

# Health History

Date of initial Health Tx: \_\_\_\_\_

Update 1 \_\_\_\_\_  
 2 \_\_\_\_\_  
 3 \_\_\_\_\_  
 4 \_\_\_\_\_  
 5 \_\_\_\_\_  
 6 \_\_\_\_\_

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information gathered for treatments is confidential except as required or allowed by law to facilitate diagnosis (assessment) or treatment.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_  
Number Street Suite City Province Postal Code

Occupation: \_\_\_\_\_ E-mail: \_\_\_\_\_

Tel (home): \_\_\_\_\_ Tel (work): \_\_\_\_\_ Cell: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Tel: \_\_\_\_\_

Physician's Address: \_\_\_\_\_  
Number Street Suite City Province Postal Code

In Emergency Notify: \_\_\_\_\_ Relationship: \_\_\_\_\_

Tel: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

General Health Status: \_\_\_\_\_

What is your primary complaint? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Have you experienced this or a similar condition in the past?  No  Yes When? \_\_\_\_\_

What aggravates it? \_\_\_\_\_ What relieves it? \_\_\_\_\_

Is the condition getting progressively worse?  No  Yes  Constant  Comes and goes

Have you been given a diagnosis for this problem? Please describe: \_\_\_\_\_

List all medications you are taking and corresponding conditions.  
 (including prescription drugs, vitamins/minerals, herbal supplements, recreational drugs, birth control pill, etc.)

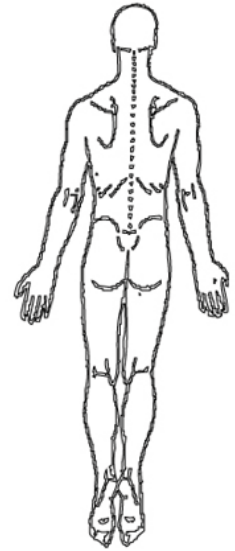
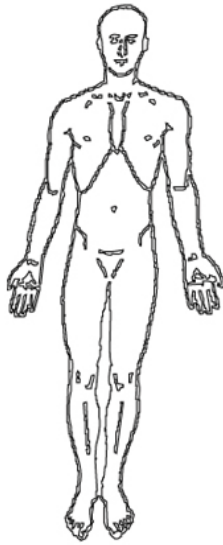
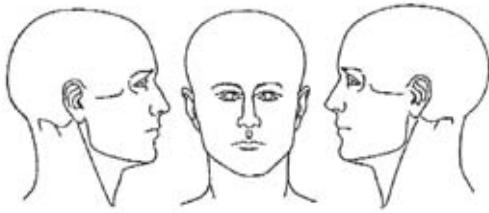
List nature of surgeries and injuries with dates: (include auto accidents and work-related injuries)

Present involvement in other healthcare?  Yes  No

Please describe: \_\_\_\_\_

Do you wear Orthotics/shoe insoles?  Yes  No  Not anymore

**Please shade all areas of pain and/or discomfort**



**Pain Scale/Disability (Office Use Only)**

1 2 3 4 5 6 7 8 9 10

Character

Frequency/Duration

Aggravating Factors

Relieving Factors

Radiation

Associated Symptoms

**Please check all items that apply**

**Musculoskeletal Pain & Discomfort**

- Neck
- Back
- Knee / Leg
- Shoulder / Arm
- Hand / Wrist
- Foot / Ankle
- Scoliosis
- Bursitis
- Tendonitis
- Sciatic
- Arthritis
- Type \_\_\_\_\_
- TMJ
- Degenerating disc
- Osteoporosis
- Edema / Swelling
- Fibromyalgia
- Chronic fatigue
- Other \_\_\_\_\_

**Head / Eyes / Ears / Nose / Throat**

- Headaches
- Duration \_\_\_\_\_
- Tension / Cluster \_\_\_\_\_
- Migraines
- Dizziness / Vision problems
- Ear problems
- Other \_\_\_\_\_

**Skin / Hair**

- Itching / Rashes
- Eczema / Psoriasis
- Plantar warts
- Sensitive skin / Bruise easily
- Dry Skin / Scalp
- Other \_\_\_\_\_

**Digestive**

- Ulcers
- Constipation
- Crohn's / Colitis
- Kidney / Bladder
- Liver / Gallbladder
- Other \_\_\_\_\_

**Gynecological**

- PMS
- Irregular periods
- Painful periods
- Light / Heavy periods
- Fibroids
- Endometriosis
- Infertility
- Currently pregnant
- How many months? \_\_\_\_\_
- Menopause or other
- \_\_\_\_\_

**Respiratory**

- Chronic cough
- Shortness of breath
- Bronchitis
- Emphysema
- Pneumonia
- Asthma / Wheezing

**Cardiovascular**

- Pacemaker
- High or low blood pressure
- Heart attack
- Stroke / CVA
- Varicose / Spider veins
- Fainting
- Hemophilia

**Other**

- Loss of sensation
- Loss of balance
- Loss of smell
- Allergies
- Cancer
- Diabetes
- Epilepsy
- Tuberculosis
- AIDS / HIV
- Hepatitis
- Surgical implants
- Pins / Wires / Plates / Prostheses
- High / Low stress level
- Regular exercise program



# Consent Information

We would like your consent. We want you to understand the services we hope to provide to you, the cost involved and what we do with personal information we obtain from you. If you have any questions on any of the following information, please do not hesitate to ask.

## Consent for Treatment

I have read and understood all of the associated forms, answered them truthfully and to the best of my knowledge and fully consent to treatment at Balance Integrated Healthcare. I understand that there is a 12-hour cancellation policy and if I fail to notify the clinic, then I may be charged for my session.

## Consent for the Cost of our Services

I understand the costs of the services that I am being provided at Balance Integrated Healthcare.

## Consent for Personal Information

I understand that in order to provide me with the services I am seeking, Balance Integrated Healthcare will collect some personal information about me (e.g. home telephone number, address, emergency contacts).

I have reviewed Balance Integrated Healthcare's privacy policy about the collection, use and disclosure of personal information, the steps taken to protect the information and my right to review my personal information. I understand how the privacy policy applies to me. I have been given the chance to ask any questions I have about the privacy policy and they have been answered to my satisfaction.

I understand that, as explained in Balance Integrated Healthcare's Privacy Policy, there are some rare exceptions to these commitments.

I understand that if I do not check off the following boxes I will receive the following:

- Please **DO NOT** send me the monthly Balance Integrated Healthcare *Healthy Insights* newsletter (find out about a new health topic every month) written by one of the practitioners at Balance Integrated Healthcare. (email required).
- I would **NOT** like to receive email/mail notices of promotions and special offers from Balance Integrated Healthcare (helps you stay on top of all the events at Balance Integrated Healthcare including upcoming seminars/workshops and newly acquired services!)

I hereby agree to Balance Integrated Healthcare collecting, using and disclosing personal information about me only with my expressed written authorization.

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Signature

Name (please print)

Date

Notes (office use only)

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