



BALANCED HEALTH

Acupuncture & Wellness Clinic

#204 2nd Floor
926 7th Avenue
Invermere, BC

☎ (250) 341-4806
📠 (250) 341-4807
info@balancedhealth.co
www.balancedhealth.co

At Balanced Health Acupuncture & Wellness Clinic, we believe that looking after ourselves is not only important, but necessary. Our core practice is acupuncture, part of the age-old Chinese medical system that uses needles to stimulate Qi. Balanced Health offers a holistic Eastern approach to health that is an effective complement to Western Medicine.

CONFIDENTIAL INTAKE FORM

ACUPUNCTURE & CHINESE MEDICINE

Chinese Medicine is a holistic medicine; this means it is treating the person as a whole. In order to come up with an accurate diagnosis and understanding of an individual all aspects of their life must be discussed. Please take your time filling out the following intake form - it will enable you to receive the care you deserve.

By analyzing the information you provide a very unique diagnosis will be explained to you and a treatment plan will be made based on the diagnosis, treating the symptoms as well as the underlying root. The goal is to bring your health and lifestyle into balance. All information is kept confidential between you and your practitioner. Thank you for taking responsibility for your health and well being.

Name:

Age:

Date of Birth:

Phone:

Cell:

Work:

Email :

Address:

City, town, postal code:

Emergency contact:

Phone:

Relationship to you:

Family doctor:

BC Health #:

Sex: M F Height:

Weight:

Marital Status: Single Married Separated Divorced Widowed

Major complaint/Health challenge

How did this condition develop?

How long has this condition persisted?

Is there anything that makes it better?

Is there anything that makes it worse?

Have you ever received treatment for this condition? Yes No

If yes, when?

Where?

By whom?

What was the diagnosis?



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The needles are reminding your body how to heal itself.

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Results of the treatment?

List any substances that you are allergic to:

List any prescription and non-prescription medications that you are currently taking:

Medication	Strength	# per day	Start date
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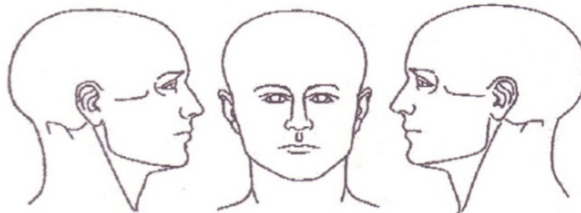
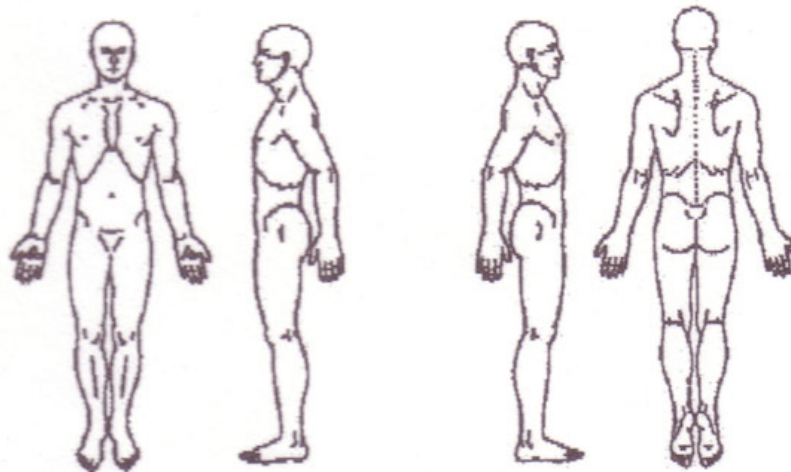
List any major surgeries you have had:

Date	Problem	Surgery
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Significant trauma (auto accidents, falls etc):

Do you have any religious or spiritual beliefs that you wish to share?

Do you experience pain or discomfort in any area of your body? Please mark where on the diagram below. *If filling out digitally, you can do this part at Balanced Health during your initial consultation.*



Check any of the following that you would use to describe your pain:

- | | | | |
|---------------------------|----------------------|---------------------|-----------|
| Burning pain | Radiating pain | Pain comes and goes | Weakness |
| Pain alleviated with cold | Constant pain | Pain moves around | Numbsness |
| Pain alleviated with heat | Fixed pain | Stabbing pain | |
| Better with pressure | Affecting daily life | Acute pain | |
| Worse with pressure | Dull pain | Chronic pain | |
| Sharp pain | Decreased mobility | Pain from trauma | |

HEALTH HISTORY
MUSKULOSKELETAL



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My purpose in life is to find the truth of my own soul and being, and to assist all those I cross paths with to do the same.

