BALANCE
INTEGRATIVE HEALTH

PATIENT INTAKE FORM - HOLISTIC HEALTH ASSESSMENT

Important: This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible, even if you do not feel certain questions pertain to your present condition. Thank you.

Today's Date:_____ Name:_____ Gender: ☐ M ☐ F

Home Address:_____ City:_____

State:_____ Zip:_____ Email:_____

Date of Birth:_____ Age:_____ If under 18, person responsible for your account:_____

Home phone:_____ Work phone:_____ Cell phone: _____

Emergency Contact: Name/Relation:_____

Contact phone:_____

Marital Status: _____single _____married _____divorced _____widowed _____with a significant other

Are you a caregiver for dependents? ☐ Yes ☐ No If yes, how many children?_____ How many adults_____

Occupation:_____ Number of years in this type of work:_____

INSURANCE COVERAGE *(copy of Insurance Card Needed)*

*Insurance Subscriber Name*_____ *Relation to Patient* _____
*Insurance Co.*_____ *Plan #*_____ *Group#*_____
*Effective Date*_____ *SS#*_____

PHYSICIANS / PROVIDERS

Primary Care Physician (PCP) _____

Please provide the name and title of all other practitioner(s), the condition(s) being treated and the length of time you have been receiving this treatment. Please include any acupuncturists, massage therapists or homeopaths.

Practitioner Name *Condition/s* *Dates of Treatment* *Phone#*

_____

_____

_____

REASON FOR TODAY'S VISIT: _____

CURRENT HEALTH CONCERNS – Please list your top 3 health concerns in order of priority.

1. _____
2. _____
3. _____

HOSPITALIZATIONS, SURGERIES, PROCEDURES, TRANSPLANTS AND/OR INJURIES (please include the dates)

_____

_____

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MEDICATIONS

Please list any medications you are currently taking, along with doses and the reason(s) you are taking them.

Medications	Reason	Date Began-	Dose	Helps Yes or No

SUPPLEMENTS

Please list any supplements (including vitamins, herbs & minerals) along with doses &the reason you are taking them.

Supplements, vitamins, etc	Reason	Date Began	Dose	Helps Yes or No

ALLERGIES

FAMILY HISTORY

Please describe your family's health, including current age or age at death, and major illness history (diabetes, heart disease, osteoporosis, cancer, allergies, mental illness, etc.)

Member	**Living?/Age_____**	**Major Illness or Chronic Conditions**
Mother		
Father		
Sisters/Brothers		
Children		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

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PLEASE CHECK THE FOLLOWING MEDICAL CONDITIONS THAT APPLY TO YOU:

☐ Alcoholism or substance abuse
☐ Arthritis/Joint Disease
☐ Blood Clot/Phlebitis
☐ Cancer (SpecificType):_____
☐ Diabetes
☐ Digestive (Ulcertive Colitis, Crohns, etc.)
☐ Frequent Infections
☐ Allergies/Sensitivities (Medicines, skin, food)
☐ Heart Attack, Heart Disease,
☐ Heart Failure
☐ High Blood Pressure
☐ High Cholesterol
☐ Liver Disease, Hepatitis
☐ Lung Disease (Asthma, COPD)
☐ Mental Trouble/ Depression/ Anxiety, etc.
☐ Thyroid Disease
☐ Urinary Difficulties (incontinence, infections, etc.)
☐ Other _____

WOMEN'S HEALTH

Age at First Menses____ Number of Pregnancies____ Birth Control? _____
Duration of Menses_____ Number of Births_____ What type? _____
Unusual Character _____ Number of Miscarriages____ Vaginal Discharge or sores_____
Perimenopausal? _____ Number of Abortions_____ Fertility Problems_____
Breast Lumps_____ Difficult Births_____
First Date of Last Menstrual Cycle _____/_____/_____ Date of Last Pap Smear _____/ _____/ _____
Did you have any abnormal findings in your last tests or anytime in the past? Please give details:
_____

MEN'S HEALTH

What date was your last prostate exam? _____ PSA Test?_____ Colonoscopy? _____
Do you have: Prostate problems_____ Testicular cancer_____
Vasectomy_____ Sexual dysfunction or impotence_____

