Well Within, LLC 709 NE 5th St Gresham, Oregon, 97030
503.734.7508 balancedneedle@yahoo.com

New Patient Information

Important: Please complete this document as thoroughly and legibly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

Patient Name:_____ Date: _____

Street address:_____

City, State, Zip:_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Email:_____

Do I have permission to email you treatment plans and summaries? _____yes _____no

Age:_____ Date of Birth:____/____/____ Height:____'____" Weight:_____

Emergency Contact:_____ Phone Number:_____

Single Married Widowed Separated Divorced

If patient is under 18, please list guardian and their relationship to patient:

_____

Occupation:_____ Employer:_____

Insurance Company:_____

Group number:_____ Member number:_____

Primary Care Physician:_____ Phone:_____

Address:_____

Please list any other practitioners you are seeing or have seen for your health concerns:

1. Name:_____ Phone:_____Specialty:_____

2. Name:_____ Phone:_____Specialty:_____

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Please indicate if this is a Workers Compensation or Car Accident Claim (circle one)

Date of Injury:_____ Claim Number:_____

Whom may we thank for referring you?_____

Have you ever received acupuncture?____ Yes ____ No From?_____

What was your experience/outcome?_____

What is your primary health concern?_____

When/How did this problem begin?_____

Has this condition been evaluated by your primary care physician? If so, list any known western

diagnosis._____

_____

What prior treatment have you had for this condition and what were the results?_____

_____

Does this condition impair your daily activities? ____ No ____ Yes If yes please explain:

_____

Please list any prescription or over the counter medications you are currently taking:

Medication: Dosage: For:

_____

_____

_____

_____

_____

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List any supplements, vitamins, herbs or minerals you are currently taking:

_____

_____

Any known allergies to medications or supplements and your reaction:_____

_____

Have you had any **recent medical tests**? If so, please let me know the results and/or bring in the reports:

(Physical, Cholesterol, Prostate, PAP, Mammography, HIV/STD, Blood Sugar, Thyroid, Vitamin D, Anemia,

Other)_____

_____

_____

Any known food allergies, sensitivities, or intolerances and your reaction:_____

_____

List any **prior surgeries**, what they were for and the date (or approximate date/year) performed:

1. Type:_____ Reason:_____ Date:_____

2. Type:_____ Reason:_____ Date:_____

3. Type:_____ Reason:_____ Date:_____

Please indicate **family history** of:

_____ Cancer _____ Heart Disease _____ Thyroid/Endocrine/Diabetes _____ Auto Immune disease

_____ Allergies _____ High Blood Pressure _____ High Cholesterol _____ Infertility

_____ Other_____

Please indicate any addiction to: _____ Nicotine _____ Prescription Medication _____ Alcohol

_____ Food _____ Other_____

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Check any current conditions (mark with a "**C**") & All conditions you may have had in the past (mark with a "**P**")

Energy:

___ Fatigue
___ Low energy
___ Chronic fatigue symptoms

Stress Level (0-10)____

Emotions:

___ Grief ___ Mood Swings ___ Mental tension
___ Irritable ___ Worry ___ Panic Attacks
___ Overwhelmed ___ Anxiety ___ Suicidal Thoughts
___ Joy ___ Anger ___ Depression
___ Fear ___ Overworked

Immunity:

___ Slow wound healing
___ Easily to catch colds

Sleep:

___ Vivid dreams ___ Difficult to fall asleep ___ Nightmares
___ Difficult to stay asleep ___ Night Sweats ___ Fatigued when wake in am
___ Busy mind ___ Restless sleep ___ Awake with pain
___ Awake to urinate (___times) ___ Other _____

Head, eyes, ears, nose, throat:

