Life in Balance Acupuncture

Brodie Welch, L.Ac., M.S.O.M.
(541) 757-4868
534 NW 4th St.
Corvallis, OR 97330

Dear Patient,

Thank you for taking the time to fill out this intake form. Please bring it with you to your first visit so we can review it together. Since Chinese Medicine is holistic, the more we know about the whole of you, the better we can treat the part that brought you here.

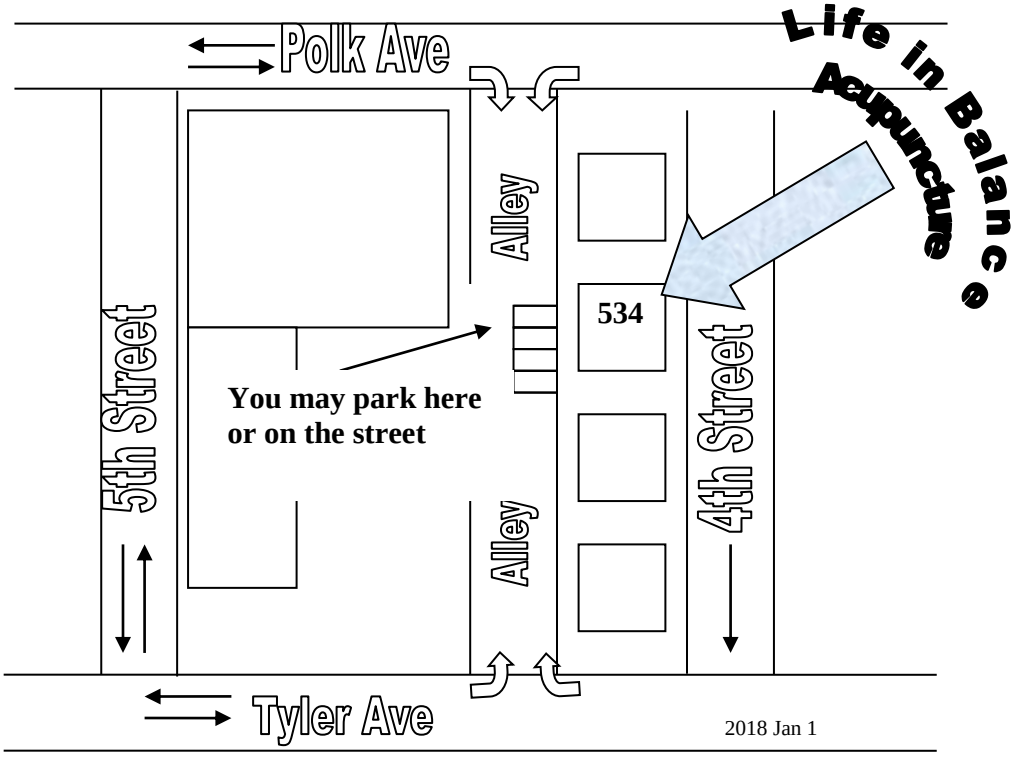
Life in Balance Acupuncture is located at 534 NW Fourth Street, about one and a half blocks north of Harrison Boulevard, between Tyler and Polk Avenues, on the west side of the street. **The entrance and parking are at the back of the building** – please park in one of the numbered parking spaces.

Please dress in loose clothing and do have something to eat a few hours before your visit. Your first visit will last about 90 minutes and costs $145 (follow-up visits are $95) with a time-of-service discount (meaning you won't be using insurance). We do not accept insurance directly, but you are welcome to submit your receipts to your insurance for reimbursement. Should you need to reschedule a visit, please call (541) 757-4868 at least 24 hours in advance to avoid being charged (for Monday appointments, we need to hear from you by Friday at 3pm).

Thank you for the opportunity to work with you on your journey towards optimal health and wellness.

Sincerely,

Brodie Welch, L.Ac.



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Patient Information

Name: _____ Date: ___/___/_____

Phone numbers:

Home: (____)_____Cell: (____)_____ Work: (____)_____

Preferred phone for messages: (circle one) Home Cell Work

Address: _____ City:_____ State:___ Zip:_____

Email: _____ Would you like to receive our e-newsletter? Y N

Age: _____ Sex: _____ Height: _____ Weight:_____ Date of Birth: ___/___/____

Relationship Status: _____ Occupation: _____

Emergency contact: _____ Emergency contact #_____

Primary Care Physician: _____ Doctor's phone: _____

Whom may we thank for this referral? _____

Have you ever had acupuncture before? Yes ☐ No ☐

Please list your top three health concerns you would like to be free of, in order of importance. (These may be physical, emotional, or spiritual issues.)

