Balanced Body Wellness Centre

New Patient Information Form

Please Print Clearly. Please complete ALL information on this form.

We must receive your completed Patient Information Form BEFORE your visit. This allows our doctors to familiarize themselves with your case and do any needed research before your visit. Therefore. you should fill out the form immediately and Email it to us, or Fax it to us.

PERSONAL INFORMATION

Today's Date: ____________________

First Name: ______________________________ Middle Initial: ___ Last Name: ______________________________

Mr., Mrs., Ms., Dr., Etc.: ______ Called (Nick) Name: ______________________________

Address: ____ Apt.#: __________

City: ______________________________ State: __________ Zip: __________

Home Phone: ____________________ Work Phone: ____________________ Ext: ______

Cell Phone: ____________________ Best Number to call for appointment Reminders: ____________________

E-mail (for patient communication, newsletters, etc.): ______________________________

Birth date: ______________ Age: ______ Sex: ☐Male ☐Female Height: ______ Weight: ______

Occupation: ____________________ Employer: ____________________

If patient is a minor, parent / guardian name(s): ______________________________

Emergency Contact Name: ____________________ Phone: ____________________

Referred By (how did you hear about us?): ______________________________

FINANCIAL INFORMATION

Person responsible for payment: ☐Self ☐Other If other: Name: ____________________ (We do not file insurance)

Method of Payment: ☐Cash ☐Check ☐ Visa / MasterCard / Discover / American Express

HEALTH HISTORY

List any major illnesses or injuries with approximate dates:

Illness or Injury Description	Aprox. Date	Complications or Comments	Full Recovery?

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Patient Information Form

List any surgery or operations with approximate dates:

Surgery Description	Aprox. Date	Complications or Comments	Full Recovery?

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PRESENT COMPLAINTS

List the main health complaints you have in order of their importance to you:

1. Description of your MAIN or WORST health problem: ____________________

First began how long ago? ____________ How often does this bother you? ____________

What treatments have you tried? ____________________

Anything that makes it better? ____________________

Anything that makes it worse? ____________________

Has this problem been getting better, worse or staying the same? ____________________

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2. Description of your SECOND WORST health problem: ____________________

First began how long ago? ____________ How often does this bother you? ____________

What treatments have you tried? ____________________

Anything that makes it better? ____________________

Anything that makes it worse? ____________________

Has this problem been getting better, worse or staying the same? ____________________

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3. Description of your THIRD WORST health problem: ______

First began how long ago? ______ How often does this bother you? ______

What treatments have you tried? ______

Anything that makes it better? ______

Anything that makes it worse? ______

Has this problem been getting better, worse or staying the same? ______

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4. Description of your FOURTH WORST health problem: ______

First began how long ago? ______ How often does this bother you? ______

What treatments have you tried? ______

Anything that makes it better? ______

Anything that makes it worse? ______

Has this problem been getting better, worse or staying the same? ______

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5. Description of your FIFTH WORST health problem: ______

First began how long ago? ______ How often does this bother you? ______

What treatments have you tried? ______

Anything that makes it better? ______

Anything that makes it worse? ______

Has this problem been getting better, worse or staying the same? ______

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6. Please write down any other complaints or problems that you haven't listed yet:

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COMMON COMPLAINTS SURVEY: PLEASE FILL OUT COMPLETELY!

Please check all boxes below that apply in your case. If you check the box, please include details of the problem on the blank line. If you have already listed the problem above as one of your main symptoms, just write "see above" on the line.

☐Headaches?: ______

☐Fatigue / Low Energy?: ______

☐Neck stiffness or pain?: ______ ☐Shoulder pain?: ______

☐Back stiffness or pain?: ______

☐Other Pain anywhere in body?: ______

☐Trouble getting to sleep?: ______ ☐Not rested in mornings?: ______

☐Wake in the night and have trouble getting back to sleep?: ______

☐Irritability, mood swings?: ______

☐Digestive gas?: ______ ☐Bloating?: ______ ☐Heartburn?: ______

☐Reflux?: ______ ☐Diarrhea?: ______ ☐Constipation?: ______

☐Allergies / Sinus Problems?: ______

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DRUGS, MEDICATIONS, SUPPLEMENTS

Current medications / drugs being taken, including "over the counter" medications: (use a separate sheet if needed):

Drug Name	Taken for What Symptom or Condition?	Taken How Often?	Aprox. Start Date (or years ago)	Are you experiencing any Side Effects?

