平衡

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Patient Name: **Date:**

CHIEF COMPLAINT(S):			
What brings you in today?	When did this begin?	What makes you feel better or worse?	Who else have you seen, and what have you tried for this condition? *(Provider, diagnosis, treatments…)*
		Better:	
		Worse:	

INDICATE IF ANY OF THE FOLLOWING HAVE BEEN PART OF YOUR PRESENT OR PAST HEALTH HISTORY:

HEALTH CONDITION	**SELF** (list date of onset & present status if applicable):	**FAMILY MEMBER** (specify where applicable):
Addiction		
Anemia		
Asthma, Seasonal Allergies or Hayfever		
Autoimmune Disorder (specify)		
Bleeding or Clotting Disorder		
Blood Clots		
Bone Fractures		
Cancer		
COPD		
Diabetes (specify type 1 or 2)		
Epilepsy		
Fainting		
Heart Disease or Heart Attack		
Hepatitis (specify type A B C D E)		
HIV+ or AIDS		
Hypertension / High Blood Pressure		
Hypotenstion / Low Blood Pressure		
Hypoglycemia		
Immune Compromised		
Implants or Prosthetics		
Mental Illness		
Osteoporosis / Osteopenia		
Pregnancy (live birth or miscarriage)		
Pacemaker / Defibrillator		
Sensory Loss (specify)		
Spinal injury		
Stones (kidney, gallbladder…)		
Stroke		
Thyroid Disorder (specify)		
Tuberculosis		

List any hospitalizations or surgeries: **Approximate date(s):**

List any known allergies or sensitivities (foods, medications, supplements, herbs, environmental or otherwise...):

Please complete on reverse…

Reveiwed by: Date: