other:_____

		MENTAL / EMOTIONAL
_____	_____	Mood swings
_____	_____	Anxiety or nervousness
_____	_____	Depression
_____	_____	Worry excessively
_____	_____	Fearful
_____	_____	Irritable / Angry outbursts
_____	_____	Sad, weepy
_____	_____	Cry easily
_____	_____	Indecision
_____	_____	Poor memory
_____	_____	Poor concentration

Other:_____

		SKIN & HAIR
_____	_____	Bruise easily
_____	_____	Acne or pimples
_____	_____	Eczema / Psoriasis
_____	_____	Hives / Rashes
_____	_____	Itching
_____	_____	Dryness, roughness
_____	_____	Skin discoloration
_____	_____	Fungal infections
_____	_____	Hair loss / Thinning / Change in color
_____	_____	Weak or brittle nails; break easily

Other:_____

Now	Past	GENITO-URINARY
_____	_____	Pain/burning when urinating
_____	_____	Difficulty urinating
_____	_____	Incomplete urination or dribbling
_____	_____	Frequent urination
_____	_____	Urinate frequently at night
_____	_____	Bedwetting
_____	_____	Copious or scanty urination
_____	_____	Dark or Pale urine
_____	_____	Cloudy urine
_____	_____	Blood in urine
_____	_____	Urinary incontinence
_____	_____	Urinary tract infections
_____	_____	Kidney infections or disease
_____	_____	Kidney stones

Other:_____

		MALE ONLY
_____	_____	Diminished or increased sexual desire
_____	_____	Erectile dysfunction
_____	_____	Premature ejaculation
_____	_____	Testicular pain or masses
_____	_____	Prostate problems
_____	_____	Difficult or unusual urination
_____	_____	Discharge from penis
_____	_____	Sores or rashes in genital area
_____	_____	Sexually transmitted infection
_____	_____	Infertility

Other:_____

Are you sexually active? Yes No
Do you use birth control? Yes No
If yes, what kind?_____

Now	Past	FEMALE ONLY
_____	_____	Irregular menstrual cycles
_____	_____	Bleeding between cycles
_____	_____	Painful menstruation
_____	_____	Heavy or excessive flow
_____	_____	Scanty flow
_____	_____	Amenorrhea
_____	_____	Menstrual cramps
_____	_____	Clots
_____	_____	PMS
_____	_____	Breast distension or tenderness
_____	_____	Breast discharge
_____	_____	Breast lumps
_____	_____	Diminished or increased sexual desire
_____	_____	Pain with intercourse
_____	_____	Uterine fibroids or polyps
_____	_____	Ovarian cysts or PCOS
_____	_____	Pelvic inflammatory disease
_____	_____	Endometriosis
_____	_____	Vaginal yeast infections
_____	_____	Vaginal discharge? Color?
_____	_____	Vaginal itching/burning
_____	_____	Vaginal odor
_____	_____	Vaginal dryness
_____	_____	Hot flashes or night sweats
_____	_____	Sexually transmitted infection
_____	_____	Infertility

Other:_____

Are you sexually active? Yes No
Do you use birth control? Yes No
If yes, what kind?_____

- Are you currently pregnant or planning to become pregnant? YES NO

Age at menarche:_____
Length of cycle:_____
Days of flow:_____Color:_____
Describe flow (watery, thick, clotted)_____
_____
Date of last menstrual period:_____
Number of pregnancies:_____
Number of live births:_____
Age at menopause:_____