Balance Point Acupuncture 999 NW Circle Blvd. Corvallis, OR 97330 541-754-2225

NEW PATIENT INFORMATION

Important: Please complete this document as thoroughly and legibly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
All information is strictly confidential.

Patient Name :_____ Today's Date:_____

Street address:_____

City, State, Zip:_____

Cell Phone: _____Home Phone: _____Work Phone: _____

Email: _____

□ Single □ Married □ Widowed □ Separated □ Divorced

Name of spouse/partner: _____ Phone number: _____

If patient is under 18, please list guardian and their relationship to patient:
_____

Age: _____ Date of Birth: ____/____/_____ Height: ___' ___" Weight: _____# (currently) _____# (past max)

Emergency Contact: _____ Phone number: _____
□same as spouse/partner

Occupation: _____ Employer:_____

Please indicate if this is a □ Worker's Compensation or □ Car Accident claim – Date of Injury: _____

Whom may we thank for referring you?_____

Name of your primary care physician: _____

Phone# (___)_____ Address:_____

Please list any other practitioners you have seen for your health concerns:

1. Name:_____ Please circle: MD/DO/NP/ND/DC/
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____

Have you ever received Acupuncture? □ No □ Yes, From:_____

Please list any prescription or over the counter medication you are currently taking, including pain medications:

Medication	For?	Medication	For?	Medication	For?

List any supplements, vitamins, herbs or minerals you are currently taking: _____

_____

What is your primary health concern? _____

When did this problem begin? _____

What makes it better or worse? _____

Has this condition been evaluated by your primary care physician? If so, please list any known western diagnosis.

_____

What prior treatment have you had for this condition and what were the results? _____

_____

Does this condition impair your daily activities? □ No □ Yes, please explain: _____

_____

Please list any other health concerns that you wish to address:

1. _____ 2. _____

3. _____ 4. _____

Please provide complete information in the following pages related to your current and past health concerns:

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
□	□	Allergies	□	□	Gonorrhea	□	□	Mononucleosis
□	□	Asthma	□	□	Heart Disease	□	□	Multiples Sclerosis (MS)
□	□	Blood Pressure – High	□	□	Hepatitis	□	□	Mumps
□	□	Blood Pressure – Low	□	□	Herpes Virus	□	□	Pneumonia
□	□	Bruise Easily	□	□	High Fever	□	□	Rheumatic Fever
□	□	Cancer	□	□	HIV	□	□	Thyroid Disorder
□	□	Chicken Pox	□	□	Jaundice	□	□	Tuberculosis
□	□	Diabetes	□	□	Lyme's Disease	Other: (please explain)		
□	□	Emphysema	□	□	Measles			
□	□	Epilepsy	□	□	Meningitis			
□	□	Glaucoma	□	□	Migraines			

Recent medical tests:

Test:	Date:	Results:	Test:	Date:	Results:
Physical:			Pap Smear:		
Cholesterol:			HIV/STD:		
Prostate:			Blood Sugar:		
Mammography:			Thyroid:		
Other:					

List any known food allergies, sensitivities or intolerances and your reaction:_____

_____

List any allergies related to medications or supplements and your reaction: _____

_____

List any prior surgeries, what they were for and the date (or approximate date/year) performed:

1. Type:_____ Reason: _____ Date: _____
2. Type:_____ Reason: _____ Date: _____
3. Type:_____ Reason: _____ Date: _____

Please indicate family history of: □ Cancer □ Heart Disease □ Thyroid/Endocrine/Diabetes □ Auto-immune Disease

□ Allergies □ High Blood Pressure □ High Cholesterol □ Infertility □ Other: _____

Please indicate any addictions to: □ Nicotine □ Prescription medication □ Alcohol □ Other: _____

Energy, emotions and Immunity:

□ Fatigue	□ Slow Wound Healing	□ Easy to catch colds	□ Chronic Fatigue Syndrome
□ Low Energy ____/10 (max)	□ Stress Level ___/10 (max)	□ Mood Swings	□ Anxious/Nervous
□ Mental Tension	□ Anger	□ Grief	□ Depression
□ Irritable	□ Joy	□ Worry	□ Fear
□ Overwhelmed	□ Overworked	□ Mental Fogginess	□ Cold Hands/Feet
□ Suicidal Thoughts	□ Panic Attacks	□	

Sleep:

□ Restless	□ Non-restful	□ Busy mind	□ Night sweats
□ Difficult to fall asleep	□ Difficult to stay asleep	□ Nightmares	□ Vivid dreaming
□ Awaken to urinate	□ Awaken with pain	□ Number of hours of sleep per night: ____	

Head, Eye, Ear, Nose, and Throat:

