PURE BALANCE HEALING ART CENTER
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Patient's Name: _____ Today's Date:_____
Last First
Date of Birth: _____ Age:_____ Sex: ☐ Male ☐ Female

PERSONAL MEDICAL HISTORY (PFSH)

Are you under the care of a physician? ☐ No ☐ Yes, for what conditions?_____

Please describe your current health problems:_____

_____

What treatment have you received for about conditions? ☐ Surgery ☐ Injections ☐ Medications ☐ Physical therapy ☐ Acupuncture ☐ Chiropractic ☐ Massage ☐ Other:_____

Please describe your progress: ☐ Worse ☐ No change ☐ 0-25% better ☐ 26-50% better ☐ 51-75% better ☐ Above 75%

Please check **ALL** of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Arthritis/Rheumatoid Arthritis
☐ Angina
☐ Artificial Joints
☐ Blood Disorder
☐ Cancer (*Type*)_____
☐ Convulsions/Seizures
☐ Colitis
☐ Crohn's disease
☐ Diabetes (*Type*)_____
☐ Depression/Anxiety/Bipolar
☐ Emphysema (COPD)
☐ Fatigue
☐ Goiter/Thyroid disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Heartburn/Acid refluxes
☐ Heart Problem
☐ IBS
☐ Lupus
☐ Kidney disease
☐ Liver Problems
☐ Migraine
☐ Pacemaker
☐ Pneumonia
☐ Pulmonary embolism (PE)
☐ Prostate Problems
☐ Sinusitis
☐ Stroke
☐ Stomach/peptic ulcer
☐ Other medical condition (*please list*)_____

***Communicable Disease**
☐ None ☐ AIDS/HIV ☐ STD ☐ TB ☐ Hepatitis ☐ Flu ☐ Other *(please list*) _____

CURRENT MEDICATIONS & SUPPLEMENTS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of Medication/Supplement	Dose *(Mg, pill, etc.)*	What's the reason for taking this?	How long have you been taking this?

MEDICATION / FOODS ALLERGIES

☐ No Allergies

Allergy from	Allergic Reaction

Patient's Name: _____ Date of Birth: _____

SURGERIES / SIGNIFICANT INJURIES

☐ No Significant Surgeries/Injuries

Type of Surgery / Injury *(specify left/right)*	Date *(mm/yy)*

WOMEN'S HEALTH HISTORY - FEMALE ONLY**

Pregnant now? ☐ No ☐ Yes, How many months?	Age of First Menstruation:	Age of Menopause:
Date of Last Menstrual Cycle:	Total Number of Pregnancies:	Number of Live Births:
Frequency of periods: every days	No. of days you flow: days	☐ Normal ☐☐ Abnormal
Cramping: ☐ None ☐ Mild ☐ Moderate ☐ Severe	PMS: ☐☐ No ☐☐ Yes	Date of Last Pap:

FAMILY HEALTH HISTORY

☐ No Significant Family History is Known *__M__-mother __F__-father __B__-brother __S__-sister __MG__-m. grand patents __FG__-f. grand p.

	M	F	B	S	MG	FG		M	F	B	S	MG	FG
Alcohol/Drug Abuse							Heart Disease						
Asthma							High Cholesterol						
Cancer							High Blood Pressure						
COPD							Kidney Disease						
Depression/Anxiety							Stroke						
Bipolar/Suicidal							Thyroid Disease						
Diabetes							Migraines						
Early Death													

SOCIAL HISTORY

TOBACCO USE	Smoke Cigarettes? ☐ No ☐ Yes *(If you never smoked, please move to Alcohol/Drug use)*		
Current: Packs/day: # of years:		***Past***: Quit date: Packs/day: # of years:	
Other Tobacco (*check one*): ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew			
ALCOHOL/DRUG USE	Do you drink? ☐ No ☐ Yes	☐ Beer ☐ Wine ☐ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? ☐ No ☐ Yes		Have you ever used needles to inject drugs? ☐ No ☐ Yes	
SEXUAL ACTIVITY	Sexually involved currently? ☐ No ☐ Yes *(If no sexual history, please continue to Exercise)*		
Sexual partner(s) is/are/have been: ☐ Male ☐ Female		Birth control method: ☐ None ☐ Condon ☐ Pill/Ring/Patch/Inj/IUD ☐ Vasectomy	
EXERCISE	Do you exercise regularly? ☐ No ☐ Yes *(If you answered no, please move to Sleep)*		
What kind of exercise?		***Duration:*** How long (min.) How often:	
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?		
DIET	How would you rate your diet? ☐ Good ☐ Fair ☐ Poor	Would you like advice on your diet? ☐ No ☐ Yes	