

Patient Health History

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M / F Marital status: S M D W
Phone No. \_\_\_\_\_ Cell / Home Email: \_\_\_\_\_
Address: St. \_\_\_\_\_ Apt \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Emergency Contact (Name, Phone No & Relationship) \_\_\_\_\_

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? \_\_\_\_\_

For what reason? \_\_\_\_\_

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you to the Balance Clinic in order of importance below:

Condition

Past Treatment

a. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

b. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

c. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

d. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

\_\_\_\_\_  
\_\_\_\_\_

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? \_\_\_\_\_

7. Do you have any infectious diseases?    Y        N        If yes, please identify: \_\_\_\_\_

<b>8. Family History:</b>	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
Check those applicable:						
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Height:** \_\_\_\_\_    **Weight:** Currently: \_\_\_\_\_    Past Maximum: \_\_\_\_\_    When? \_\_\_\_\_

10. **Blood Pressure:** What is your most recent blood pressure reading? \_\_\_\_\_/\_\_\_\_\_    When was this reading taken? \_\_\_\_\_

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever/Diphtheria    Rheumatic Fever    Mumps    Measles    German Measles    Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio    Tetanus    Rubella/Mumps/Rubella    Pertussis    Diphtheria    Hepatitis B

Others: \_\_\_\_\_

13. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

15. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings                      Nervousness                      Mental Tension                      Other

16. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue                      Slow Wound Healing                      Chronic Infections                      Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision                      Eye Pain/Strain                      Glaucoma                      Glasses/Contacts                      Tearing/Dryness  
 Impaired Hearing                      Ear Ringing                      Earaches                      Headaches                      Sinus Problems  
 Nose Bleeds                      Frequent Sore Throats                      Teeth Grinding                      TMJ/Jaw Problems                      Hay Fever

18. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia                      Frequent Common Colds                      Difficulty Breathing                      Emphysema  
 Persistent Cough                      Pleurisy                      Asthma                      Tuberculosis  
 Shortness of Breath                      Other Respiratory Problems: \_\_\_\_\_

19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease                      Chest Pain                      Swelling of Ankles                      High Blood Pressure  
 Palpitations/Fluttering                      Stroke                      Heart Murmurs                      Rheumatic Fever                      Varicose Veins

20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers                      Changes in Appetite                      Nausea/Vomiting                      Epigastric Pain                      Passing Gas                      Heartburn  
 Belching Gall Bladder Disease                      Liver Disease                      Hepatitis B or C                      Hemorrhoids                      Abdominal Pain

21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease                      Painful Urination                      Frequent UTI                      Frequent Urination                      Heavy Flow  
 Kidney Stones                      Impaired Urination                      Blood in Urine                      Frequent Urination at Night

22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles                      Breast Lumps/Tenderness                      Nipple Discharge                      Heavy Flow  
 Vaginal Discharge                      Premenstrual Problems                      Clotting                      Bleeding Between Cycles  
 Menopausal Symptoms                      Difficulty Conceiving                      Painful Periods

23. **Menstrual/Birthing History:**

- |                               |                              |                            |
|-------------------------------|------------------------------|----------------------------|
| 1. Age of First Menses: _____ | 4. Birth Control Type: _____ | 7. # of Abortions: _____   |
| 2. # of Days of Menses: _____ | 5. # of Pregnancies: _____   | 8. # of Live Births: _____ |
| 3. Length of Cycle: _____     | 6. # of Miscarriages: _____  |                            |

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24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties      Prostrate Problems      Testicular Pain/Swelling      Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain      Muscle Spasms/Cramps      Arm Pain      Upper Back Pain      Mid Back Pain  
Low Back Pain      Leg Pain      Joint Pain (if so, where?): \_\_\_\_\_

26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness      Paralysis/ Numbness/Tingling      Loss of Balance      Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid      Hypoglycemia      Hyperthyroid      Diabetes Mellitus      Night Sweats      Feeling Hot or Cold

28. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia      Cancer      Rashes      Eczema/Hives      Cold Hands/Feet

Is there anything else we should know? \_\_\_\_\_  
\_\_\_\_\_

29. **Lifestyle:**

a. Do you typically eat at least three meals per day?      Y      N      If no, how many? \_\_\_\_\_

b. Exercise routine: \_\_\_\_\_

c. Spiritual practice: \_\_\_\_\_

d. How many hours per night do you sleep? \_\_\_\_\_      Do you wake rested?      Y      N

e. Level of education completed:      High School      Bachelors      Masters      Doctorate      Other

f. Occupation: \_\_\_\_\_      Employer: \_\_\_\_\_      Hours/Week: \_\_\_\_\_

Do you enjoy work?      Y/N      Why/Why not? \_\_\_\_\_

g. Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_

h. Have you experienced any major traumas?      Y      N

a. Explain: \_\_\_\_\_

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? \_\_\_\_\_

j. Television habits: \_\_\_\_\_      Reading habits: \_\_\_\_\_

k. Interests and hobbies: \_\_\_\_\_

l. Anything else you'd like the doctor to know? \_\_\_\_\_