



Welcome to BalancePoint Integrative Medicine

In order to provide you with the best professional care, please take the time to answer this questionnaire fully. To help you properly, I need to understand your unique history and patterns of health and wellbeing.

Thank you for taking the time to answer these questions thoroughly.

Name *Date*

Address

City *State* *Zip Code*

Home Phone *Work Phone* *Cell Phone*

Date of Birth *Social Security Number (for Workman's Comp claims)*

Gender *Marital Status*

Occupation *Employer*

Emergency Contact *Phone*

Referred By

If you have to cancel an appointment, please call me.

What is Bothering You?

What is your primary problem?

When did this first begin?

Were you experiencing any unusual emotional, physical or mental stress? *Please describe.*

Were you ill at the time?

Have you received any diagnosis or treatment for your problem? *Please describe.*

Do you have any other problems?

What have you tried already for your primary problem?

How effective was it?

Are you still doing it?

Are You in Pain?

If not, please skip to the next page.

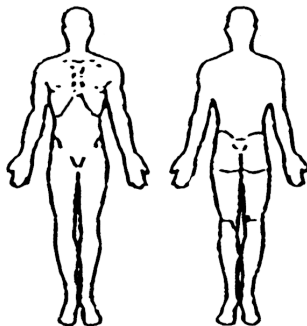
Please describe the pain?

On a scale of 1-10, with 10 being so severe you would pass out,
How much does it hurt right now? ____ How much does it usually hurt? ____

What makes the pain better?

What makes the pain worse?

Where does it hurt? Please mark any areas of pain or discomfort.



What kind of pain is it?

If you have more than one type of pain, please draw a line connecting the type of pain to the location on the diagram.

- Sharp or stabbing pain
- Pins & needles
- Dull or aching
- Numbness
- Burning
- Other: _____

When did your pain begin?

Does your pain travel to another part of the body?

Do your symptoms limit the following activities?

	<i>Severely Limited</i>	<i>Somewhat Limited</i>	<i>No Effect</i>	<i>Makes It Feel Better</i>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resting in Bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Typing / Computers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shower & Shampoo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vacuuming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does heat make the symptoms better or worse?

Does cold make the symptoms better or worse?

Does pressure make the symptoms better or worse?

Do you suffer from:

	<i>Occasional</i>	<i>Moderate</i>	<i>Chronic</i>
Backache or neck ache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain? <i>Please specify.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle aches or cramps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches? <i>Location of pain?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please Tell Me About Your Medical History

Do you have any history of:

Now Past

- | | | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Pressure Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Candida (Yeast Problems) |
| <input type="checkbox"/> | <input type="checkbox"/> | Circulatory Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Edema |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy / Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Epstein - Barr virus |
| <input type="checkbox"/> | <input type="checkbox"/> | Food Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Colds |
| <input type="checkbox"/> | <input type="checkbox"/> | Gallstones |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastric Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Now Past

- | | | |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Gallstones |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastric Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Hay fever / Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Head Injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A B C |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> | Immunosuppression |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Mononucleosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Nose Bleeds |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Serious Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgeries: _____ |

Do you experience any of the following?

- Dizziness / Vertigo
- Ringing in your ears High Pitch Low Pitch
- Hearing loss
- Any unusual hair loss or premature gray
- Tooth problems
- Numbness or tingling sensations. Where?
- Heart palpitations
- Chest pain
- Bruise easily
- Heal Slowly
- Shortness of breath
- Shallow Breathing
- Grind you teeth
- Jaw pain or TMJ
- Tremors or shaking of any kind
- A lump in your throat that you cannot swallow
- Pain under or along rib cage
- Mouth or tongue sores / ulcers

Tell me about your medications?

Do you use, or have you ever used:

Now Past

When

- | | |
|--|-------|
| <input type="checkbox"/> <input type="checkbox"/> Antacids / Tagamet | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Anti-Depressants | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Antibiotics | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Pain Medication | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Sleeping Pills | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Steroids / Prednisone | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid Medication | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Tranquilizers / Valium | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Tobacco | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Alcohol (in excess) | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Other: _____ | _____ |

What medications, herbs or supplements are you currently taking?

Do you have allergic reactions to any medications, herbs, foods, etc.?

Do you have a family history of the following?

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other: _____ |
-

How Do You Feel?

If you have a cold or the flu, please tell us how you are when you are not feeling sick.

How are your energy levels?

