**ACUPUNCTURE INITIAL INTAKE FORM**
**BOULDER BODY BALANCE ACUPUNCTURE CLINIC**

## PERSONAL CONTACT INFORMATION

Name: _____ Date: _____
Address: _____
Telephone Numbers: (home) _____ (work/cell) _____
Email address: _____
Can Boulder Body Balance Acupuncture use your email address to contact you concerning your care? Y/N
Birth date: _____ Age: _____ Gender: M/F Number of children: ____
Emergency Contact & Relationship: _____
Telephone: _____
How did you hear about this clinic: _____

## PHYSICIAN INFORMATION

Do you see a medical doctor? Y/N If so, name: _____
Telephone:_____
Other types of health care: (ie. physiotherapy, massage therapy) _____
_____

## MAIN HEALTH CONCERNS

My usual health is: Excellent Good Fair Poor
Please list, in order of importance, your chief concerns:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

## CONTEXT OF CARE SUMMARY

**Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient. The nature of your responses to the following questions will go a long way in assisting my understanding of your truest desires and your constitutional body type. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs. Everything in my office will remain confidential.**

## FAMILY HISTORY

**Please check off if any family members, including yourself, have had or currently have:**

| | | | |
|---|---|---|---|
| Cancer | Stroke | Eczema | Asthma |
| Arthritis | Thyroid Disease | Autoimmune Disease | High Blood |
| Kidney Stones | Gallstones | High Blood Pressure | Diabetes |
| Mental illness | Liver Disease | Heart Disease | Additions |
| Allergies | | | |

## PAST MEDICAL HISTORY

**Childhood illness: (please circle)**

| | | | | |
|---|---|---|---|---|
| Measles | German Measles | Scarlet Fever | Mumps | Rheumatic Fever |
| Tuberculosis | Chickenpox | Ear/Throat Infections | Cancer | |

**Vaccinations: (please circle)**

Polio Flu MMR(Measles/Mumps/Rubella) Smallpox Hep A and/or B
DPT(Diphtheria/Pertussis/Tetanus) Other

**What hospitalizations, surgeries, x-rays, CAT scans, MRIs, EEGs, or EKGs have you had?**
Year: _____ Description: _____
Year: _____ Description: _____
Year: _____ Description: _____
Year: _____ Description: _____
Major accidents/trauma: (falls, motor vehicle accidents, loss of loved one, etc.)
_____
_____

**CURRENT MEDICAL HISTORY**
**Current illnesses, conditions or disease: (if not previously stated above)**
_____
_____

**Allergies/sensitivities**
Drugs: _____
Food: _____
Chemicals: _____
Other: _____

**Medications & Supplements**
**Please list any prescription or over-the-counter medications and vitamins/supplements you are currently taking (include dose and frequency):**
1. Med/Supp: _____
2. Med/Supp: _____
3. Med/Supp: _____
4. Med/Supp: _____
5. Med/Supp: _____
6. Med/Supp: _____
7. Med/Supp: _____
8. Med/Supp: _____

Height: _____ Weight: _____ Weight 1 yr ago: _____ Maximum weight: _____
When during the day is your energy the best? _____ Worst? _____
Trouble falling asleep: Y/N Trouble staying asleep? Y/N Rested in AM? Y/N
Hours of sleep per night on average: _____ Do you wake to urinate more than once/night? Y/N
Level of stress on a scale of 1-10 (10 = highest): _____ Main cause: _____
How do you feel about your diet? _____
Do you crave certain foods? Y/N
If yes: _____
Occupation: _____ Do you enjoy work? Y/N
Hours week: _____
Hobbies: _____

**Please indicate the frequency of your habits by checking the boxes:**

| **HABIT** | **NEVER** | **1-3 x/wk** | **4-6 x/wk** | **DAILY** |
|---|---|---|---|---|
| Alcohol | | | | |
| Caffeine (incl. tea) | | | | |
| Tobacco | | | | |
| Drugs | | | | |
| Soft Drinks/Pop | | | | |
| Salty Foods | | | | |
| Sweet Foods | | | | |
| Worrying/stressed | | | | |
| How much water? | | | | |
| Exercise | | | | |
| Meditation or Prayer | | | | |
| Play Time | | | | |

**Please circle: 0 = never 1 = rarely 2 = occasionally 3 = frequently 4 = always**

0 1 2 3 4 low appetite
0 1 2 3 4 loose stools or constipation
0 1 2 3 4 gas/abdominal bloating
0 1 2 3 4 fatigue after eating
0 1 2 3 4 hemorrhoids
0 1 2 3 4 bruise easily
0 1 2 3 4 anemia
0 1 2 3 4 tired/fatigued often