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ACUPUNCTURE & CHINESE MEDICINE

Type(s) of care that interest you:

- | | | |
|----------------------|--------------------------|-------------------------|
| Acupuncture | Allergy treatment (NAET) | Other wellness services |
| Esoteric acupuncture | Aromatherapy | |
| Herbal medicine | Reflexology | |

What are your health goals? e.g. Run a marathon. Feel more balanced. Get pregnant.

Have you ever had acupuncture before? Yes No
How did you hear about Balanced Health?

MAJOR ILLNESS

- AIDS/HIV
- Alcoholism
- Arthritis
- Autoimmune Disease
- Birth Trauma
- Cancer
- Childhood illness
- Diabetes
- Drug Addictions
- Eating disorder
- Epilepsy
- Gallstones
- Heart disease
- Hepatitis
- Rheumatic Fever
- Seizures
- Stroke
- Thyroid disease
- Venereal disease

EYES & VISION

- Cataract
- Eyes dry
- Eye pain/strain
- Eyes watery
- Eyes itchy
- Eyes red/inflamed
- Vision - corrected
- Vision - see halos
- Vision - blurred
- Vision - double
- Vision - floaters

DIET/LIFESTYLE

- Vegetarian
- Healthy diet
- Eat too much fried foods
- Eat too much meat
- Smoke cigarettes
- Drink alcohol
- Drink coffee
- Use drugs
- Eats lots of sweets
- Take melatonin
- Take steroids
- Exercise regularly
- Exercise excessively

HEAD & NECK

- Heaviness in head
- Phlegm in throat
- Hoarseness
- Nosebleeds
- Sore throat (recurrent)
- Nasal obstructin
- Nasal discharge
- Sense of smell loss
- Headaches
- Sinus infections
- Sinus congestion
- Coughing of phlegm
- Runny nose
- Sores on lips
- Sores on tongue
- Sores in mouth
- Taste change
- Teeth problems

EARS & HEARING

- Earache
- Ear discharge
- Hearing loss
- ringing in the ears
 - high pitch
 - low pitch

EMOTIONAL

- Anxiety
- Depression
- Difficulty expressing
- Insecure
- Insomnia
- Irritability
- High levels of stress
- Often feel angry
- Troubling dreams
- Cry uncontrollably
- Feel sad a lot
- Forgetful
- Mind not clear
- Not satisfied with relationship
- Poor memory
- Much fear
- Unrestrained joy
- Terrors

WEIGHT

- Underweight
- Normal for height
- Overweight

NEUROLOGICAL

- Fainting
- Convulsions
- Handwriting change
- Paralysis
- Stroke
- Seizures
- Tremor
- Recent clumsiness
- Drowsiness
- Vertigo

SKIN

- Thick skin
- Broken blood vessels
- Blood not clotting
- Bruise easily
- Discolouration
- Dark circles around eyes
- Bags under eyes
- Lumps in groin
- Lumps underarm
- Dry skin
- Acne
- Skin rash
- Brittle nails
- Premature grey hair
- Dry brittle hair
- Hair falling out

Describe your body temperature:

- Hot Cold Comfortable Sweat spontaneously Sweat at night Sweat with slight exertion

Do you ever have:

- Aversion to heat Aversion to cold Cold hands Cold feet Cold nose Cold limbs Cold low back

Rate your energy level (0 = low, 5 = moderate, 10 = high) :

GOALS

GENERAL HEALTH



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Quiet your mind and listen to what your body is truly saying

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ACUPUNCTURE & CHINESE MEDICINE

Check the applicable:

GASTROINTESTINAL

- Abdominal pain
- Acid reflux
- Anus itching/burning
- Bad breath
- Bloating
- Belching
- Bowels - lose control over
- Constipation
- Crohn's disease
- Diarrhea/loose stools
- Diarrhea - urgent early a.m.
- Difficulty swallowing
- Gas
- Heartburn/reflux
- Hemorrhoids
- Hernia
- IBS
- Indigestion
- Stomachache
- Stools black
- Stools bloody
- Stools dry/hard
- Stools alternate soft/hard

