The Balanced Path Wellness Center—INTAKE FORM

DATE: ________________EMAIL ADDRESS: ________________________________

Name: _______________________ Phone: (H)_______________(W)_______________

Address: ________________________City: ________________ State: ___ Zip: _______

Birthday: ____________ Age: _______ Occupation: _______________ Ht: ___ Wt: ___

Physician Name/Phone: ___________________________ Date last seen: ____________

Have you seen a Medical Doctor for condition you are currently seeking help? ________

Diagnosis given: ___________________Treatment path chosen by Dr. ______________

How were you referred to us? ____

Is there a possibility you are pregnant? _______ Do you: Smoke? ___________
Drink coffee? _______ Drink Alcohol? _______ (Please list quantity of each consumed)

MAIN COMPLAINT(S): (NO WESTERN MEDICAL DIAGNOSES, DESCRIBE PROBLEM(S) IN YOUR OWN WORDS)

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HISTORY: Please circle if you have, or have had any of the following conditions:
Arthritis - Asthma - Cancer (what kind/where?)________ -Coronary Artery Disease
Diabetes - Eczema - Heart Attack- Heart Disease- Hemophilia- High Blood Pressure
HIV/AIDS- Hyperthyroid- Hypothyroid- Hepatitis- Kidney Disease- Liver Disease
Lyme Disease- Mononucleosis- Rheumatic Fever- Scarlet Fever- Seizures/Epilepsy
STD (what?)_________- Stroke- Tuberculosis- OTHER: ______________________

Please list all surgeries and approx. dates: ______________________________________

____

Please list all medications (prescription and OTC), supplements, and herbs you are currently taking: ____

____

General Energy: ___excellent ___good ___fair ___poor ___up and down
Are you often too hot or cold? (circle one) Do you prefer hot or cold drinks? (circle one)

PERSPIRATION: Do you-

__perspire when you should __perspire w/ slight exertion __perspire for no app. reason
__perspire profusely __not perspire __have night sweats
__have cold sweats __have foul body odor __other: ________________

SLEEP: Do You-

__have difficulty going to sleep __sleep shallowly __awaken at night-time_____
__have difficulty returning to sleep __need to take naps __have dream-disturbed sleep
__feel "wired and tired" __OTHER: ________________________________

EXERCISE:

What kind of exercise do you get weekly? ______________________________________
Are your symptoms better or worse with exercise/movement? (circle one)
If you aren't exercising regularly, why not? _____________________________________

RESPIRATION: Do you have-

__shortness of breath __difficulty inhaling __difficulty exhaling __sneezing
__cough (__wet __dry __hacking __with phlegm-{what color____________} __blood)

PAIN: Do you have-

__rapid onset __gradual onset __dull pain __sharp pain __burning pain
__chest pain __low back pain __joint pain __fixed pain __wandering pain
__pain under ribs __Headaches (where: ____________________)

EYES: Do you-

__have blurry vision __have red eyes __have dry eyes __have floaters
__have itchy eyes __have watery eyes __have poor night vision
__have a change in your vision (recent)

EARS: Do you-

__have difficulty hearing __have ear pain __have ringing (high or low pitch)

MOUTH: Do you have-

__tongue ulcers __canker sores __bleeding gums __toothache
__sour regurgitation __bitter taste __sore throats __difficult to swallow
__sensation of something stuck in throat

MUSCLES: Do you have-

__weakness __tension __aches __tics __spasms __cramps
Locations: ____

DIGESTION/DIET:

Please describe your general diet/eating habits: ________________________________
____

Do you have-

__bloating __indigestion __noisy stomach __abdominal pain __cramping
__constipation __diarrhea __excess gas __nausea __vomiting
__regular meals __alternating constipation/diarrhea

Appetite: __poor __good __excessive
Cravings: __salty __sour __bitter __sweet __spicy

ELIMINATION:

STOOLS: What color are your stools? _______________Does it vary? _______
How many bowel movements per day? __________
Do you have-
__hard stools __soft stools __bloody stools __mucus in stools
__very foul odor to stools __undigested food in stools

URINE: What color is your urine? ___________Urinary frequency___________
Is your liquid intake about equal to your output? __________________
Do you-
__have urgency __have difficulty starting __have a weak flow
__have pain __notice blood in urine __have UTI's
__have strong smelling urine __have cloudy urine
__awaken at night to urinate (how many times ____)

REPRODUCTION:

How often do you engage in sexual activity? _________Birth control? _________
Do you have-
__low sexual energy __excessive sexual energy __premature ejaculation
__pain w/ sex __genital discharge (color______)
__impotence __OTHER: __________________________________
How many pregnancies have you had? ________Any miscarriages? ____How many? __
How long is your menstrual cycle? _______days. Is it regular? ____ Color of blood____
How long is the flow? ____________days. Clots? ____ Cramps? ____ Pain? _________

What do you want to accomplish with these treatments? _________________________

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Are you interested in feeling as good as you possibly can? ________________________
Are you willing to sacrifice/work to obtain this goal? ____________________________
Do you believe that health maintenance/preventative care is important? _____________

MEDICAL RECORDS RELEASE:

I understand that The Balanced Path Wellness Center takes my privacy seriously and that my information will be kept private. I hereby permit The Balanced Path Wellness Center to release my medical records upon request by my Attorney, Doctor, or Insurance Company.

Patient Signature: ____________________________________

PATIENT AGREEMENT:

I understand that The Balanced Path Wellness Center is a cash-only practice, meaning that I will pay for my visits the day of each visit by cash or check. The Balanced Path Wellness Center will provide receipts upon request, or fill out certain insurance forms upon request, but billing of insurance companies and verification of benefits is my responsibility. A $40 fee will be charged for all missed appointments (no-shows) or cancellations within a 24 hr. period. If I have to cancel or reschedule an appointment, I understand that I must call 774-283-2726 at least 24 hrs in advance of my scheduled visit to avoid the late-cancel fee.

Patient Signature: ____________________________________

Date: _________________