□ Impaired Vision	□ Eye Pain/Strain	□ Glaucoma	□ Tearing/Dryness
□ Impaired Hearing	□ Ear Ringing	□ Earaches	□ Swollen glands
□ Headaches	□ Migraines	□ Teeth Grinding/TMJ/Jaw Problems	□ Allergies
□ Sinus Problems	□ Nasal Discharge	□ Frequent Sore Throats	□ Nose Bleeds
□ Sores on tip of tongue	□ Gum Disease	□ Teeth problems	□ Dry Mouth

Respiratory:

□ Cough	□ Shortness of Breath	□ Pneumonia	□ Pleurisy
□ Asthma			

Skin:

□ Rash	□ Eczema	□ Psorasis	□ Itchy skin
□ Dry Skin	□ Hives	□ Acne	□ Dandruff

Cardiovascular:

□ Heart Disease	□ Chest Pain	□ Swelling of Ankles	□ Heart Murmurs
□ High Blood Pressure	□ Palpitations/Fluttering	□ Poor Circulation	□ Varicose Veins

Gastrointestinal:

□ Nausea/Vomiting	□ Heartburn	□ Belching/gas	□ Abdominal Pain
□ Undigested food in stool	□ Gurgling in Stomach	□ Fatigue after eating	□ Mucous in stool
□ Ulcers	□ Incomplete stools	□ Bloating	□ Epigastric Pain
□ Diarrhea	□ Constipation	□ Gall Bladder Disease	□ Liver Disease
□ Hemorrhoids	□ Hernia	□ Food Cravings: _____	

Genito-Urinary Tract:

□ Painful Urination	□ Frequent Urination	□ Blood in Urine	□ Impaired Urination
□ Frequent UTI	□ Frequent Urination at Night	□ Kidney Stones	□ Kidney Disease
□ Incontinence	□ Pain during intercourse	□ Urgent urination	□ Veneral Disease: _____

Endocrine:

□ Hypothyroid	□ Hypoglycemia	□ Hyperthyroid	□ Diabetes Mellitus
□ Feel Hot	□ Feel Cold	□ Low libido	□ Hair loss

Neurologic:

□ Vertigo/Dizziness □ Numbness/Tingling □ Loss of Balance □ Paralysis

Pain:

□ Neck/Shoulder Pain □ Low Back Pain □ Upper Back Pain □ Mid Back Pain
□ Muscle Spasms/Cramps □ Arm Pain □ Leg Pain □ Arthritis
□ Tendonitis □ Bone Pain □ Swollen Joints □ Repetitive Strain
□ Sharp Pain □ Fixed Pain □ Moving Pain □ Dull Pain
□ Achy Pain □ Burning □ Numbness/tingling □ Radiating Pain

What makes pain better:

□ Soft pressure □ Hard Pressure □ Heat □ Cold
□ Rest □ Activity □ Other: _____

What makes pain worse:

□ Pressure □ Heat □ Cold □ Activity
□ Rest □ Standing or sitting too long □ Other: _____

Please rate your pain:

Current:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

No Pain Mild Moderate Severe Very Severe

Male Reproductive*:

□ Sexual Difficulties □ Prostrate Problems □ Testicular Pain/Swelling □ Penile Discharge

Female Reproductive*:

□ Irregular Cycles □ Amenorrhea (no periods) □ Painful Periods □ PMS
□ Bleeding Between Cycles □ Light Flow □ Heavy Flow □ Clotting
□ Vaginal Discharge □ Vaginal itching/burning □ Sores on genitalia □ Vulvodynia
□ Menopausal Symptoms □ Breast Lumps/Tenderness □ Nipple Discharge

Are you currently pregnant? □ No □ Yes, please list due date: _____
Are you currently taking BCP? □ No □ Yes – please list medication: _____

*If you are seeing us for fertility enhancement or infertility concerns, please make sure you fill out our separate questionnaire.

Habits/Lifestyle:

Exercise: ____ times/week □ mild □ moderate □ intense
Occupation: _____ #hrs/wk_____
Work Activity: □ Sitting □ Standing □ Computer
□ Light Labor □ Heavy Labor
Do you enjoy your work? □ No □ Yes
Reading: □ No □ Yes - How many hrs per day? ____
Stress level? □ None □ Small □ Medium □ High
Spiritual Practice? □ No □ Yes
Have you experienced any major traumas? □ No □ Yes, please explain: _____
_____

Hobbies: _____
Alcohol: □ No □ Yes – How much per day?____ week?____
Caffeine: □ No □ Yes – How many cups per day?____
Tobacco: □ No □ Yes – How many per day?_____
Television: □ No □ Yes – How many hrs per day?_____

Breakfast:	Lunch:
Dinner:	Snacks:

Patient Signature: _____ Date: _____

LAc Signature: _____ Ondria Holub, LAc Date: _____