- Are you fatigued or do you fatigue easily?
- Do you feel tired when you wake up?
- Does your energy level drop at a certain time each day? When?
- Do you need to take naps?
- Do you have good energy levels?

How is your sleep?

Do you suffer from:

- Insomnia
- Excessive, disturbing dreams
- Racing thoughts
- Difficulty falling asleep
- Difficulty staying asleep
- Waking up too early

How many hours, on average, do you sleep each night?

Is that enough sleep for you?

How is your body temperature generally?

- Hot Cold Comfortable
- Do you have cold hands?
- Do you have cold feet?
- Do you have a low-grade fever? What time of day?

Do you perspire:

- Easily, without exertion
- Easily, upon exertion
- Moderately
- Very little, even with exercise
- At night in your sleep (night sweats)
- Sweaty hands and/or feet

Do you exercise?

What type and how often?

Do you have more or less energy after exercise?

Do you have dry:

- Eyes Hair Nails Nose
- Skin Mouth Lips

Do you feel thirsty?

- All the time
- Some of the time
- Rarely
- Never
- Yes, but I don't feel the urge to drink?

Does drinking quench your thirst?

How many glasses do you drink each day?

Water	_____
Coffee	_____
Tea	_____
Soda Pop	_____
Juice	_____
Milk	_____
Alcohol	_____

Do you prefer your drinks: Ice Cold Hot Room Temperature

How about your emotions?

Do you experience any of the following emotions excessively or do any interfere with your relationship or activities?

- Anger
- Fear
- Worry
- Sadness
- Anxiety
- Depression

Do you experience:

- Irritability
- Mood Swings

Do mood swings seem to be related to eating or not eating?

Tell Me About Your Appetite and Digestion

How is your Appetite?

- Has your appetite changed recently? Increased Decreased
- Are you always hungry?
 - Are you rarely hungry?
 - Do you have a bitter taste in your mouth?

Do you crave certain types of food?

- Sweet
- Salty
- Sour
- Bitter
- Hot or Spicy
- Other:

Tell me about your diet?

Do you eat at regular times?

What foods do you eat the most in a week and what do you eat the least?

Use 0 through 10 to rank food choices (10 for always, 0 for never),

- ___ Poultry
- ___ Fish
- ___ Tofu
- ___ Breads
- ___ Fruit
- ___ Dairy
- ___ Pasta
- ___ Vegetables (cooked)
- ___ Vegetables (raw)
- ___ Rice, Grains
- ___ Beans / Legumes
- ___ Sweets

Do you have any dietary restrictions?

How is your digestion?

- After eating, do feel bloated? Where? Upper belly / Stomach Lower Abdomen

Do you experience:

- Excessive belching
 - Gas
 - Intestinal pain / cramping
 - Heartburn
 - Excessive stomach gurgling
 - Nausea
 - Feeling full after eating only a little food
-

Is your urine:

- Unusually clear and a large amount
- Usually yellow and a moderate amount
- Unusually dark and a small amount

Do you experience:

- Difficulty urinating
- Burning with urination
- Dribbling of urine
- Incontinence of urine at any time

- Do you wake more than once a night to urinate? if so, how often?
- Do you urinate more than 6 times a day?
- Do you urinate less than 5 times a day?

- Do you have bowel movements less than five times a week?
- Do you have bowel movements more than two times a day?
- Do you have blood or pus in your stools?
- Do you suffer from hemorrhoids?

Are your stools:

- Unusually hard
 - Alternating loose / hard
 - Unusually loose
 - Usually well formed
 - Contain undigested food
-

Questions for Men

Do you experience:

- | | |
|--|--|
| <input type="checkbox"/> Reduced sex drive | <input type="checkbox"/> Unusual discharge |
| <input type="checkbox"/> Excessive sex drive | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Genital pain |
| <input type="checkbox"/> Ejaculations during sleep | |

Questions for Women

Do you have a history of:

- Irregular periods
- No periods (Amenorrhea)
- Ovarian cyst
- Pelvic inflammatory disease
- Uterine fibroids
- Chronic vaginal or yeast infections
- Menstrual cramps
- Ectopic pregnancy
- Endometriosis
- Reduced sex drive
- Bladder infections
- Painful periods

Tell me about your periods:

If you no longer have periods, indicate what they were like before they stopped:

- How old were you when you began menstruating?
- Is your period regular? How many days is your cycle?
- How many days do you bleed: ___ Heavily ___ Lightly
- Do you bleed excessively?
- Do you bleed very little?
- What color is your menstrual blood?
- Do you discharge clots?

