Balancing Point Wellness

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PATIENT INTAKE FORM

Name: _____
First Name Last Name Middle Initials

Birth Date: _____/_____/_____ Weight: _____ Height: _____

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

Address: _____ Apartment #: _____

City: _____State: _____ Zip Code: _____

Sex: Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Email Address: _____

Occupation: _____

Physician: _____ Referred By: _____

Main Problem: _____ Onset: _____

Other Concurrent Therapies: _____

CONTACT IN CASE OF AN EMERGENCY

Emergency Contact Name: _____

Emergency Contact Phone #: _____ Relationship to Patient: _____

AVERAGE DAILY DIET

Morning _____ Afternoon _____ Evening _____

Habits: ___Cigarettes ___Coffee ___Tea ___Cola ___Alcohol ___ Drugs ___Sugar ___Salt Other _____

Family Medical History: ___Diabetes ___ Cancer ___ High Blood Pressure ___ Heart Disease ___Stroke ___ Seizures ___ Asthma ___ Allergies ___ Alcoholism ___ Other.

Notes: _____
_____
_____

GENERAL

_Poor appetite _Heavy appetite _Poor sleep _Heavy sleep
_Insomnia _Fatigue _Tremors _Vertigo
_Cold hands _Cold feet _Cold back _Cold abdomen
_Fevers _Chills _Night sweats _Sweat easily
_Cravings _Localized weakness _Poor coordination _Change in appetite
_Sudden energy drop at _____ time. _Peculiar taste/smells _____
_Strong thirst (cold/hot drinks) _____ _Bleed or bruise easily (where) _____
_____
_____

SKIN AND HAIR

_Rashes _Ulcerations _Hives _Itching
_Eczema _Pimples _Dandruff _Loss of Hair
_Change in hair/skin texture _Purpura _Other hair/skin problems _____
_____
_____

HEAD, EYES, EARS, NOSE AND THROAT

_Dizziness _Concussions _Migraines _Glasses
_Eye Strain _Eye Pain _Poor Vision _Night Vision
_Color Blindness _Cataracts _Blurry Vision _Earaches
_Ringing in Ears _Poor hearing _Nose bleeds _Sinus problems
_Mucus _Dry Throat _Dry Mouth _Copious Saliva
_Teeth problems _Jaw clicks _Grinding teeth _Facial pain
_Gum problems _Spots in eyes _Recurrent sore throats_____/mouth
_Sores on lips or tongue _Headaches (where and when) _____
_Other head or neck problems _____
_____
_____

CARDIOVASCULAR

_High blood pressure _Low blood pressure _Chest Pain _Irregular heartbeat
_Dizziness _Fainting _Cold hands/feet _Swelling in hands/feet
_Blood clots _Phlebitis _Difficulty breathing _Other
_____
_____

RESPIRATORY

_Cough _Coughing blood _Asthma _Bronchitis
_Pneumonia _Difficulty in breathing when lying down _Tight chest
_Production of phlegm _____what color _____ _Other lung problems
_____
_____

GASTROINTESTINAL

_Nausea _Vomiting _Diarrhea _Bowel Movement:
_Gas _Belching _Black stools _____ Frequency
_Bad Breath _Rectal Pain _Hemorrhoids _____ Color
_Constipation _Bloody Stools _Sensitive abdomen _____ Odor
_Pain or cramps _Laxative use: _____/weeks; type _____ _____ Texture/form
_____
_____

GENITO-URINARY

_Pain on urination _Frequent urination _Blood in urine _Urgency to urinate
_Unable to hold urine _Kidney stones _Venereal disease _Impotency
_Wake up to urinate How often _____/night; time _____ _Other G/U problems

_____

_____

PREGNANCY AND GYNECOLOGY

_Number pregnancies _Number births _Premature births _Miscarriages
_Age at first menses _Period (days) _Duration _Irregular periods
_Flow (describe) _Clots Last PAP_____ Last menses _____
_Vaginal discharge _Vaginal sores _Breast lumps Menopause _____
_Birth Control type & duration _____ _Changes in body/psyche prior to menstruation

_____

_____

MUSCULOSKELETAL

_Neck pain _Muscle pains _Back pain (where) _Joint pain (where)
_Other joint or bone problems? _____ _____

_____

_____

NEUROPSYCHOLOGICAL

_Seizures _Areas of numbness _Poor memory _Concussions
_Depression _Anxiety _Bad Temper _Easily stressed
_Treated for emotional problems _Considered/attempted suicide
_Other neurological or psychological problems?

_____

_____

CLASSICAL

Preference	**Most Liked**	**Least Liked**
Season	_____	_____
Taste	_____	_____
Climate	_____	_____
Time of Day	_____	_____
Temperature	_____	_____

Body Type: _____
Color: _____
Tone: _____
Odor: _____
Yin/Yang: _____
Firm/Weak: _____
Hot/Cold: _____
Surface/Interior: _____

COMMENTS

_____

_____