Original Date:
Date Revised:
Height:
Weight:
Blood Pressure:

BODIES IN BALANCE
ACUPUNCTURE

REGISTRATION & HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Today's Date: / /	Primary MD/PCP:

PATIENT INFORMATION

Last Name:	First:	Middle:			☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Date of Birth: / /	Age:	Sex: ☐ M ☐ F ☐ Other
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other:					
Street Address:			Social Security Number:		Preferred Contact: ☐ Home ☐ Mobile ☐ Email
P.O. Box:	City:		State:	ZIP Code:	
Home phone number: ( )	Mobile phone number: ( )	Email address:			
Occupation:	Employer:		Employer phone number: ( )		
Chose clinic because/Referred to clinic by (check one):	☐ Doctor	☐ Family	☐ Friend		
☐ Close to home/work	☐ Internet	☐ Other:			
Previous or referring doctor:	Date of last physical exam:				

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone number: ( )	Work/mobile phone number: ( )

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. IF USING HEALTH INSURANCE, I AUTHORIZE MEDICAL CLAIMS TO BE INITIATED BY MY PROVIDER TO MY HEALTH INSURANCE COMPANY, AND FOR INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE. I ALSO AUTHORIZE BODIES IN BALANCE ACUPUNCTURE OR MY INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

_____ _____

Patient / Guardian Signature ***Date***

PERSONAL HEALTH HISTORY

What is your primary reason for this visit?		
When did this episode of your symptom(s) begin?	**Is this condition DIRECTLY related to a:**	☐ Sports/Exercise Injury – Date:
	☐ Automobile Injury – Date:	☐ Other Illness / Condition:
	☐ Work Injury – Date:	

Do you have any other issues or concerns?

List any medical problems that other doctors have diagnosed

Surgeries/Injuries

Year	Description

Other hospitalizations

Year	Description

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of Drug	Dosage	Frequency Taken

Allergies – Medical and Environmental

Name of Drug / Substance	Reaction You Had

Are you allergic to latex?	☐ Yes	☐ No

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary	☐ Mild exercise	☐ Occasional vigorous exercise	☐ Regular vigorous exercise		
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician - prescribed diet?				☐ Yes	☐ No
	Number of meals you eat in an average day?					
	Rank salt intake:	☐ High	☐ Medium	☐ Low		
	Rank fat intake:	☐ High	☐ Medium	☐ Low		
	How much water do you drink in a day?					
	Do you get thirsty?				☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soda	☐ Diet Soda	
	Number of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?		How many drinks per week?			
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day:	☐ Chew – #/day:	☐ Pipe – #/day:	☐ Cigars – #/day:		
Drugs	Do you currently use recreational street drugs?				☐ Yes	☐ No
	Have you ever taken these drugs intravenously?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy, list a contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
Sleep	What time do you normally go to bed?					
	What time do you normally wake up in the morning?					
	Do you have trouble:	☐ Falling asleep	☐ Staying asleep	☐ Getting going in the morning		
	Do you wake rested?				☐ Yes	☐ No
	Do you take medication or supplements to help you sleep?				☐ Yes	☐ No
	What position do you sleep in?	☐ Back	☐ Left side	☐ Right side	☐ Stomach	☐ All over
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you experience dizzy spells?				☐ Yes	☐ No
	Physical and/or mental abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling(s)	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
What do you do to deal with your stress?		
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No
Do you experience any issues related to your memory?	☐ Yes	☐ No
Do you ever experience “foggy” brain or “fuzzy” thinking?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have or have had any symptoms in the following areas to a significant degree and briefly explain.			
☐ Skin	☐ Throat	☐ Bowel	Recent changes in:
☐ Head/Neck	☐ Lungs	☐ Circulation	☐ Weight
☐ Eyes	☐ Chest/Heart	☐ Teeth / Gums	☐ Energy level
☐ Ears	☐ Back	☐ Bladder	☐ Ability to sleep
☐ Nose	☐ Intestinal	☐ Other Area:	
Explain:			

Do you often experience headaches or migraines?	☐ Yes	☐ No
Do you often experience tingling sensations or numbness?	☐ Yes	☐ No

If experiencing other pain/discomfort, explain:

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Do you experience clots?	☐ Yes	☐ No
Number of pregnancies _____ Number of births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Any menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		
Do you currently or have you ever experienced postpartum depression?	☐ Yes	☐ No

MEN ONLY

Do you experience night sweats?	☐ Yes	☐ No
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, number of times?		
Do you feel pain or burning during urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from your penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Do you experience any dribbling after urination?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicular pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		
Have you had a vasectomy?	☐ Yes	☐ No
If yes, when?		

