Balance Matters
@ Republic of Wellness
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Health Evaluation Form

Please fill out our evaluation form as possible.
Your answers and information is absolutely confidential.

DATE ____/____/_____ Email _____

NAME _____ Date of Birth ____/____/____

Address _____

City _____ State _____ Zip _____

Phone/ Work _____ Mobile _____ Home _____

Male/Female Height _____ Weight _____ Married/Single/Divorce/Widowed

Occupation _____

Physician (MD, DO, DC, L. Ac. etc)_____

Emergency contact _____ Phone _____

How did you find out about us? _____

What is your Main Problem? _____

How long has this condition existed? _____

Briefly describe any treatments you have tried for this condition. (Medication, surgery, exercise, chiropractic, acupuncture, nutrition, etc.)

List any Medications your are currently taking, and reason(s) for taking.

Medical History – circle if ***you*** have ever had:

Adverse reactions to drugs	Allergies (drugs, chemicals, foods)	Cancer
Diabetes	Drug or narcotic habit	Excessive Alcohol use
Gallbladder stones/ trouble	Heart attack	Heart disease
Hepatitis	High Blood Pressure	Heart murmur
Jaundice	Kidney stone(s)	Hemorrhoids
Seizures	Rheumatic fever	STD's
Stomach/liver/intestinal trouble	Tumors, cysts, boils	Thyroid disease

Other health problem(s)

Family Medical History (other than yourself)

Allergies	Asthma	Alcoholism
Cancer	Diabetes	Heart disease
High Blood Pressure	Seizures	Stroke

Other health problem(s)

