The Balance Center

251 E. Main St. El Cajon 92020 Phone: (619) 440-4333 Fax: (619) 440-4099

The following is a confidential questionnaire to determine the best possible treatment plan for you. Please take your time in completing the information. Thank You!

Name: ______________________ DOB: ______________

Address:

____

City: ____________________ State: ___ Zip: ____________

Phone #s Home: ________________
Work: ________________
Cell: ________________

e-mail address: ________________

Marital Status: ( ) Married ( ) Single

Emergency contact:

Name: ____________________ Phone #: ________________

Who referred you to our office?

____

Insurance information:
Carrier: __________________ Phone #: ________________

ID #: ____________________ Group #: ________________

Address: ____

Name of physician: ________________ Phone #: ____________

Have you been treated by an acupuncturist before? If so, Please give the name of the the doctor:

____

Continue to next Page

Medical History:

Height:__________ Weight:____________ M ( ) F ( )

When where you last seen by a physician? ________________________________

Reason for Dr. visit ____

Please Indicate any hospitalizations you have had:

1:____ Date:______________

2:____ Date:______________

Please describe the reason for your visiting to this office:

____

____

Please indicate any other health problems you have:

____

Have you ever been diagnosed with HIV or Hepatitis B/C?_______________

Please list any prescriptions you are taking with dosages:

____

____

____

How often do you drink coffee, tea, or alcohol?

____

How often do you exercise?____

For Women:

Are you pregnant?: Yes ( ) No ( ) When was your last period:__________

Continue to next Page

In the last 6 months, which of the following symptoms have you experienced

	Never	Sometimes	Often
Difficulty to stop bleeding			
Excessive Appetite			
Loose Stools/Diarrhea			
Vomiting			
Belching or Burping			
Heartburn			
Feeling of Food retention			
Colitis or diverticulitis			
Constipation			
Hemorrhoids			
Cough			
Shortness of breath			
Decreased sense of smell			
Skin problems			
Feeling of claustrophobia			
Bronchitis			
Lower back pain			
Sciatica			
Knee Problems			
Hearing impairment			
Ringing in ears			
Kidney Stones			
Decreased sex drive			
Hair Loss			
Urinary problems			
Insomnia			
Difficulty sleeping			
Heart Palpitations			
Nightmares			
Mentally Restless			
Chest Pain			

Eye Problems ________ ________ ________

Jaundice ________ ________ ________

Difficulty digesting ________ ________ ________
oily foods

Gall Stones ________ ________ ________

Light colored stools ________ ________ ________

Soft/brittle nails ________ ________ ________

Easily angered/agitated ________ ________ ________

Spasms/twitching muscles ________ ________ ________

Fatigue ________ ________ ________

Edema ________ ________ ________

Blood in stools ________ ________ ________

Asthma ________ ________ ________

Easily catch colds ________ ________ ________

Intolerant to ________ ________ ________
weather changes

Allergies ________ ________ ________

Tendency to faint ________ ________ ________

High blood pressure ________ ________ ________

High Cholesterol ________ ________ ________

Sudden weight loss ________ ________ ________

Any related comments you would like to share?