Do any of the following apply to you?

- ☐ **Weight Loss**
- ☐ **Weight Gain**
- ☐ **Strong Thirst**
- ☐ **No Thirst**
- ☐ **Sweating Easily**
- ☐ **Night Sweats**
- ☐ **Tics / Tremors**
- ☐ **Numbness**
- ☐ **Tingling**
- ☐ **Weakness**
- ☐ **Chest Pain**
- ☐ **Shortness of Breath**
- ☐ **Difficulty Breathing**
- ☐ **Abdominal Pain**
- ☐ **Bleeding from Mouth or Anus**
- ☐ **Vomiting Blood**
- ☐ **Blood in Urine**
- ☐ **Black, Tarry Stools**
- ☐ **Dizziness / Vertigo**
- ☐ **Headache**
- ☐ **Tenderness/Swelling in Calf or Thigh**
- ☐ **Infection**
- ☐ **Chronic Pain**
- ☐ **Masses or Lumps**
- ☐ **Skin Lesions**
- ☐ **Rashes**
- ☐ **Discharge from Breast**
- ☐ **Excessive Vaginal Bleeding**
- ☐ **Poor Hearing**
- ☐ **Vision Problems**
- ☐ **Ringing in Ears**
- ☐ **Visual Floaters**
- ☐ **Swelling of Hands, Feet, or Ankles**
- ☐ **Swelling of Abdomen**
- ☐ **Fainting**
- ☐ **Blood Clots**
- ☐ **High or Low Blood Pressure**
- ☐ **Cough**
- ☐ **Cough with Blood**
- ☐ **Cough with Phlegm**
- ☐ **Nausea / Vomiting**
- ☐ **Diarrhea**
- ☐ **Loose Stools**
- ☐ **Constipation**
- ☐ **Belching**
- ☐ **Indigestion**
- ☐ **Gas / Bloating**
- ☐ **Hemorrhoids**
- ☐ **Easy Bruising or Bleeding**
- ☐ **Bad Breath**
- ☐ **Painful Urination**
- ☐ **Menstrual Difficulties**
- ☐ **Urinary Dribble**
- ☐ **Decreased Urinary Flow**
- ☐ **Genital Sores or Discharges**
- ☐ **Mood Swings**
- ☐ **Stress / Tension**
- ☐ **Anxiety**
- ☐ **Depression**
- ☐ **Insomnia**
- ☐ **Autoimmune Disorder(s)**
- ☐ **Birth Trauma**
- ☐ **Bladder Disease**
- ☐ **Bone Disease**
- ☐ **Blood Disease**
- ☐ **Bowel Disease (Crohn's, IBS, etc.)**
- ☐ **Cancer**
- ☐ **Diabetes**
- ☐ **Endocrine Disease**
- ☐ **Gallbladder Disease**
- ☐ **Heart Disease**
- ☐ **Gynecological Disorder(s)**
- ☐ **High Cholesterol**
- ☐ **Skin Disorder(s)**
- ☐ **Joint Problems**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Lung Disease**
- ☐ **Musculoskeletal Disorder(s)**
- ☐ **Neurological Disorder(s)**
- ☐ **Male Reproductive Disorder(s)**
- ☐ **Stomach Disorder(s)**
- ☐ **Psychological / Psychiatric Disorder(s)**
- ☐ **Other:** _____

BODIES IN BALANCE
ACUPUNCTURE

LATE ARRIVAL / NO-SHOW POLICY

Our office runs on an appointment system and our practitioners make every effort to be on time. Late arrivals and patients failing to show for their scheduled appointments can create problems for our office. This problem, coupled with the unpredictable nature of health care, makes it difficult for us to keep our schedule running on time. **Patients arriving late to their scheduled appointments may be asked to reschedule at the discretion of the practitioner. Patients who do not show for their scheduled appointment will be assessed a charge of $50.00.**

CANCELLATION POLICY

In consideration of our limited time and the needs of other patients, please give our staff notice **at least 24 hours in advance** of your appointment should you need to cancel or reschedule.

Failure to provide notice 24 hours in advance will result in your being billed $25.00. This also applies to the use of gift certificates, prepaid services or alternative payment methods, which will then be reduced in value by $25.00 or become null and void.

Thank you for your cooperation with these policies.

I, _____, HAVE READ AND UNDERSTAND THE ABOVE POLICIES OF THIS OFFICE. I ACKNOWLEDGE THAT FAILURE TO COMPLY WITH THESE POLICIES WILL RESULT IN THE BILLING OF THE ABOVE PRICES.

_____ _____

Patient Signature Date