1)_____
How long has this been a concern? _____How did it begin? _____

2)_____
How long has this been a concern? _____How did it begin? _____

3) _____
How long has this been a concern? _____How did it begin? _____

How do these conditions affect your life?_____
_____
_____

Have you been treated for this by anyone else? Yes ☐ No ☐
What kinds of treatments have you had? _____
Name of practitioner(s) _____
Have these treatments helped? Yes ☐ Somewhat ☐ Not much ☐ Not at all ☐

Health History

Please write "C" in the box next to conditions you <u>currently</u> have and "P" in the box next to conditions you have had in the <u>past</u>.

☐ Alcoholism	☐ Hepatitis (Type ___)	☐ Liver or Gallbladder problem	
☐ Allergies	☐ Herpes	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Anemia	☐ High blood pressure	☐ Obesity	☐ Ulcer
☐ Asthma	☐ HIV / AIDS	☐ Pancreatitis	☐ Varicose Veins
☐ Cancer	☐ Kidney Disease	☐ Pneumonia	☐ Other:
☐ Diabetes	☐ Lupus	☐ Polio	_____
☐ Epilepsy	☐ Malaria	☐ Stroke	_____
☐ Heart Disease	☐ Mental illness	☐ Thyroid problem	_____

What conditions run in your family? _____

Do you have a pacemaker? Yes ☐ No ☐

Known or suspected allergens: _____

How was your health as a child? Excellent ☐ Good ☐ Average ☐ Poor ☐

Did you feel safe and nurtured as a child? Always ☐ Usually ☐ At times ☐ Never ☐

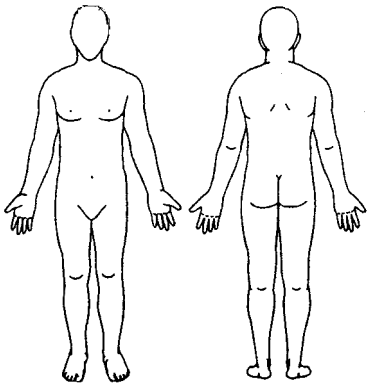
Please list any surgeries, hospitalizations, and accidents with their dates:

_____

_____

Pain

On the pictures below, please indicate all areas of pain, numbness, or discomfort:



Is the sensation: dull ☐ achy ☐ comes and goes ☐ moves around ☐
☐ sharp ☐ stabbing ☐ constant ☐ burning ☐ radiating to: _____

How painful is it, on a scale of 0 (none) to 10 (excruciating)? _____

What helps the pain? Movement ☐ Pressure ☐ Rest ☐ Heat ☐ Ice ☐
Nothing ☐ Drugs ☐ Other ☐ _____

What aggravates the pain? Movement ☐ Pressure ☐ Rest ☐ Heat ☐ Ice ☐
Nothing ☐ Other specific activity ☐ _____

Please put a check mark (✓) by the symptoms you have **now**.
Place an X by any symptoms that you have noticed **in the past 3 months**.

- ☐ allergies (respiratory)
- ☐ persistent cough
- ☐ shortness of breath
- ☐ wheezing
- ☐ frequent colds/ flu
- ☐ nosebleeds
- ☐ sore throat
- ☐ grief, sadness
- ☐ tiredness
- ☐ nasal congestion
- ☐ abdominal fullness
- ☐ abdominal pain
- ☐ bloating
- ☐ belching
- ☐ bruising easily
- ☐ eating disorder
- ☐ dizziness with standing up
- ☐ gas
- ☐ hemorrhoids
- ☐ cold hands and feet
- ☐ heavy feeling in head
- ☐ heavy feeling in limbs
- ☐ nausea
- ☐ prolapsed organs
- ☐ low appetite
- ☐ loose stools
- ☐ diarrhea
- ☐ constipation
- ☐ dry stools
- ☐ sticky stools
- ☐ headaches
- ☐ incomplete bowel movements
- ☐ soreness near ribs
- ☐ migraines
- ☐ irritability
- ☐ feeling of a lump in throat
- ☐ difficulty swallowing
- ☐ high blood pressure
- ☐ breast tenderness
- ☐ incomplete urination
- ☐ dry mouth or throat
- ☐ bitter taste in mouth
- ☐ red or sore eyes
- ☐ anger
- ☐ rapid hungering
- ☐ burning sensation in chest or throat
- ☐ heartburn
- ☐ bad breath
- ☐ mouth / tongue sores
- ☐ bleeding gums
- ☐ hot flashes
- ☐ night sweats
- ☐ dizziness
- ☐ ringing in ears
- ☐ thirst
- ☐ excessive libido
- ☐ frequent urination
- ☐ incontinence
- ☐ get up more than once a night to urinate
- ☐ cold feet (only)
- ☐ feeling cold
- ☐ low libido
- ☐ low back pain
- ☐ swollen ankles
- ☐ thinning hair
- ☐ dry, brittle nails
- ☐ dry hair or scalp
- ☐ dry skin
- ☐ dry eyes
- ☐ floating spots in vision
- ☐ decreased night vision
- ☐ muscle spasms/ tics
- ☐ difficulty staying asleep
- ☐ difficulty falling asleep
- ☐ dream-disturbed sleep
- ☐ anxiety, nervousness
- ☐ panic attacks
- ☐ lassitude, depression
- ☐ heart pounding/ racing
- ☐ memory problems
- ☐ difficulty concentrating
- ☐ chest pain
- ☐ dark yellow urine
- ☐ skin rash or sores
- ☐ yellow/green phelgm
- ☐ burning feeling with defecation
- ☐ loose stools that are very dark, yellowish or foul smelling
- ☐ difficult, painful or burning urination

