



Brodie Welch, L.Ac.
Supporting The Phases Of Your Evolution.

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 I know about the whole of you, the better we can treat the part that brought you here.

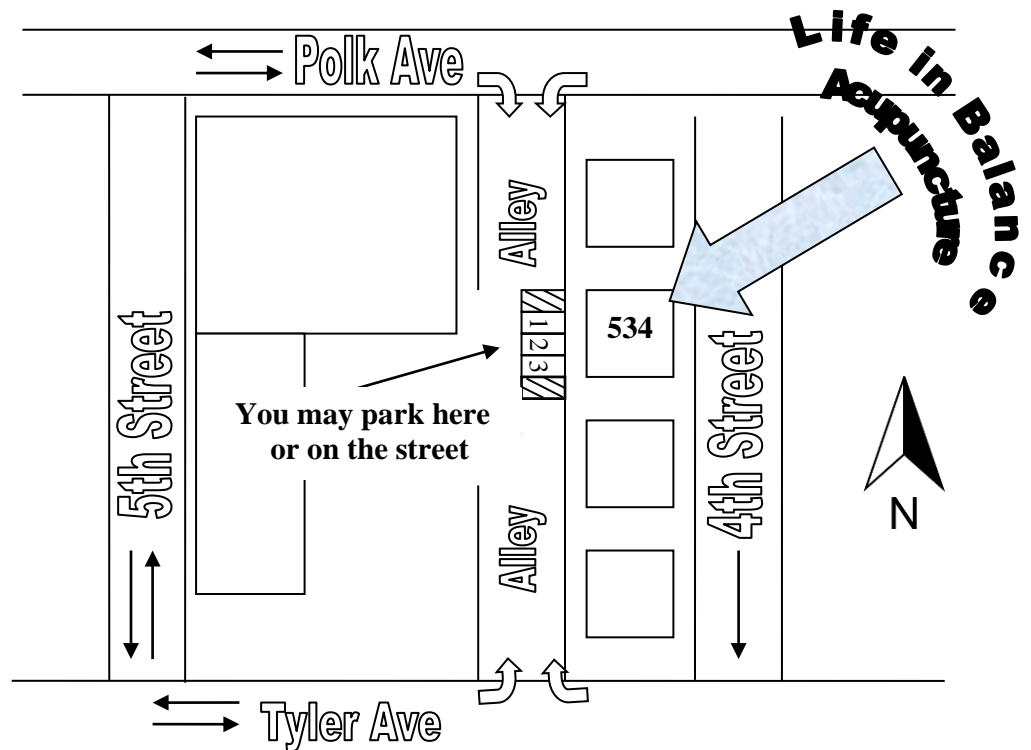
Life in Balance Acupuncture is located at 534 NW Fourth Street, about one and a half blocks north of Harrison Blvd, between Tyler and Polk Avenues, on the west side of the street. **The entrance and parking are at the back of the building.** *Numbered parking spots only, please.*

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 runs \$175. You are responsible for full payment at the time of service.

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 currently have and "P" in the box next to conditions you have had in the past.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Hepatitis (Type ____) | <input type="checkbox"/> Liver or Gallbladder problem | |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Herpes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Obesity | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malaria | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Thyroid problem | _____ |

What conditions run in your family? _____

Do you have a pacemaker? Yes No

Known or suspected allergens: _____

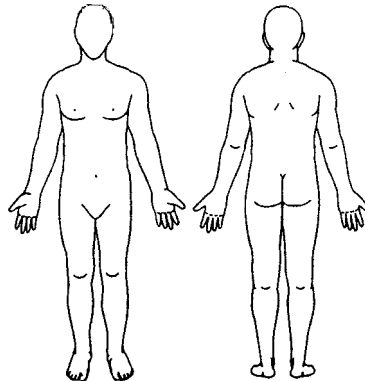
How was your health as a child? Excellent Good Average Poor

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 _____

Health Inventory

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**.

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

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

Men Only

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

You are responsible for full payment of your account in the form of cash, check, or credit at the time of service. (Any insurance reimbursement that may be possible is between you and your insurance company.)

Should you need to reschedule or cancel a visit, please call the office at (541) 757-4868 at least 24 hours in advance to avoid being charged for the appointment (for Monday appointments, we need to hear from you by Friday at 3pm).

Please sign below to acknowledge your acceptance of these policies and to certify that all the information provided is true to the best of your knowledge. Thank you.

Signature: _____ Date: _____

Parent / Guardian signature (if applicable) _____