ANTIBIOTICS: # antibiotic runs past year: _____ Avg. # runs per year for past 5 years: ____________ Past antibiotics? _______________

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Please list any dietary supplements that you take regularly:

Supplement Name or Description	Taken For:	Started How Long Ago?	Results or Effects you've noticed?

To your knowledge, have you ever had long-term exposure to chemicals, pesticides, herbicides, radiation, solvents or heavy metals? ☐No ☐Yes

If yes, explain: ____

Do you have, or have you ever had, "silver" fillings in your teeth? ☐No ☐Yes Root canal(s)? ☐No ☐Yes

Have you had tooth extractions? ☐No ☐Yes Are you currently having any trouble with your teeth? ☐No ☐Yes **If YES, please explain:**

____

____

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WOMEN ONLY: MENSTRUAL HISTORY

Date of Last Menstrual Period: ______________________ Age at first onset: ______________________

Are your periods regular? ☐No ☐Yes If not, explain: ______________________

Do you experience cramping? ☐No ☐Slight ☐Moderate ☐Severe Do you have any PMS symptoms? ☐No ☐Yes

If so, what? ☐Bloating ☐Cravings ☐Back pain ☐Irritable ☐Moody ☐Other: ______________________

Are you currently pregnant? ☐No ☐Yes

Birth Control Pill Information: Have you ever used Hormonal-type Birth Control? (Pills, Patch, Injection, Implant, Hormone IUD) ☐No ☐Yes

Are you currently on Hormonal-type Birth Control? ☐No ☐Yes Total years on Hormonal-type Birth Control? _____. Stopped ____ years ago.

I was originally on Birth Control Pills for: ☐Birth Control ☐PMS / Irregular Cycle / Other problem (Fibroids, Endometriosis, etc.).

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FAMILY HISTORY

Marital Status: ☐S ☐M ☐W Name of spouse: ______________________ Number of Children, if any: ________

Describe health of spouse: ______________________

Name of Child	Age	Sex	Any physical conditions or concerns?
____________	___	☐M / F	______________________
____________	___	M / F	______________________
____________	___	M / F	______________________
____________	___	M / F	______________________

Any family history of serious illnesses? Cancer ☐Diabetes ☐Heart ☐Other: ______________________

Any household pets or other animals you or family members are in close contact with: ______________________

Do pets have health conditions of any kind? ______________________

DOCTOR OR PHYSICIAN

Are you currently under the care of a physician or other health care professionals? ☐No ☐Yes

If Yes, Doctor's name: ______________________ Specialty: ______________________ Date of last visit: ____________

GENERAL HEALTH QUESTIONS

What is your present weight? ____________ What is your ideal weight? __________ Are you currently: ☐Gaining Weight ☐Losing Weight

What time(s) of day are you most tired? ______________________

Do you get: ☐Depression ☐Worry ☐Lack of concentration ☐Memory Problems ☐Anxiety ☐Panic Attacks ☐Other: ____________

More Information on above problems: ______________________

Number of bowel movements: ☐More than 1/day ☐1 /day ☐Every 2 days ☐3 /week ☐2 /week ☐1 /week ☐Other: ____________

List any allergies or foods / substances you are sensitive to: ______________________

STRESS or MAJOR LIFE CHANGES: (example: divorce, losses, trauma, major problems in life, etc.): ______________________

____

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DIET AND LIFESTYLE:

☐Coffee (☐sugar ☐milk ☐non-dairy creamer) _____ Cups per: ☐Day ☐Week ☐Month

☐Tea (☐sweet ☐unsweet) _____ Glasses per: ☐Day ☐Week ☐Month

☐Alcohol What kinds and how often? ______________________________

Have you consumed large amounts of alcohol, or had frequent drinks over a period of a year or more (☐currently ☐past)? ______________

☐Chocolate or candy _____ Times per: ☐Day ☐Week ☐Month ☐Diet Soda _____ Glasses per: ☐Day ☐Week ☐Month

☐Regular Soda _____ Glasses per: ☐Day ☐Week ☐Month ☐Artificial sweeteners _____ Times per: ☐Day ☐Week ☐Month

☐Laxatives _____ Times per: ☐Day ☐Week ☐Month ☐Fast Food _____ Times per: ☐Day ☐Week ☐Month

☐Milk / Cream _____ Times per: ☐Day ☐Week ☐Month (include cream in coffee, milk on cereal, etc.)