Do you experience pain with your periods?

Describe what kind of pain and when you feel it:

- Do you get headaches during menstruation or ovulation?
 - Do you experience pain at ovulation (middleschmerz)?
 - Do you experience spotting when you are not menstruating? *Please describe.*
-

Do you experience symptoms of PMS?

- Breast distension
- Water retention / bloating
- Mood swings
- Irritability
- Depression
- Headache

How many days before your period do PMS symptoms begin?

What kind of birth control have you used?

- Birth control pills How many years?
- IUD How many years?
- Other: How many years?

Tell me about your pregnancy history:

How many times have you been pregnant?

- Are you presently pregnant?
- Do you have children? How old? Genders?
- Have you had any miscarriages? How many?
- Have you had any abortions? How many?

Following birth or abortion, did you have any health problems, including prolonged fatigue? *Please explain.*

Are you presently experiencing any symptoms of menopause?

- Hot flashes
 - Night Sweats
 - Weight Gain,
 - Memory Loss,
 - Fatigue,
 - Mood Changes,
 - Decreased Libado
 - Other:
-



Linda Raford, RN, CNM, LAc.

Colorado law requires that all acupuncturists provide the following information to clients at the first visit.

Disclosure Statement

Clients are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if know.

All rules and regulations specified by the Colorado Department of Health and pertaining to acupuncture are strictly adhered to in this center, including the proper cleaning and sterilization of equipment and office. Linda Raford also follows clean needle technique, using sterile, disposable needles.

Clients may seek a second opinion from another health care professional, or may terminate therapy at any time.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

Acupuncture is regulated by the Department of Regulatory Agencies.
Any complaints should be directed to:

Department of Regulatory Agencies
Office of Acupuncturists Registration
1650 Broadway, Suite 1545
Denver, CO 80202
303.894.2464

Payment, Fee Schedule and Client Responsibility

Unless prior arrangements have been made, you are responsible for payment at the time service is rendered. If you need to cancel, please give 24-hours notice.

I have read and agree to the above conditions prior to treatment.

Client Signature

Date



Acupuncture & Chinese Medicine Consent

Client

Date

Time

I voluntarily consent to be treated by Linda Raford, RN, CNM, LAc., a registered acupuncturist in the state of Colorado.

I understand that acupuncture is performed by the insertion of sterilized, disposable needles through the skin, or by application of heat to the skin, or by both, at certain points on or near the surface of the body. The procedure has been fully explained to me.

I have also been made aware that certain adverse side effects may result from my treatment. These could include, but are not limited to, some local bruising, bleeding, fainting, nausea, temporary pain or discomfort, and the possible aggravation of symptoms existing prior to my acupuncture treatment.

I accept that no guarantee is made concerning the results of my acupuncture treatments and I have been informed that I may stop treatment at any time. I also understand that Acupuncture and Chinese Medicine is not a substitute for standard Western medicine, that certain health disorders may require conventional, allopathic diagnosis and treatment, and that I am free to seek allopathic medical advice and treatment at any time, either in lieu of or concurrently with acupuncture treatments.

I understand that at anytime during the course of our work together, Linda Raford can not make any diagnosis. Any suggestions made are only recommendations.

I have read the above consent and I understand what it says:

Client Signature

Date

The client is unable to consent because_____. I, therefore consent for the client.

Relative / Guardian / Representative

Relationship to Client



Release of Information to Your Healthcare Provider

Although it is not required, we suggest that you discuss your use of complementary therapies (like acupuncture and Chinese medicine) with your physician or healthcare provider. This allows both your healthcare provider and BalancePoint Integrative Medicine to have full knowledge of your treatment plan and it helps them provide the best comprehensive health services for you.

I, _____, authorize BalancePoint Integrative Medicine to share information with my healthcare provider or insurance company: _____ . I understand that BalancePoint Integrative Medicine is under no obligation to communicate with my healthcare provider or providers listed above. However, information that may be helpful in providing quality health services to me will be shared with my healthcare provider at the discretion of BalancePoint Integrative Medicine, upon request from my healthcare provider, or upon my specific request.

I understand that I do not have to sign this release to receive treatment.

I have read the above consent and understand what it says:

Client Signature

Date