PLEASE CHECK IF YOU HAVE EXPERIENCED ANY OF THESE SYMPTOMS (IN THE LAST YEAR)

GENERAL
☐ Fevers
☐ Tremors
☐ Change in Appetite
☐ Chills
☐ Seizures
☐ Fatigue
☐ Night Sweats
☐ Poor Sleep/ Insomnia
☐ Day Sweating
☐ Headaches
☐ Bleeding or Bruising
☐ Emotional Changes

CARDIOVASCULAR
☐ Dizziness
☐ Swelling of Hands
☐ Irregular heartbeat
☐ Fainting
☐ Difficulty in Breathing
☐ Palpitations
☐ Low blood pressure
☐ Cold Sweats
☐ Chest pain
☐ Swelling of Feet
☐ Phlebitis
☐ Other_____

RESPIRATORY
☐ Cough
☐ Pain w/ Deep Breaths
☐ Difficulty Breathing
☐ Bronchitis
☐ Shortness of Breath
☐ Easily Winded w/ exertion or when laying down
☐ Coughing Blood
☐ Production of phlegm

GASTROINTESTINAL
☐ Nausea
☐ Abdominal Pain/Cramps
☐ Vomiting
☐ Constipation
☐ Indigestion / reflux
☐ Diarrhea
☐ Blood in Stool
☐ Hernia
☐ Hemorrhoids

GENITOURINARY
☐ Pain on Urination
☐ Decrease in Urine
☐ Kidney stones
☐ Urgent Urination
☐ Blood in Urine
☐ Waking up to Urinate
How often?_____
☐ Frequent Urination
☐ Unable to Hold Urine

NEUROPSYCHOLOGICAL
☐ Areas of Numbness
☐ Anxiety
☐ Lack of Coordination
☐ Poor Memory
☐ Dizziness
☐ Loss of Balance
☐ Easily Angered
☐ Headaches
☐ Fainting
☐ Depression
☐ Migraines
☐ Mania
☐ Susceptible to Stress

MUSCULOSKELETAL
☐ Muscular Weakness
☐ Recent Sprains
☐ Muscle Cramps
☐ Spasms
☐ Joint Pain
☐ Injuries or Falls
☐ Localized Weakness
☐ General Aches
☐ Joint Instability

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HABITS AND LIFESTYLES

Emotional Stress Scale (*Please circle)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you smoke?_____ If yes, what? _____ How much per day? _____ Since when?_____

How many attempts have yo made at quitting smoking?_____

Do you drink alcohol? _____ If yes, what? _____ How much? _____ Since when?_____

EXERCISE

Do you exercise regularly? _____ If yes, describe what you do: _____

NUTRITION

What are your greatest nutrition concerns?_____

How many meals do you generally eat per day? Do you skip meals?_____

How many servings of fruit do you consume per day? _____

How many servings of vegetables do you consume per day?_____

Are you currently on a special diet?_____ What foods do you avoid?_____

Are you vegetarian or Gluten-free?_____

Do you drink coffee?_____ If yes, how much per day?_____

Do you drink soda pop? ☐ regular ☐ diet ☐ none *(Please circle one)* If yes, how often?_____

Do you have regular eating habits? ☐ Yes ☐ No Do you have a healthy appetite? ☐ Yes ☐ No

Do you eat more when under stress or feeling depressed? ☐ Yes ☐ No

Do you experience sudden drops in energy? ☐ Yes ☐ No If yes, when?_____

What was your weight one year ago?_____

What is the most you have ever weighed?_____ When?_____

How often do you have a bowel movement?_____

SLEEP / RELAXATION

How many hours do you usually sleep per night?_____ When do you go to bed?_____

Do you wake feeling refreshed?_____

How did you hear about us? _____

Did someone refer you to Balance? ☐ Yes ☐ No If so, who? _____

Everything I have written and answered in this form is true to the best of my knowledge. I will update this office when there are significant changes.

Signature_____

We occasionally send emails about events and specials happening at our clinic. Opt out of these notification by checking the box. ☐