☐Cigarettes How many and how often? ______________________________

☐Past Cigarettes How many and how often? ______________________________ Quit how long ago? ______________

☐Recreational Drugs What drugs and how often? ______________________________

☐Past Recreational Drugs If any heavy use of drugs in past, what drugs and how long ago? ______________________________

Hobbies / activities you enjoy ______________________________

Hobbies / activities that are limited or prevented by your current health condition? ______________________________

____

Past and Current Diet Information:

Give some examples of *foods you were raised on as a child*:

Breakfast: ______________________________

Lunch: ______________________________

Snacks: ______________________________

Dinner: ______________________________

Liquids: ______________________________

How many meals do you usually eat per day? _____ If less than 3, which do you skip most often? ☐Breakfast ☐Lunch ☐Dinner

Do you have any diet restrictions? ☐Yes ☐No If yes, what are they? ______________________________

Do you eat breakfast? ☐Yes ☐No When? ______________________________

Example of breakfast foods eaten: ______________________________

Do you eat lunch? ☐Yes ☐No When? ______________________________

Example of lunch foods eaten: ______________________________

Do you eat dinner? ☐Yes ☐No When? ______________________________

Example of dinner foods eaten: ______________________________

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Do you snack? ☐Yes ☐No Check all that apply:

☐During the day / between meals ☐Give example of foods eaten: ____

☐After dinner ☐Give example of foods eaten: ____

☐Before bed ☐Give example of foods eaten: ____

Check all that apply:

☐Digestive issues ☐Low energy ☐Tired before or after meals

☐Can't get full ☐Salt/Sugar Cravings ☐Sugar cravings after meals

☐Uncontrollable cravings

What are your food challenges? Check all that apply:

☐I hate to cook ☐My family won't eat healthy food ☐My schedule is crazy

☐I don't know how to cook ☐Healthy food is too expensive ☐I don't like vegetables

☐Healthy food doesn't taste good ☐Real food takes too long to prepare ☐I'm a vegetarian – how do I get protein?

☐I'm not the cook in the house ☐I hate food shopping ☐I don't know how to meal plan

☐I don't know how to follow a recipe ☐I'm never home/ eat out all the time ☐Other? ____

Are you: ☐Vegetarian ☐Vegan If YES, why? ☐Philosophical or Religious ☐Health ☐Personal Preference

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SYMPTOM SURVEY FORM

Patient: ______________________________ Date: ______________

Date of Birth: ______________________________ Blood Pressure: ______________

Instructions: **(1)** for **MILD** symptoms (occur once or twice a year)
(2) for **MODERATE** symptoms (occur several times a year)
(3) for **SEVERE** symptoms (you are aware of it almost constantly)
Leave the box **BLANK** if it does not apply to you!

GROUP 1

1 ☐ Acid foods upset
2 ☐ Get chilled, often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meals
6 ☐ Keyed up-fail to calm
7 ☐ Cuts heal slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Hearts pounds after retiring
14 ☐ "Nervous" stomach
15 ☐ Appetite reduced
16 ☐ Colds sweats after
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach frequent

GROUP 2

21 ☐ Joint stiffness after arising
22 ☐ Muscle-leg-toe cramps at night
23 ☐ "Butterfly" stomach, cramps
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seems hungry; feels lightheaded often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" infrequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

GROUP 3

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals are delayed
49 ☐ Hearts palpitates if meals are missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours of sleep--hard to get back to sleep
53 ☐ Crave candy or coffee in after-noons
54 ☐ Moods of depression--"blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks.

