in balance

Acupuncture

JB Baranzini, MS, L.Ac., CMT

Patient Information Sheet

CONFIDENTIAL

Patient Information

Last Name:	First Name	Middle:
Address: City:	State:	Zip:
Tel. - Home:	Work:	Mobile:
Fax:	E-mail:	
Would you like to receive e-mail reminders prior to appointments? [ ] Yes. [ ] No.		
Date of Birth:	Age:	Occupation:
Employment Status (check all that apply): [ ] Full-time [ ] Part-time [ ] Self-employed [ ] Retired [ ] Unemployed [ ] Student		
Emergency Contact:	Relationship:	Phone:
Social Security #	Height:	Weight:
How did you hear about In Balance Acupuncture:		
Marital status: [ ] Married [ ] Domestic Partner [ ] Single [ ] Divorced [ ] Other: _____		

Confidentiality: *Your patient records and information will be kept strictly confidential and will only be shared when necessary to provide your care, or under your written authorization, or when required by law.*

Primary Care Physician Information

Primary Physician:	Telephone:
Physician's Address (or name of clinic/hospital):	

Insurance Information (if applicable)

Insurance Company:	Policy Holder Name:	Birth Date: ____/____/____	Relationship to Patient:
Insurance Company Address:		Telephone:	
Policy # / ID #:		Group #:	

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Patient Intake Form

Patient _____ Date _____

Major Complaint(s), in order of importance to you:

	Severe	Moderate	Slight		How Long?	Pain Level (1-10)
1.	❑	❑	❑	_____		
2.	❑	❑	❑	_____		
3.	❑	❑	❑	_____		

FAMILY HISTORY: Complete for each family member, placing an ✘ in the appropriate box.

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder / Anemia							
Diabetes							
Cancer or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
Drug / Alcohol Use or Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression / Mental Illness							
Suicide Attempt							
Age at Death							
Other							

TRAVEL – Have you ever traveled or lived outside of the U.S? ❑ Yes ❑ No

Any health problems when abroad? ❑ Yes ❑ No If yes, what? _____

MEDICATIONS – Please list all prescription medications you use. Include those you may only use occasionally. Remember inhalers, eye drops, nose drops.

Prescription Name	Purpose	How long	Dose	How often	Last Dose

Patient _____ Date _____

MEDICAL CONDITIONS – Please list conditions & surgeries you have or have had and year diagnosed.		**ALLERGIES** Medications, Seasonal, Environmental, Food	**OCCUPATIONAL CONCERNS** Check (✔) if your work exposes you to the following:
Year	Condition/Surgery		Occupation
			❑ Stress
			❑ Heavy Typing/Computer Use
			❑ Hazardous Substances
			❑ Heavy Lifting
			❑ Other

SYMPTOMS – For each symptom you currently have, rate its severity from 1-3 (3 being worst). Leave blank if N/A.

LV/GB
___ Irritability
___ Depression
___ Headaches/migraines
___ Visual problems
___ Red eyes
___ Dry/itching eyes
___ Spots in front of eyes
___ Blurred vision
___ Feeling of lump in throat
___ Clenching of teeth at night
___ Muscle cramping
___ Muscle twitching
___ Joints feel tight/stiff
___ Cold hands/feet
___ Soft/brittle nails
___ Craving/avoiding sour foods

KD/UB
___ Urinary problems
___ Frequent urination
___ Incontinence
___ Weakness/pain in lower back
___ Aching bones
___ Feel cold easily
___ Low sexual energy
___ Excess sexual desire
___ Poor memory
___ Loss of hair
___ Hearing problems
___ Ringing in ears
___ Craving/avoiding salty foods

HT/SI
___ Heart palpitations
___ Chest pain
___ Dizziness
___ Insomnia
___ Easily startled
___ Restlessness/agitation
___ Anxiety
___ Breathlessness
___ Vivid dreams
___ Dreams are bothersome
___ Lack of joy in life
___ Laughing for no reason
___ Craving/avoiding bitter foods

LU/LI
___ Dry cough
___ Cough with sputum
___ Nasal discharge
___ Poor sense of smell
___ Nose bleeds
___ Itchy, red or painful throat
___ Dry mouth
___ Skin rashes
___ Itchy skin
___ Grief, sadness
___ Shortness of breathless
___ Allergies
___ Low resistance to colds or flu
___ Low physical stamina
___ Mild fever comes and goes
___ Craving/avoiding spicy foods

SP/ST
___ Heaviness anywhere in body
___ Fatigue
___ Hard to get up in the morning
___ Edema (swelling)
___ Muscles feel tired often
___ Easy bruising and bleeding
___ Bad breath
___ Low appetite
___ Snacking
___ Tendency towards hypoglycemia
___ Difficulty digesting oily foods
___ Nausea
___ Vomiting
___ Gas/belching
___ Bloating
___ Hemorrhoids
___ Constipation
___ Diarrhea
___ Abdominal pain
___ Indigestion/heartburn
___ Over-thinking
___ Tendency to become obsessive
___ Craving/avoiding sweets

OTHER
___ _____
___ _____
___ _____
___ _____
___ _____
___ _____

Patient _____ Date _____

HABITS – Please check any habits which apply to you now or in the past

Coffee	❑ Yes ❑ No	# per day _____	age started _____	age quit _____
Tobacco	❑ Yes ❑ No	# per day _____	age started _____	age quit _____
Marijuana	❑ Yes ❑No	# per day _____	age started _____	age quit _____
Alcohol	❑ Yes ❑ No	# per day _____	age started _____	age quit _____
Crack/Cocaine	❑ Yes ❑ No	# per day _____	age started _____	age quit _____
Heroin	❑ Yes ❑ No	# per day _____	age started _____	age quit _____

FEMALES -

Form of birth control_____	Pregnant ❑ Yes ❑ No	❑ Clotting	❑ Hot flashes
Last period _____	Last PAP test_____	❑ Heavy bleeding	❑ Vaginal dryness
Age started menstrual cycle_____	Age stopped_____	❑ Vaginal discharge	❑ Other_____
❑ Menstrual Pain	❑ Water retention	No. Pregnancies _____	_____
❑ Low backache	❑ Mood changes	No. Vaginal Deliveries_____	No. Miscarriages_____
❑ Irregular menses	❑ Painful breast	No. Cesareans_____	No. Abortions_____

Please describe any restricted diet you follow(ed) now or in the past_____

_____

Please describe your typical daily diet -

Breakfast _____ Morning Snack _____

Lunch _____ Afternoon Snack _____

Dinner _____ Evening Snack_____

Please describe any regular program of exercise - _____

_____

Have you ever had an Acupuncture treatment? When and for what reason?_____

_____