Balanced Health
Creating a better tomorrow

1150 Montreal Ave. #102
St. Paul, MN 55116
Phone: (612) 812-9121
CreatingBalancedHealth.com

Health Information Sheet

Name (please print):		Date:	
Street Address:	City:	State:	Zip:
Telephone:		Date of Birth: Age:	
Email Address:		Sex: ___Male ___Female	
How did you hear about us?	Occupation:		

Considering your overall health, list your biggest complaints:

1._____ When did this start?_____

2._____ When did this start?_____

3._____ When did this start?_____

How many times a week do you consume the following:			
Soda Pop:	Coffee:	Grains:	Alcohol:
Fast Food:	Dairy:	Fruit:	Veggies:
Meat/Poultry:	Fish:	Nuts/Seed:	Cigarettes:
Sweets:	Beans/Legumes:	Recreational Drugs:	If so, what kind?

Check any that you crave:	___Salty Foods	___Chocolate	___Sweets	___Breads	Other:
How many times a week do you exercise:	What type of exercise/physical activity do you do?				
How many ounces of water do you drink daily?	Check how many bowel movements do you have a day? ___0 ___1 ___2 ___3 ___4+				
Are your bowel movements: ___loose ___well formed ___sometime loose and sometimes well formed ___incomplete ____dry and hard ___have to take laxatives to go					

List all allergies:

List any major illnesses or surgeries you've had and how long ago:

_____
_____
_____
_____
_____
_____
_____

On a scale from 1 to 10, 10 being the highest level of energy, how much daily energy do you have?

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How many hours of sleep each night?	How many times do you wake up in the middle of the night?	When waking in the night, is it difficult to fall back asleep?
Current Height:	Current Weight:	What weight are you most comfortable at?

Emotions: (check predominate emotions)				
___Happy	___Worry	___Obsessive	___Depressed	___Stuck
___Irritable	___Indecisive	___Withdrawn	___Sad	___Angry
___Anxiety	___Nervous	___Fear	___Suicidal	___Even natured
List any mental or emotional disorders you have been diagnosed with:				
Were you medicated for this? ___Y ___N	If so, for what length of time?			

Please list all current medications and supplements as well as why you are taking them:			
Medication/Supplement	**Dosage**	**Length of Time Taken**	**Reason**

Check any health issue that you currently have or had in the past. Please indicate how long ago and if the issue is current or a re-current issue:

___Acne	___ADD/ADHD	___Allergies	___Alzheimer's	___Anemia
___Appetite	___Arteriosclerosis	___Arthritis	___Asthma	___Back Pain
___Bad Breath	___Bell's Palsy	___Bug Bites	___Bladder issues	___Blood Pressure (high)
___Blood Pressure (low)	___Cancer	___Candida	___Canker sores	___Carpal Tunnel
___Cataracts	___Cholesterol	___Body Temperature (low)	___Body Temperature (high)	___Colic
___Constipation	___Cough	___Dandruff	___Diabetes	___Dizzy Spells
___Ear Infections	___Ear Ringing	___Edema	___Emphysema	___Epilepsy
___Eyesight	___Fatigue	___Fevers	___Flu	___Gallstones

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___Gangrene	___Gas	___Gout	___Gums	___Hair Issues
___Headaches	___Heartburn	___Bloating	___Acid Reflux	___Hemorrhoids
___Herpes	___Hernia	___Hives	___Hormonal Imbalances	___Hyperactive
___Hypertension	___Hyperthyroidism	___Hypothyroidism	___Hypoglycemia	___Impotence
___Incontinence	___Insomnia	___Joint Pain	___Kidney Stones	___Leukemia
___Lung Issues	___Lupus	___Menopause	___Menstrual Cramps	___Migraines
___Mononucleosis	___Nail Issues	___Nausea	___Nose Bleeds	___Parkinson's
___Perspiration	___PMS	___Pneumonia	___Polyps	___Pregnancy
___Prostate Issues	___Psoriasis	___Rash	___Reproductive Issues	___Rheumatism
___ Ring Worm	___Seizures	___Shingles	___Sinus Issues	___Skin Issues
___Snoring	___Sore Throat	___Stress	___Stroke	___Teething
___Tumors	___Ulcers	___Urinary Infections	___Varicose Veins	___Vertigo
___Overweight	___Underweight	___Yeast Infections	___Alcoholism	___Diverticulitis
___Intestinal Parasites	___Appendicitis	___Kidney Disease	___Liver Disease	___Glaucoma
___Mental Illness	___Bipolar	___Miscarriage	___Bleeding Disorder	___Heart Disease
___Multiple Sclerosis	___Neuropathy	___Osteoporosis	___Pacemaker	___Crone's
___Colitis/IBS	___Hysterectomy	___Take Oral Contraceptives	___Have IUD, patch, ring or another form of contraceptive	