GROUP 4

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hunger"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Opens windows in closed room
61 ☐ Susceptible to colds and fevers
62 ☐ Afternoon "yawner"
63 ☐ Get "drowsy" often
64 ☐ Swollen ankles worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion
68 ☐ Bruise easily, "black/blue" spots
69 ☐ Tendency to anemia
70 ☐ "Nose bleeds" frequent
71 ☐ Noises in head or "ringing in ears"
72 ☐ Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

73 ☐ Dizziness
74 ☐ Dry Skin
75 ☐ Burning feet
76 ☐ Blurred vision
77 ☐ Itching skin and feet
78 ☐ Excessive falling hair
79 ☐ Frequent skin rashes
80 ☐ Bitter, metallic taste in mouth in mornings
81 ☐ Bowel movement painful/difficult
82 ☐ Worrier, feels insecure
83 ☐ Feeling queasy; headache over eyes
84 ☐ Greasy foods upset
85 ☐ Stools light-colored
86 ☐ Skin peels on foot soles
87 ☐ Pain between shoulder blades
88 ☐ Use laxatives
89 ☐ Stools alternate from soft to watery
90 ☐ History of gallbladder attacks or gallstones
91 ☐ Sneezing attacks
92 ☐ Dreaming, nightmare-type bad dreams
93 ☐ Bad breath (halitosis)
94 ☐ Milk products cause distress
95 ☐ Sensitive to hot weather
96 ☐ Burning or itching anus
97 ☐ Crave sweets

GROUP 6

98 ☐ Loss of taste for meat
99 ☐ Lower bowel gas several hrs after eating
100 ☐ Burning stomach sensations, eating relieves
101 ☐ Pass large amounts of foul-smelling gas
102 ☐ Coated tongue
103 ☐ Indigestion 1/2-1 hr after eating; may be up to 3-4 hrs.
104 ☐ Mucus colitis or "irritable bowel"
105 ☐ Gas shortly after eating
106 ☐ Stomach "bloating" after eating

SYMPTOM SURVEY FORM (CONT.)

CONFIDENTIAL

GROUP 7

(A)

- 107 ☐ Insomnia
- 108 ☐ Nervousness
- 109 ☐ Can't gain weight
- 110 ☐ Intolerance to heat
- 111 ☐ Highly emotional;
- 112 ☐ Flush easily
- 113 ☐ Night sweats
- 114 ☐ Thin, most skin
- 115 ☐ Inward trembling
- 116 ☐ Heart palpitates
- 117 ☐ Increased appetite without weight gain
- 118 ☐ Pulse fast at rest
- 119 ☐ Eyelids and face twitch
- 120 ☐ Irritable and restless
- 121 ☐ Can't work under pressure

(B)

- 122 ☐ Increase in weight
- 123 ☐ Decrease in appetite
- 124 ☐ Fatigue easily
- 125 ☐ Ringing in ears
- 126 ☐ Sleepy during day
- 127 ☐ Sensitive to cold
- 128 ☐ Dry or scaly skin
- 129 ☐ Constipation
- 130 ☐ Mental sluggishness
- 131 ☐ Hair coarse, falls out
- 132 ☐ Headaches upon arising wear off during day
- 133 ☐ Slow pulse, below 65
- 134 ☐ Frequency of urination
- 135 ☐ Impaired hearing
- 136 ☐ Reduced initiative

(C)

- 137 ☐ Failing memory
- 138 ☐ Low blood pressure
- 139 ☐ Increased sex drive
- 140 ☐ Headaches, "splitting or rending type"
- 141 ☐ Decreased sugar tolerance

(D)

- 142 ☐ Abnormal thirst
- 143 ☐ Bloating of abdomen
- 144 ☐ Weight gain around hips or waist
- 145 ☐ Sex drive reduced or lacking
- 146 ☐ Tendency to ulcers, colitis
- 147 ☐ Increased sugar tolerance
- 148 ☐ Women: menstrual disorders
- 149 ☐ Young girls: lack of menstrual function

(E)

- 150 ☐ Dizziness
- 151 ☐ Headaches
- 152 ☐ Hotflashes
- 153 ☐ Increased blood pressure
- 154 ☐ Hair growth on face or body (female)
- 155 ☐ Sugar in urine (not diabetes)
- 156 ☐ Masculine tendencies (female)

