Please fill in this form, save it and email it to info@wellnessmedicine.com.au

Wellness MEDICINE

Bio Balance
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2013 Walsh Research Institute Gold Coast Outreach

Health History Form

Date: _____

Gender

Please Select

Patient Name: _____

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 select 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	☐