BALANCE FOR HEALTH

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APPLIED KINESIOLOGY TECHNIQUE USED

PATIENT PERSONAL RECORD

Name _____ Today's Date _____

Address _____ Town:_____ St:_____ Zip:_____

Email:_____

Phone Numbers: Business _____ Home _____ Cell _____

Occupation: _____ Sex: _____ Age: _____ Date of Birth: _____/_____/_____

Job Description: *(e.g. heavy lifting, computer/sitting all day, stressful, etc.)* _____

_____

Referred By: _____

PERSONAL HEALTH HISTORY

Present complaint, reason for this visit: _____

How long have you had this condition? _____ Is it getting worse? ❑ Yes ❑ No

List **ALL** medications that you are presently taking and reason for taking. Including over the counter meds (Tums, aspirin, nasal spray etc). This information is **VERY** important to be able to check for any contraindications.

_____

List all vitamins, herbs etc you are taking: _____

List all doctors you are seeing. Be sure to give name of PCP (Primary Care Physician) _____

_____

Past Medical History: List all surgeries, pregnancies, illnesses _____

_____

Do you have or have you had any of the following?

- ❑ Insomnia
- ❑ Headaches (chronic)
- ❑ Back Problems
- ❑ Joint Pain
- ❑ Seizures
- ❑ Abdominal Pain
- ❑ Nervous Tension
- ❑ Arthritis, Bursitis or Gout
- ❑ Allergies? To what?

_____

_____

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Stroke
- ❑ Heart Attack
- ❑ Cancer
- ❑ Colitis
- ❑ HIV
- ❑ Diarrhea
- ❑ Constipation
- ❑ Heartburn

- ❑ Stomach Pain
- ❑ Water Retention
- ❑ Mood Swings
- ❑ SAD
- ❑ Anxiety
- ❑ Depression
- ❑ Herpes Simplex
- ❑ Irregular Heartbeat
- ❑ Dry, Itchy Skin
- ❑ Hair Loss

- ❑ Hives
- ❑ Asthma, Bronchitis
- ❑ Fatigue
- ❑ Sinus Problems
- ❑ Bleeding Gums
- ❑ Panic Attacks
- ❑ Frequent Urination
- ❑ Yeast Infections
- ❑ ADD
- ❑ ADHD

List any health conditions about immediate family members, bothers sisters, parents and grandparents that could give a possible hereditary component. _____

Do you smoke? ❑ Yes ❑ No If yes, how much? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much? _____ exercise?_____