0 1 2 3 4 abnormal sweating
0 1 2 3 4 allergies
0 1 2 3 4 asthma or bronchitis
0 1 2 3 4 shortness of breath
0 1 2 3 4 cough
0 1 2 3 4 dry nose/mouth/skin/throat

0 1 2 3 4 sore, cold or weak knees
0 1 2 3 4 low back pain
0 1 2 3 4 frequent urination
0 1 2 3 4 urinary incontinence
0 1 2 3 4 ear/hearing problems
0 1 2 3 4 ringing in ears (tinnitus)
0 1 2 3 4 early morning diarrhea
0 1 2 3 4 irritable and/or mood swings

0 1 2 3 4 spasms/twitches
0 1 2 3 4 ligament/tendon issues
0 1 2 3 4 tight feeling in chest
0 1 2 3 4 alternating diarrhea/constipation
0 1 2 3 4 sigh frequently
0 1 2 3 4 neck/shoulder tension
0 1 2 3 4 PMS symptoms or irregular menses
0 1 2 3 4 ravenous appetite
0 1 2 3 4 heartburn/acid reflux
0 1 2 3 4 mouth sores
0 1 2 3 4 belching or vomiting
0 1 2 3 4 gums bleeding/swollen
0 1 2 3 4 thirst
0 1 2 3 4 bad breath
0 1 2 3 4 organ prolapse (ie. uterine)

0 1 2 3 4 catch colds easily
0 1 2 3 4 tired after little exertion
0 1 2 3 4 general weakness or fatigue
0 1 2 3 4 nasal discharge
0 1 2 3 4 sinus congestion
0 1 2 3 4 feel cold often
0 1 2 3 4 swollen ankles or edema
0 1 2 3 4 poor memory/concentration
0 1 2 3 4 hair loss or thinning

0 1 2 3 4 infertility
0 1 2 3 4 libido (0 = low; 4 =high)
0 1 2 3 4 muscle
0 1 2 3 4 numb extremities
0 1 2 3 4 dry eyes or blurry vision

0 1 2 3 4 ringing in ears
0 1 2 3 4 easy to anger
0 1 2 3 4 red eyes
0 1 2 3 4 abdominal distention

**Urination: (circle all that apply)**
Burning Difficult Urgent Profuse Scanty Dribbling

Frequency of bowel movements: _____ Any undigested food, blood or mucus: Y/N _____
**Consistency:(Circle)**
Well-formed Loose Hard Alternates

Thirsty: Y/N If so, do you crave hot/warm or cool/cold drinks: _____
Is your body temperature generally on the cold or hot side: _____
Do you often get headaches or migraines: Y/N Location: _____

**Circle mood tendency(ies):**
Irritable, angry, frustrated, Nervous, anxious, Sad, depressed, unhappy, Flat, Peaceful, happy, Manic

**Women Only**
Are you currently pregnant? Y/N Are you on the birth control pill? Y/N
# of pregnancies: _____ # of live births: _____ # of miscarriages: _____ # of abortions: ____
How old were you when you had your first period? ____ Pre- menopause/Menopause? Y/N
If you are experiencing menopausal symptoms, please describe: _____
_____
Vaginal Discharge? Y/N Color:_____
Is your period regular? _____ (ie. same time, same length month to month)
Cycle length (ie. 28 days): _____ Days of bleeding (ie. 5): _____ Flow is: Light/Normal/Heavy
Color of menstrual blood is (circle all that apply): Pale/Normal/Dark/Bright Red/Brown/Purple
Blood clots? Y/N Do you get pain or cramps? Y/N Severe? Y/N
Nature of pain (circle all that apply): Sharp/Dull/Constant/Intermittent/Burning/Aching

**Do you experience any of the following before or during your menstrual period?**
Water retention Diarrhea Breast Tenderness/Swelling Constipation Irritability
Nausea Migraines Hot Flashes Insomnia Night Sweats

**Men Only**
Date of last prostate checkup (if over 45 yrs): _____ Results: _____

**(Circle all that apply):**
Groin Pain Testicular pain Dribbling urination Increased/Decreased Libido Impotence
Incontinence Painful urination Premature ejaculation Nocturnal emissions Difficult urination
Nocturnal emissions

**I understand that I have the right to ask any questions and discuss satisfaction of services in regards to my health. In particular, I have the right to be informed of:**
· The suspected diagnoses or condition(s)
· The nature, purpose, goals and potential benefits of the proposed care
· The inherent risk, complications, potential hazards, or side effects of a treatment or procedure
· The probability or likelihood of success
· Reasonable available alternatives to the proposed treatment procedure
· Potential consequences if treatment or advice is not followed and/or nothing is done

I recognize that even the gentlest therapies may potentially have complications in very young children,the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns and all medications, including over-the counter medications and supplements.