Bio Balance

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Date: _____

Patient Name: _____ Gender: M / F

Address: _____

DOB: _____ Height: _____ Weight: _____ Occupation: _____

Phone Number: (H) _____ (M) _____ (W) _____

It is our practice policy that you provide at least 48 hours' notice if you are unable to keep an appointment, unless there are unavoidable circumstances. If due notice is not given a fee of $100 may be charged to your account for the appointment.
If there is an outstanding account due to missed appointments or late cancellations, you may not be given another appointment until the account is settled.

1. Education: (last grade completed)

_____

2. Significant birth events: _____

3. Injuries: _____

4. Surgeries: _____

5. Pregnancies: _____

6. Allergies to ragweed pollen, grasses? _____

7. Food or chemical sensitivities? _____

8. Present medications: _____

_____

9. Previous medications: _____

_____

10. Primary diagnosis: _____

11. Present treatment approach: _____

12. Please describe your diet: _____

_____

13. Do you often get sleepy after meals? Yes _____ No _____

14. Sleep problems? _____

15. Do you usually recall dreams? _____

_____

16. Do you smoke cigarettes? _____ How many daily? _____

17. Do you drink alcohol? _____ How frequently? _____

18. Did you enjoy school? Yes _____ No _____

19. Typical grades in school: A B C D E F

20. Favourite subjects: _____

21. Difficult subjects: _____

22. Tendency for anger: High _____ Average _____ Low _____

23. Tendency for anxiety: High _____ Average _____ Low _____

24. Hobbies: _____ Sports: _____

25. Do you experience depression? Often _____ Sometimes _____ Never _____

26. Pain threshold: High _____ Average _____ Low _____

27. Do you function well under stress? Yes _____ No _____

28. Are you competitive at sports? Very _____ Average _____ No _____

29. Did you continue to grow taller after age 16? Yes _____ No _____

30. Ever married? _____ Children? _____

PLEASE TICK THE SYMPTOMS OR TRAITS THAT APPLY TO YOU			
Poor stress control		Poor short-term memory	
Sensitivity to bright lights		Sensitivity to loud noises	
Morning nausea		Affinity for spicy and salty foods	
Tendency to delay or skip breakfast		Tendency to be overweight	
Very dry skin		Obsessive/compulsive tendencies	
Pale skin, inability to tan		Extreme mood swings	
High irritability and temper		History of a reading disorder	
History of underachievement		Severe inner tension	

Little or no dream recall		Frequent infections	
Autoimmune disorders		Premature greying of hair	
White spots on fingernails		Abnormal or absent menstrual periods	
Ringing in the ears		Poor muscle development	
History of perfectionism		“Fruity” breath and/or body odour	
Stretch marks (striae) on skin		Spleen-area pain	
Severe depression		Severe anxiety	
Fear of airplane travel, tornadoes etc.		Very strong-willed	
Obsessions with negative thoughts		Joint pains	
Delayed puberty		Poor wound healing	
Dark or mauve-coloured urine		Psoriasis	
Abnormal EEG		Tendency to stay up very late	
Delusional thoughts		Auditory hallucinations	
Social isolation		Enjoys spicy foods	
Dry eyes and mouth		Artistic or musical ability	

MEDICAL HISTORY

Primary symptoms: _____

_____

_____

Onset of condition: _____

_____

_____

Treatments that were effective: _____

_____

_____

Treatments that failed: _____

_____

_____

Are there any family members with similar symptoms? _____

_____

Please circle any of the following that apply to a relative:

Temper tantrums	ADD/ADHD	Cancer
Panic disorder	Anxiety disorder	Dementia
Asthma	Ulcers	Heart disease
Stroke	Bipolar disorder	Kidney problems
Depression	Autism	Psoriasis
Diabetes	Arthritis	Schizophrenia