The Balance Point Acupuncture & Wellness
901 Willow Drive, Suite 1
Chapel Hill, NC 27514
(919) 260-4844

Female Adult Intake

PATIENT INFORMATION Date(mo/day/yr):_____/_____/_____

Name: _____Date of birth(mo/day/yr):_____Gender: _____
Occupation:_____
Address:_____City:_____Zip:_____
Phone: _____ E-mail: _____
Emergency contact: _____ Relationship: _____Phone: _____
Primary Care Provider (MD, ND): _____ Phone:_____

How did you hear about The Balance Point?_____

Optimal health is only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this confidential overview will greatly assist my understanding of your healthcare needs and desires.

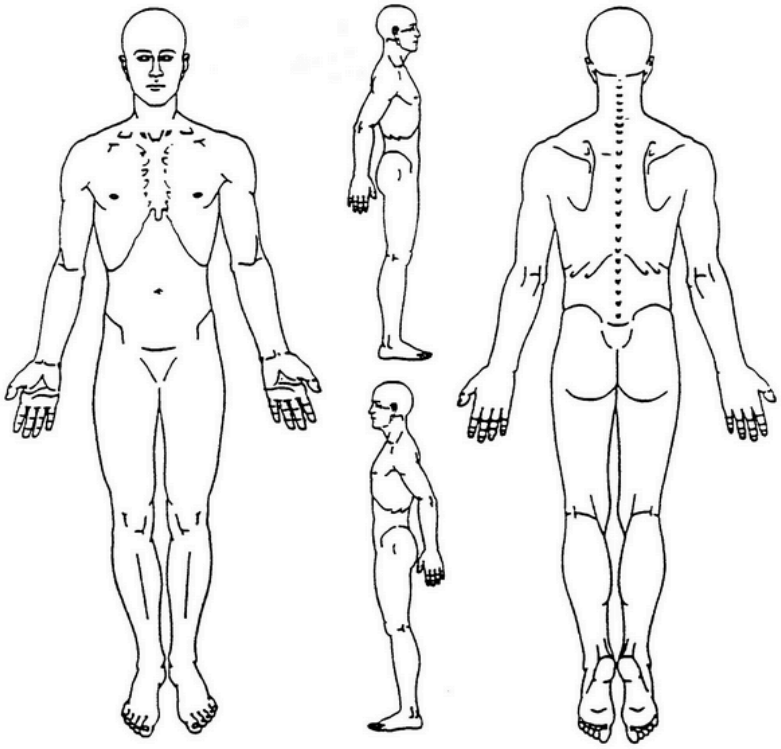
HEALTH INFORMATION

Main reason(s) for seeking treatment?
_____
_____
_____

What other treatments have you received to address this?
_____
_____

Please list any other health concerns (physical, mental, or emotional), including any diagnoses from Healthcare Professionals, as well as what improves and/or worsens your symptoms (certain movements, temperature, stress level...etc).
_____
_____
_____
_____
_____

Please list any medications or supplements you are currently taking: _____
_____
_____
_____
_____



Please circle any areas of pain, numbness, or discomfort on the diagrams above

(1 = low, 10 = very high)

How do you rate your level of energy? 1__2__3__4__5__6__7__8__9__10
How do you rate your level of stress? 1__2__3__4__5__6__7__8__9__10
How do you rate your overall health? 1__2__3__4__5__6__7__8__9__10

Please list (with approx. dates) any serious conditions, illnesses or injuries, and hospitalizations:

_____

_____

_____

DIET & LIFESTYLE FACTORS

Please list foods and drinks that are a part of your average week: _____

_____

_____

Please list any dietary restrictions:_____

Please list all allergies (food, environmental, or medications):_____

_____

_____

Do you experience insomnia? Y/N How many hours of sleep do you get on an average night? _____

Do you exercise? Y / N

What type of exercise and how often? _____

_____

What do you do for recreation and relaxation? _____

_____

_____

Marital status: Single Married Divorced Partnership

Number of children: _____

For the following, please indicate any that you use (Y/N) and how often

Caffeine: Y/N	(daily)___(weekly)___(once a month)___(rarely)___(never)___
Alcohol: Y/N	(daily)___(weekly)___(once a month)___(rarely)___(never)___
Tobacco: Y/N	(daily)___(weekly)___(once a month)___(rarely)___(never)___
Marijuana: Y/N	(daily)___(weekly)___(once a month)___(rarely)___(never)___
Recreational Drugs: Y/N	(daily)___(weekly)___(once a month)___(rarely)___(never)___
Birth Control Pills: Y/N	(daily)___(weekly)___(once a month)___(rarely)___(never)___
Pain relievers: Y/N	(daily)___(weekly)___(once a month)___(rarely)___(never)___
Appetite suppressant:Y/N	(daily)___(weekly)___(once a month)___(rarely)___(never)___
Diet pills: Y/N	(daily)___(weekly)___(once a month)___(rarely)___(never)___
Laxatives: Y/N	(daily)___(weekly)___(once a month)___(rarely)___(never)___
Aspirin: Y/N	(daily)___(weekly)___(once a month)___(rarely)___(never)___
Antacids: Y/N	(daily)___(weekly)___(once a month)___(rarely)___(never)___
Sleeping pills: Y/N	(daily)___(weekly)___(once a month)___(rarely)___(never)___