____

____

____

____

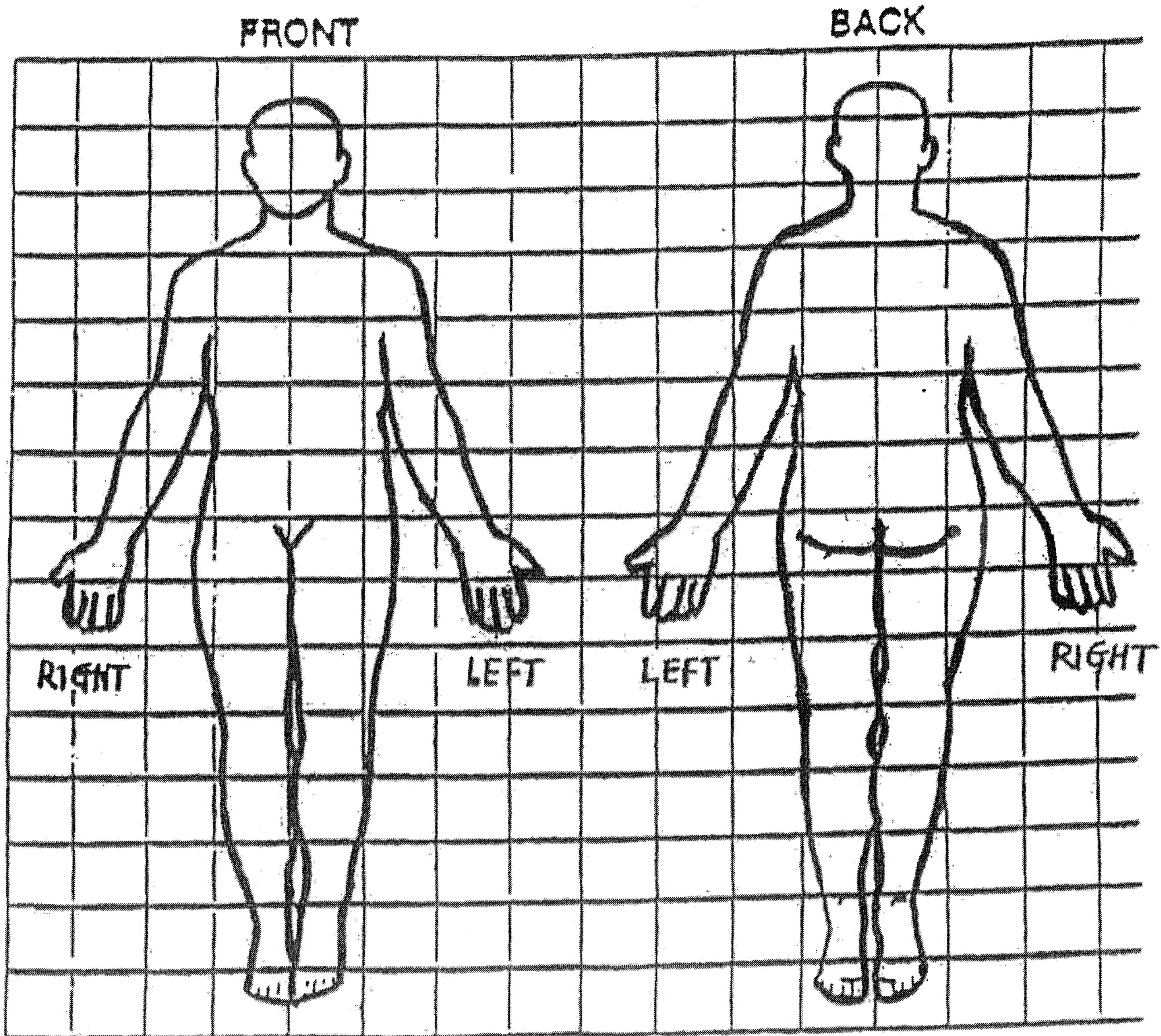
Patient signature: ____________________ Date: ____________

<u>If you have NO pain stop here</u>

PAIN DRAWING GRID ASSESSMENT

DATE____________________ PATIENT'S NAME____

A: ACHE B: BURNING N: NUMB S:STABBING O: OTHER



** CONTINUE PLEASE **

1. How long have you had the present pain? ______________________

2. How long have you been off work/housework? ______________________

3. (Check appropriate Box)

My pain begins:

( ) Gradually

( ) Suddenly

( ) From Injury

And Is:

( ) Off and On

( ) Continuous

Is Worse when it:

( ) cough or sneeze

( ) Sit down

( ) Bend forward

( ) lay down

( ) Wake up

( ) Walk

4. Have any treatments made your pain better?

____

____

5. Have any treatments made your pain worse?

____

____