

Balance Point Acupuncture

Health Questionnaire

Although some of the questions may seem unrelated to your condition, they may play a contributing role in diagnosis and treatment. Thank you for filling this out completely.

Contact Information

Today's Date: ___ / ___ / ___

Last Name: _____ First: _____ Sex F M Date of Birth: ___ / ___ / ___ Age: _____

Street: _____ Email Address: _____

City: _____ State: _____ Zip: _____ Best Phone Number: _____

Marital Status: M S D W # of Children _____ Occupation: _____

Name of Emergency Contact: _____ Phone #: _____ Relation: _____

Have you had acupuncture before? Y N Would you like us to check your insurance for coverage Y N

Who can we thank for referring you to us? _____

Major Health Complaint(s)

Please list in order of significance to you and circle which you would like us to focus on today.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

When did the circled problem begin? _____ What are the precipitating factors? _____

Have you been given a diagnosis for this problem? If so, please describe. _____

What kind of treatments have you tried? _____

What makes this problem worse? _____ Better? _____

Is there anybody in your family with the same problem? _____ \ _____

Please describe how these conditions affect or impair your daily activities? Examples may include your overall quality of life, work, family life, hobbies or self-esteem.

Past Medical History

Check any conditions that you have had in the past or are currently experiencing:

- | | | | | |
|--|---|---|---|------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Vein Condition | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Profuse Bleeding or Hemorrhage | |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Auto Immune Disorder | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Arthritis |

Other Conditions: _____

Known allergies (food or other): _____

Significant trauma (car accident, sports injuries etc.): _____

Immunizations: _____

Hospitalizations (procedures and dates): _____

Dental Procedures (include any silver fillings/mercury amalgams): _____

Do you have a history of frequent antibiotic use? Please Describe. _____