- Nausea
- Taste in mouth - abnormal
- Ulcers
- Vomiting
- Vomiting blood

GENITO-URINARY

- Blood in urine
- Dilute urine
- Dark urine
- Cloudy urine
- Burning sensation
- Kidney Stones
- Prone to bladder infections
- Abnormal smell to urine
- Difficulty starting
- Scanty urine
- Profuse urine
- Frequent urination
- Poor bladder control
- Urgency urinate

RESPIRATORY

- Asthma

- Hay fever
- Persistent cough
- Coughing blood
- Shortness of breath
- Recurrent bronchitis
- Phlegm production
- Difficulty inhaling
- Difficulty exhaling

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Low blood pressure
- Sighing
- Lump in throat
- Tightness in chest
- Heart palpitations
- Irregular heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins
- Hypochondriac pain
- Distention in chest or hypochondrium

How many glasses per day?

Water Pop Coffee Tea Alcohol

Which do you prefer?

Warm beverage Cold beverage

Describe your thirst: Thirsty often Have to force myself to drink Never thirsty

Can't quench my thirst Normal

Are you satisfied with your diet? Yes No

Do you have any particular food cravings? Yes No

If yes, what are they?

Food intolerances?

Describe your appetite:

Always hungry Low appetite Normal appetite

Do you have children? Yes No

Difficulty conceiving? Yes No

How would you describe your libido (sex drive)? Low High Healthy

Are you happy with your sex life? Yes No

Are you satisfied with your method of birth control? Yes No

Are you interested in learning more about a natural form of birth control? Yes No

HEALTH IN DETAIL DIET & APPETITE SEX



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SEXUAL HEALTH

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MEN

Genital pain
Genital sores
Impotence
Lump in testicles
Abnormal penis discharge
Nocturnal emissions
Premature ejaculation

Inability to maintain erection
Inability to obtain an erection
Pain associated with ejaculation
Low sperm count
Decreased sperm motility
Prostate problems
Low sexual energy

Sexually transmitted infections

DURING/AFTER INTERCOURSE

Pain or discomfort
Headaches
Fatigue

WOMEN

Abnormal pap smear
Abortion
Bleed between periods
Breast lumps
C-section
Chlamydia
Facial hair
Fibroids
Low sexual energy
Periods - irregular
Periods - heavy
Endometriosis
Painful periods
Premenstrual tension
Mastitis
Lactation difficulties

Polycystic ovaries
Post-partum depression
Prone to yeast infections
Sores on genitalia
Abnormal vaginal discharges
Vaginal dryness
Menopausal
Miscarriage
Uterine prolapse
Nipple discharge
Pelvic Inflammatory Disease
Loss of head hair
May be pregnant
Difficulties during pregnancy
Difficulties during labour

CURRENT BIRTH CONTROL

Pill
Diaphragm
Condom
Fertility Awareness
Depo-Provera
Withdrawal
IUD
Spermicide
Other

DURING/AFTER INTERCOURSE

Pain or discomfort
Headaches
Fatigue

WOMEN - MENSTRUATING

Is your cycle regular? Yes No

Days between menstrual cycles? e.g. 26, 28, 32

How many days do you bleed?

Do you have blood clots? Yes No

Colour of your menstrual flow? Bright red Dark red Pale red Brown Purple Crimson

Menstrual flow? Light Heavy Medium Flooding

Please check any of the following that occur before, during or after your menstrual cycle:

Depression	Dull achy pain	Loose stools	Water retention
Stabbing pain	Heavy sensation	Cravings	Coldness in lower back
Burning pain	Bloating	Headache	Pain in low back
Pain relieved by heat	Nausea	Fatigue	Pain in knees
Pain relieved by cold	Breast tenderness	Anger	Other
Acne	Constipation	Irritability	

WOMEN - MENOPAUSAL OR PERI-MENOPAUSAL

When was your last menstrual cycle?

Please describe any symptoms you have experienced related to menopause:

Have you had a hysterectomy? Yes No

Are you currently on HRT or have you been in the last year? Yes No



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A person in balance
shows no signs of
disease and handles
stress with ease.

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ACUPUNCTURE & CHINESE MEDICINE

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage, and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

Patient signature

Date

CONSENT