in balance

Acupuncture

JB Baranzini, MS, L.Ac., CMT

Patient Information Sheet

CONFIDENTIAL

Patient Information

Last Name: First Name Middle:

Address:

City: State: CA 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:

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 #:

in balance

Acupuncture
JB Baranzini, MS, L.Ac., CMT

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?_____

_____