FAMILY HISTORY

Please indicate whether any of your family members have, or have had the following:

	Relative		Relative
Alcoholism		Asthma	
Diabetes		Kidney disease	
Allergies		Cancer (indicate type)	
Drug abuse		Osteoporosis	
Alzheimer's disease		Depression	
Heart disease		Stroke	
Arthritis		Other mental illness	
High blood pressure		Suicide	

Your birth history (if known): premature forceps delivery prolonged labor C-section

REVIEW OF SYSTEMS

Please place a **check** (✓) if you are currently experiencing any of the following or write a **P** if you have experienced it in the past.

General symptoms
- ☐ Headache
- ☐ Head injury
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Dizziness
- ☐ Fainting
- ☐ Loss of sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Weight problems
- ☐ Numbness in arm/leg/hand
- ☐ Allergy
- ☐ Convulsions

Skin
- ☐ Hives or allergy
- ☐ Acne or skin eruptions
- ☐ Itching
- ☐ Bruises easily
- ☐ Dryness
- ☐ Boils
- ☐ Varicose veins
- ☐ Sensitive skin
- ☐ Change in mole

Kidneys & Reproduction
- ☐ Inability to control urine
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Sores on genitals

Eyes, Ears, Nose, Throat
- ☐ Dental decay
- ☐ Gum trouble
- ☐ Frequent colds
- ☐ Enlarged thyroid
- ☐ Tonsillitis
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Enlarged glands
- ☐ Glaucoma
- ☐ Failing vision
- ☐ Cataracts
- ☐ Eye pain
- ☐ Ear discharge
- ☐ Loss of hearing
- ☐ Ear ache
- ☐ Nasal drainage
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Sinus infection
- ☐ Hay fever

Musculoskeletal
- ☐ Neck pain
- ☐ Muscle weakness
- ☐ Swollen joints
- ☐ Leg Pain
- ☐ Foot/Hand pain
- ☐ Arm pain
- ☐ Hernia
- ☐ Low back pain
- ☐ Joint pain/stiffness
- ☐ Spinal curvature

Neurological
- ☐ Nervousness/Anxiety
- ☐ Convulsions
- ☐ Tingling/Numbness
- ☐ Depression
- ☐ Paralysis
- ☐ Confusion
- ☐ Fainting
- ☐ Forgetfulness

Cardiovascular
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Previous heart stroke
- ☐ Hardening of the arteries
- ☐ Swelling of the ankles
- ☐ Poor circulation
- ☐ Paralytic stroke
- ☐ Irregular heart beat
- ☐ Shortness of breath
- ☐ Chest pain

Gastrointestinal
- ☐ Excessive thirst
- ☐ Poor/Excessive hunger
- ☐ Heartburn/Reflux
- ☐ Gas (flatulence)/Belching
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal cramps
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colon trouble
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Gallbladder problems
- ☐ Jaundice
- ☐ Colitis

Respiratory
- ☐ Asthma
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Difficult breathing

WOMEN'S HEALTH

Are you currently pregnant? Y/N If yes, how many weeks?_____

Do you get regular screening tests done by another doctor (blood work, Pap)? Y / N

Date of last Pap?(month/yr) _____/_____ Have you ever had an abnormal Pap? Y / N

Age of first period? _____ Is your period regular? Y / N Date of last period? _____
Length of monthly cycle (days)? _____ Average length of period or flow (days)? _____
Do you experience PMS? Y / N Are you menopausal? Y / N. If yes, age of last period____

Are you currently sexually active? Y / N Have you been sexually active in the past? Y / N
Current forms of contraception? _____
Have you ever had a sexually transmitted disease? Y / N

Number of pregnancies? _____ Births? _____ Miscarriages? _____ Abortions? _____
Have you had a hysterectomy? Y / N

Have you had any of the following concerning your breasts?(circle)
Pain Lumps Infections Cysts Nipple Discharge

Do you experience vaginal infections? Never Rarely Frequently
Do you experience bladder infections? Never Rarely Frequently

Any other female concerns not addressed:_____
_____
_____
_____

What are your treatment goals and expectations? _____
_____
_____
_____

Is there anything else that you feel has not been covered? _____
_____
_____
_____

Thank you for taking the time to complete this form.