Women Only

Are you pregnant? Yes ☐ # of months _____ No ☐ Maybe ☐ Trying ☐
Date of last period: _____ Age of first period: _____ Age of menopause: ___
# of days you bleed: ____ From 1st day of period until 1st day of the next is: ___ days
Number of pregnancies: ____ Births: ____ Abortions: ____ Miscarriages: _____
Do you take birth control pills, shots, implants? Yes ☐ No ☐ Past use? Yes ☐ No ☐
Date you stopped taking birth control pills/ shots/ implants: _____
Have you had a hysterectomy? Yes ☐ No ☐ Partial ☐ Complete ☐

Please check all that apply:

Color of menstrual blood: Pale red ☐ Bright red ☐ Maroon ☐ Purple ☐ Brown ☐
☐ Cramps, which: occur before the bleeding ☐ occur after bleeding begins ☐
dull ☐ sharp ☐ stabbing ☐ better w/ heat ☐ better w/ pressure ☐
☐ Clots with period? Approximate size? _____

☐ Abnormal PAP smear
☐ Back pain with period
☐ Bleeding between periods
☐ Breast lumps (type?) _____
☐ Breast tenderness
☐ Fibrocystic breasts
☐ Nipple discharge
☐ Endometriosis
☐ Uterine fibroids
☐ Ovarian cysts
☐ Irregular timing of period
☐ Heavy bleeding
☐ Scanty bleeding
☐ Headaches with period
☐ Cycle-related mood swings
☐ Tubal ligation
☐ Low libido
☐ Vaginal discharge
☐ Vaginal dryness
☐ Vaginal itching
☐ Other: _____

Men Only

☐ Prostate cancer
☐ Swelling of prostate
☐ Testicular pain, swelling or redness
☐ Pain with intercourse
☐ Vasectomy; Date _____
☐ Impotence
☐ Pre-mature ejaculation
☐ Nocturnal emissions
☐ Low libido
☐ Other _____

Outlook

In general, how do you feel about the following areas of your life in the past month?

Yourself Great ☐ Good ☐ Fair ☐ Bad ☐ Comments _____
Family Great ☐ Good ☐ Fair ☐ Bad ☐ Comments _____
Job Great ☐ Good ☐ Fair ☐ Bad ☐ N/A ☐ Comments _____
Significant Other Great ☐ Good ☐ Fair ☐ Bad ☐ N/A ☐ Comments_____
Spiritual/ Philosophical Great ☐ Good ☐ Fair ☐ Bad ☐ N/A ☐ Comments_____
_____

Diet and Lifestyle

How often do you. . .	3 x/day or more	Once a day	3-4 x per week	Weekly	Monthly	Rarely
Cook from scratch						
Eat organic food						
Eat whole grains						
Overeat						
Eat within 3 hours of sleeping						
Eat refined sugar						
Eat white flour products (bread, baked goods, pasta)						
Eat something artificial						
Eat fried foods						
Consume dairy products						
Drink iced liquids						
Drink soda						
Drink coffee						
Drink tea						
Eat non-organic meat / dairy						
Eat raw food						
Skip meals						

How much water do you drink in a typical day? _____

Do you drink alcohol? Yes ☐ No ☐ How much?_____ How often?_____

Past use? Yes ☐ No ☐ Date stopped?_____

Do you smoke/use tobacco? Yes ☐ No ☐ How much?_____ How often?_____

Past use? Yes ☐ No ☐ Date stopped?_____

Do you use recreational drugs? Yes ☐ No ☐ What kind(s)? _____

Past use? Yes ☐ No ☐ How much?_____ How often?_____

Foods or tastes you crave? _____When?_____

How stressful do you feel your life is, on scale of 0-10, 10 being high? _____

Comments _____

How well do you feel you handle stress? Great ☐ Well ☐ Fair ☐ Not well ☐

Hours of sleep you average per night? _____ hours

How often do you exercise? _____ What kind(s)? _____

Medications / Supplements	**Reason for Taking**	**Dose**	**Frequency**

Acknowledgement

Please sign below to certify that all the information provided is true to the best of your knowledge. Thank you.

Signature: _____ Date: _____
Parent/ Guardian signature (if applicable) _____