



## 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.*

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*Name* *Date*

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*Address*

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*City* *State* *Zip Code*

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*Home Phone* *Work Phone* *Cell Phone*

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

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*Gender* *Marital Status*

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*Occupation* *Employer*

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*Emergency Contact* *Phone*

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*Referred By*

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

## ***What is Bothering You?***

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*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?

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## ***Are You in Pain?***

*If not, please skip to the next page.*

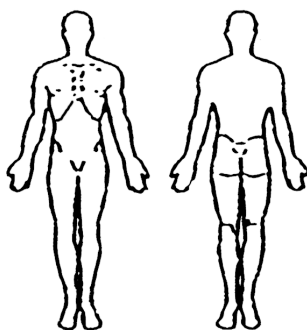
### ***Please describe the pain?***

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"/>

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***Please Tell Me About Your Medical History***

***Do you have any history of:***

*Now Past*

- Anemia
- Arthritis
- Asthma
- Blood Pressure Problems
- Cancer
- Candida (Yeast Problems)
- Circulatory Problems
- Chronic Cough
- Depression
- Diabetes
- Edema
- Epilepsy / Seizures
- Epstein - Barr virus
- Food Allergies
- Frequent Colds
- Gallstones
- Gastric Problems
- Other: \_\_\_\_\_

*Now Past*

- Gallstones
- Gastric Problems
- Hay fever / Allergies
- Head Injury
- Headaches
- Heart Disease
- Hepatitis A B C
- Herpes
- Immunosuppression
- Kidney Stones
- Mononucleosis
- Nose Bleeds
- Osteoporosis
- Prostate Problems
- Serious Fever
- Skin Problems
- Stroke
- 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: _____  |
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**Linda Rafor, 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 Rafor 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.

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*Client Signature*

*Date*



## Acupuncture & Chinese Medicine Consent

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*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:

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*Client Signature*

*Date*

The client is unable to consent because\_\_\_\_\_. I, therefore consent for the client.

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*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:

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*Client Signature*

*Date*