Personal Habits

consume alcohol how much _____
how often _____

drink coffee / tea
how much _____ daily

do you smoke how often _____
how much _____

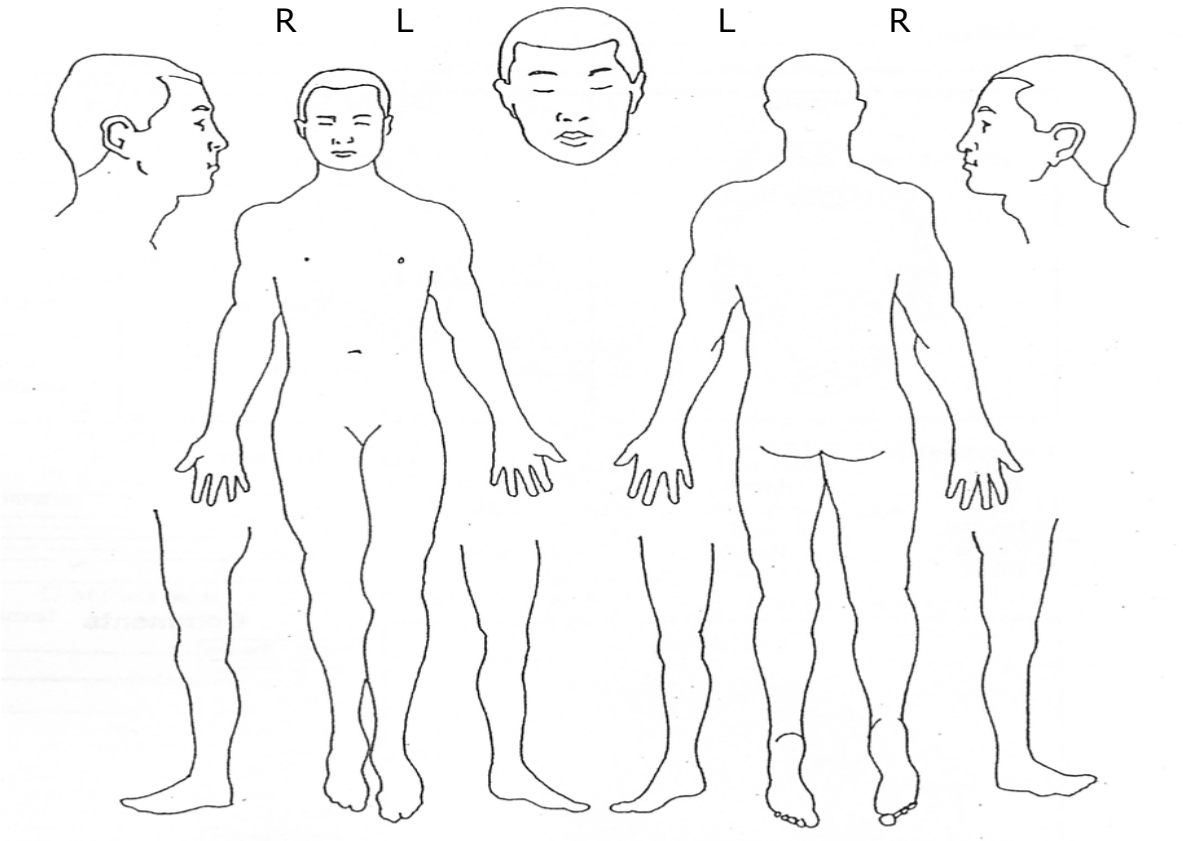
Ever had a drug/alcohol dependency

do you exercise
what type _____
describe how much
how often

Miscellaneous

Athlete's foot	Frequent infections
Balance problems	Headaches
Bleed or bruise easily	Insomnia
Chills	Intolerance to heat/cold
Concussion	Migraines
Convulsions	Nausea
Chronic fatigue	night sweats
Chronic weakness	Shaking / Trembling
Dizzy spells	Sudden drop in energy time of day
Fever	Sudden weight gain/ loss

Injuries List all injuries/trauma with dates	**Surgeries** List all surgeries and dates



Place an **X** where you have pain

Please circle if you **have ever** had or **now** have

Cardiovascular

Blood clots
Chest pain
Cold hands/feet
difficulty breathing
Dizziness
Fainting
High blood pressure
Irregular heartbeat
Low blood pressure
Phlebitis
Poor circulation in any part of the body
Rapid heartbeat
Shortness of breath
Swelling in hand/feet
other Heart problem(s)

Respiratory

Asthma
Bronchitis
Chest pains
Cough
Coughing blood
Difficulty breathing
Emphysema
Excessive sweating
Excessive phlegm color
Lack of perspiration
Pneumonia
Seasonal allergies
Sneezing
Sore throats
other respiratory problem(s)

Please circle if you **have ever** had or **now** have

Eyes

Blurry vision
Cataracts
Color Blindness
Double vision
Eye strain
Night blindness
Pain or pressure in eyes
Recent worsening of eyesight
See spots or "floaters"
Wear glasses or contacts
other eye problem(s)

Ears

Discharge from ears
Earache(s)
Ear infection(s)
Hearing difficulties
Loss of balance
Ringing or buzzing
other ear problems

Nose and Throat

Difficulty swallowing
Loss of sense of smell
Nasal or sinus congestion
Nasal discharge
Nasal polyps
Nose bleeds
Sore throats
Sinus headaches
Sinus infections
Sneezing spells
other nose or throat problem(s)

Gastrointestinal

Abdominal pain
Belching
Black bowel movement
Blood in stools
constipation
decreased appetite
Decreased thirst
Diarrhea
Gas
Halitosis (bad breath)
Hemorrhoids
Increased appetite
Increased thirst
Indigestion
Nausea
Rectal pain
Reflux
Use laxatives how often?
Vomiting

Frequency of bowel movements
daily
or _____ times per week
other gastrointestinal problem(s)

Please circle if you **have ever** had or **now** have

Musculo-skeletal

Do you experience back pain

upper back/ middle back/ lower back

Do you experience neck pain

Do you experience cramps

Arthritis/ joint pain

Rheumatism/ muscular pain

Pain or swelling in joints

Weakness in muscles

other muscular or skeletal problem(s)

Genito-urinary

Bladder infection

Blood or other discharge in urine

Burning or painful urination

Kidney or bladder stone(s)

Loss of sexual desire or function

Lower back pain

Vaginal infection

Unable to hold urine

Urgency to urinate

Wake up to urinate

Time_____ How often_____

other genito-urinary problem(s)

Endocrine

Diabetes

Thyroid problem

other endocrine problem(s)

Gynecology & pregnancy

Age of first menstruation

Breast lumps/ pain/ swelling

Date of last PAP

Date of last period

normal/excessive/scanty

Do you use birth control yes/no

Duration of period _____ days

Had STD's

Interval between periods _____ days

Irregular menstruation

Number of births

Number of miscarriages

Number of pregnancies

Painful menstruation

PMS

Vaginal discharge

Vaginal sores

other GYN problem(s)

Allergies

List ALL allergies (environmental,food, medicinal, seasonal and when you first experienced them)

Please circle if you **have ever** had or **now** have

Mouth/Teeth/Gums

Grind your teeth

Sores on lips or tongue

Sore or bleeding gums

Sore or sensitive tongue

Unusual coating on tongue

Unusual taste in mouth

other mouth or dental problems

Skin and Hair

Athlete's foot

Bruising

Dandruff

eczema

Falling hair

Hives

Itching

Pimples

Psoriasis

Rashes

Recent moles, lumps, or other growths

Ulcerations

other skin or hair problem(s)

Psychological

Anxiety attack

Considered / attempted suicide

Currently in therapy

Easily irritated

Easily susceptible to stress

Lapses of memory

Nervous breakdown

Prone to depression

Prone to fear

Recently emotionally upset

Take sedatives or mood elevators

other psychological problem(s)

Do you have *any* other health problems or health concerns not already discussed?