

# HEALTHY BALANCE THERAPEUTICS

## CONFIDENTIAL HEALTH HISTORY

NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

PHONE # (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_ (Include if you would like to receive our quarterly newsletter)

OCCUPATION \_\_\_\_\_ DATE OF BIRTH: M \_\_\_\_\_ D \_\_\_\_\_ YR \_\_\_\_\_ AGE \_\_\_\_\_

MEDICAL DOCTOR \_\_\_\_\_ CITY OR PHONE #: \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE #: \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR CLINIC? \_\_\_\_\_

MY CHIEF COMPLAINT TODAY IS: \_\_\_\_\_

**MEDICAL CONDITIONS** - Please check/circle the conditions that apply to you (past or present).

<b>Cardiovascular Conditions</b>	<b>Respiratory Conditions</b>	<b>Systemic Conditions</b>
Family History Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chronic Congestive Heart Failure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Phlebitis/Blood Clots <input type="checkbox"/> History of Myocardial Infarction (Heart Attack) <input type="checkbox"/> History of Cerebro-Vascular Infarction (Stroke) <input type="checkbox"/> Pacemaker (or similar device) <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> High Cholesterol Other _____	Family History Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Bronchitis <input type="checkbox"/> Chronic Cough Other _____ <hr/> <p style="text-align: center;"><b><u>Infectious Conditions</u></b></p> <input type="checkbox"/> Hepatitis : type _____ <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Infectious skin conditions Other _____	Family History Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer : type _____ <input type="checkbox"/> Epilepsy <input type="checkbox"/> Thyroid Conditions <input type="checkbox"/> Allergies: type _____ <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis: Type _____ Where _____ <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Chronic Fatigue Syndrome Other _____
<b>Skin Conditions</b>	<b>Digestive Conditions</b>	<b>Neurological Conditions</b>
<input type="checkbox"/> Allergies <input type="checkbox"/> Rashes <input type="checkbox"/> Dermatitis <input type="checkbox"/> Eczema <input type="checkbox"/> Acne Other _____	<input type="checkbox"/> Constipation <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Eating Disorders Other _____	Family History Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Numbness/Tingling Where: _____ <input type="checkbox"/> Neuralgia/Neuritis <input type="checkbox"/> Sciatica <input type="checkbox"/> Multiple Sclerosis Other _____

**Women Only Conditions**

Pregnancy (due date: \_\_\_\_\_)

PMS/Cramps

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OTHER CONDITIONS- Please check/circle the conditions that apply to you (past or present).

<u>General Conditions</u>	<u>Painful Conditions</u>
<input type="checkbox"/> Fatigue <input type="checkbox"/> Dizziness <input type="checkbox"/> Depression <input type="checkbox"/> Blurred vision <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Smoker	<input type="checkbox"/> Back pain (please circle)      low / mid / upper <input type="checkbox"/> Neck pain/Whiplash <input type="checkbox"/> Bursitis <input type="checkbox"/> Tendonitis <input type="checkbox"/> Headaches (please circle)      migraine / tension / other <input type="checkbox"/> Fractures <input type="checkbox"/> Muscle Aches/Cramps <input type="checkbox"/> Scoliosis <input type="checkbox"/> Joint Pain (Where: _____) <input type="checkbox"/> Joint Dislocation/Instability <input type="checkbox"/> Jaw Pain/TMJ Syndrome <input type="checkbox"/> Other _____

**MEDICATIONS** - Please list ALL medications you are currently taking and the condition they're for (please include over-the-counter and prescription drugs).

Medication _____	Condition _____
Medication _____	Condition _____
Medication _____	Condition _____

**ACCIDENTS, INJURIES AND SURGERIES**- Please list all previous accidents, injuries and surgeries and the treatment received (include motor vehicle accidents, falls, sports injuries, etc. i.e.: fractures, sprains, whiplash, etc. - if more room is needed, please continue on the back of the page).

Injury _____	Year _____	Treatment _____
Injury _____	Year _____	Treatment _____
Injury _____	Year _____	Treatment _____
Surgery _____	Year _____	Condition _____
Surgery _____	Year _____	Condition _____

**HEALTH CARE PROFESSIONALS** - Please check if you receive regular treatment or consultation from any of the following individuals:

<input type="checkbox"/> General Practitioner (annual)	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Massage Therapist
<input type="checkbox"/> Physiotherapist	<input type="checkbox"/> Acupuncturist	<input type="checkbox"/> Naturopath
<input type="checkbox"/> Homeopath	<input type="checkbox"/> Personal Trainer	<input type="checkbox"/> Other _____

**CONSENT TO TREATMENT** - Please read carefully, and sign and date below.

I declare that I have given the most accurate information to my knowledge, and I understand that the information given will be used to create a personal treatment plan and create a client file. I understand that the Therapist will give me a full explanation as to the treatment to be provided and any future treatment plans. I have also read the information regarding the use of my personal information. I therefore give my consent to the Therapist to perform this assessment, and to collect and use my personal information.

**CANCELLATION POLICY: PLEASE NOTIFY US AT LEAST 24 HOURS PRIOR TO SCHEDULED APPOINTMENTS. THE CANCELLATION FEE WILL BE EQUAL TO THE COST OF THE MISSED APPOINTMENT.**

Signature _____	Date _____
Update 1 _____	Update 2 _____
Update 3 _____	Update 4 _____

# HEALTHY BALANCE THERAPEUTICS

## CANCELLATION POLICY

Healthy Balance Therapeutics is enforcing the cancellation policy due to missed appointments or same day phone calls prior to their appointments.

**PLEASE NOTIFY US AT LEAST 24 HOURS PRIOR TO SCHEDULED APPOINTMENTS. THE CANCELLATION FEE WILL BE EQUAL TO THE COST OF THE MISSED APPOINTMENTS.**

Thank you,

The staff of HEALTHY BALANCE THERAPEUTICS

**Patient Signature**\_\_\_\_\_ **Date:** M\_\_\_\_D\_\_\_\_Y\_\_\_\_\_

Special circumstances will be taken into consideration at the discretion of the clinic.