___ Headache ___ Impaired Hearing ___ Swollen glands ___ Migraine
___ Itchy ears ___ Sore throat ___ TMJ ___ Ringing ears
___ Sores on tongue ___ Spots/Floaters ___ Discharge from ears ___ Gum disease
___ Glaucoma ___ Nose bleeds ___ Teeth pain ___ Eye Pain/Strain
___ Sinus problems ___ Changes in taste ___ Impaired vision ___ Allergies
___ Dry mouth ___ Tearing/Dryness ___ Nasal discharge ___ Other _____
___ Itchy/burning eyes ___ Changes in smell ___ Poor Night Vision _____

Skin:

____Rash ___Eczema ___Psorasis ___Itchy skin
___Dry skin ___Hives ___Acne ___Dandruff

Cardiovascular:

___Heart disease ___Chest pain ___Swelling of ankles ___Heart Murmurs
___High blood pressure ___Palpitations/fluttering ___Poor circulation ___Varicose Veins

Gastrointestinal:

___Nausea/vomiting ___Heartburn ___Belching/gas ___Abdominal pain
___Gurgling in stomach ___fatigue after eating ___Mucus in stool ___Undigested food in stool
___Ulcers ___Incomplete stools ___Bloating ___Epigastric pain
___Diarrhea ___Constipation ___Gall Bladder disease ___Liver disease
___Hemorrhoids ___Hernia ___Food Cravings:_____

Genito-Urinary Tract:

___Painful urination ___Frequent urination ___Blood in Urine ___Impaired urination
___Frequent urination at night ___Frequent UTI ___Kidney stones ___Kidney disease
___Pain during intercourse ___ Incontinence ___Urgent urination ___Venereal disease_____

Endocrine:

___Hypothyroid ___Hypoglycemia ___Hyperthyroid ___Diabetes Mellitus
___Feel hot ___Feel cold ___Low libido ___Hair loss

Neurologic:

___Vertigo/dizziness ___Numbness/tingling ___Loss of balance ___Paralysis

Pain:

___Neck/shoulder pain ___Low back pain ___Upper back pain ___Mid back pain
___Muscle spasms/cramps ___Arm pain ___Leg pain ___ Foot pain
___Arthritis ___Tendonitis ___Bone pain ___Swollen joints
___Repetitive strain ___Sharp pain ___Fixed pain ___Moving pain
___Dull pain ___Achy pain ___Burning ___Numbness/tingling

What makes pain better:

___Soft pressure ___Hard pressure ___Heat ___Cold
___Rest ___Activity ___Other _____

What makes pain worse:

___Pressure ___Heat ___Cold ___Activity
___Rest ___Standing or sitting too long ___Other_____

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Please rate your pain:

Current	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10
Worst	0	1	2	3	4	5	6	7	8	9	10

Male Reproductive:

___Testicular pain/swelling ___ Sexual difficulties ___Prostate problems ___Penile discharge

Female Reproductive:

___Amenorrhea (no periods) ___Irregular cycles ___Painful periods ___PMS

___Bleeding between cycles ___Light flow ___Heavy flow ___Clotting

___Vaginal itching/burning ___Vaginal discharge ___Sores on genitalia ___Vulvodynia

___Menopausal symptoms ___Nipple discharge ___Breast lumps/tenderness

Are you currently pregnant? ___no ___yes, please list due date:_____

Are you currently taking birth control pills? ___no ___yes, please list medication:_____

Habits/Lifestyle:

Exercise:____times/week ___Mild ___Moderate ___Intense

Occupation:_____

Work activity ___sitting ___standing ___computer

Do you enjoy your work? ___no ___yes

Reading: ___no ___yes, hours per day?____

Stress level? ___none ___small ___medium ___high

Hobbies:_____

Alcohol ___no ___yes , per day?___ per week?___

Caffeine ___no ___yes, cups per day?____

Tobacco ___no ___yes, per day?____

Television ___no ___yes, hours per day?____

Have you experienced any major traumas? ___no ___yes, please explain_____

_____

_____

Anything else you think I should know to best manage your care:_____

_____

_____

_____

Patient Signature:_____ Date:_____

Practitioner Signature:_____ Date:_____