(F)

- 157 ☐ Weakness, dizziness
- 158 ☐ Chronic fatigue
- 159 ☐ Low blood pressure
- 160 ☐ Nails weak, ridged
- 161 ☐ Tendency to hives
- 162 ☐ Arthritic tendencies
- 163 ☐ Perspiration increase
- 164 ☐ Bowel disorders
- 165 ☐ Poor circulation
- 166 ☐ Swollen ankles
- 167 ☐ Crave salt
- 168 ☐ Brown spots or bronzing of skin
- 169 ☐ Allergies--tendency to asthma
- 170 ☐ Weakness after colds, influenza
- 171 ☐ Exhaustion--muscular and nervous
- 172 ☐ Respiratory disorders

FEMALE ONLY

- 173 ☐ Very easily fatigued
- 174 ☐ Premenstrual tension
- 175 ☐ Painful menses
- 176 ☐ Depressed feeling before menstruation
- 177 ☐ Menstruation excessive and prolonged
- 178 ☐ Painful breasts
- 179 ☐ Menstruate too frequently
- 180 ☐ Vaginal discharge
- 181 ☐ Hysterectomy/ovaries removed
- 182 ☐ Menopausal hot flashes
- 183 ☐ Menses scanty or missed
- 184 ☐ Acne, worse at menses
- 185 ☐ Depression of long standing

MALE ONLY

- 186 ☐ Prostate trouble
- 187 ☐ Urination difficult or dribbling
- 188 ☐ Night urination frequent
- 189 ☐ Depression
- 190 ☐ Pain on inside of legs or heels
- 191 ☐ Feeling of incomplete bowel evacuation
- 192 ☐ Lack of energy
- 193 ☐ Migrating aches and pains
- 194 ☐ Tire too easily
- 195 ☐ Avoids activity
- 196 ☐ Leg nervousness at night
- 197 ☐ Diminished sex drive

____

____

____

____

____

Please use the numbered teeth below to indicate on the other side which teeth have had dental interventions. ALSO, please use the KEY to mark appropriately on the dental chart, and answer upper/lower, if appropriate.

Use a mirror!

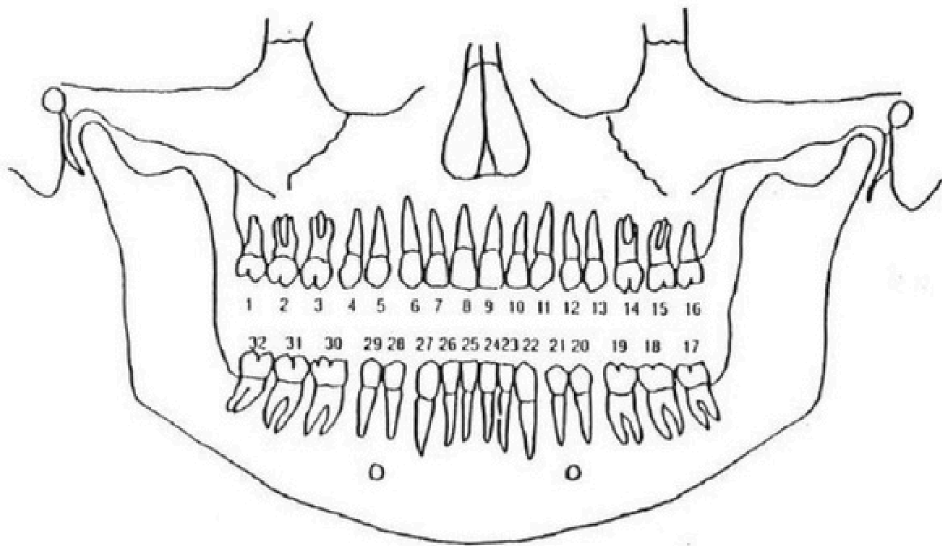
(#1, 16, 17 & 32 are wisdom teeth)

KEY

Pulled teeth	**X**
Cavities filled	●
Crowns	■
Bridge	⏞
Root canals	**o**

Dentures? _____ _____

Right side



Left side

Mark an "X" where you have pain or dysfunction.