bio balance HEALTH

BIO BALANCE HEALTH LIMITED

INITIAL CONSULTATION PATIENT QUESTIONNAIRE

Patient to complete the questionnaire prior to their first consultation with their Bio Balance Health trained doctor.

Date: ___________________________________

Patient Name ____________________________ Birth Date: ________________

Address: ________________________________ Height: __________________

____ Weight: __________________

Occupation: _____________________________ Gender: M or F

Patient Phone Number: ___________________ __________________________

- -

Medical History

Primary Symptoms: ____

____

Onset of condition: ____

Treatments that were effective: ____

____

Treatments that failed: ____

____

____

Any family members with similar symptoms?

____

____

INITIAL CONSULTATION PATIENT QUESTIONNAIRE

Personal history details:

1. Education: (Last grade completed) _____
2. Significant birth events _____
3. Injuries _____
4. Surgeries _____
5. Pregnancies _____
6. Allergies to pollen, grasses? _____
7. Food or Chemical Sensitivities? _____
8. Current Medications _____
9. Previous Medications: _____

_____

_____

10. Primary Diagnosis _____
11. Present Treatment Approach _____
12. Please describe your diet _____

_____

_____

13. What are some of your favourite foods? _____
14. Do you often get sleepy after meals? Yes _____ No _____

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15. Sleep problems? _____

16. Do you usually recall dreams? _____

17. Do you smoke cigarettes? _____ How many daily? _____

18. Do you drink alcohol? _____ How frequently? _____

19. Did you enjoy school? Yes _____ No _____

20. Typical grades in school: A B C D F

21. Favourite subjects: _____

22. Difficult subjects: _____

23. Tendency for Anger: High _____ Average _____ Low _____

24. Tendency for Anxiety: High _____ Average _____ Low _____

25. Hobbies? _____ Sports? _____

26. Do you experience depression? Often _____ Sometimes _____ Never _____

27. Pain threshold: High _____ Average _____ Low _____

28. Do you function well under stress? Yes _____ No _____

29. Are you competitive at sports? Very _____ Average _____ No _____

30. Did you continue to grow taller after age 16? Yes _____ No _____

31. Ever married? _____ Children? _____

INITIAL CONSULTATION PATIENT QUESTIONNAIRE

Please Select the Symptoms or Traits that Apply to You

Family members or a carer can help fill out this form if required.

- ☐ poor stress control
- ☐ sensitivity to bright lights
- ☐ morning nausea
- ☐ tendency to delay or skip breakfast
- ☐ very dry skin
- ☐ pale skin, inability to tan
- ☐ high irritability and temper
- ☐ history of underachievement
- ☐ little or no dream recall
- ☐ autoimmune disorders
- ☐ white spots on fingernails
- ☐ ringing in the ears
- ☐ history of perfectionism
- ☐ stretch marks (striae) on skin
- ☐ severe depression
- ☐ fear of airplane travel, tornadoes, etc.
- ☐ obsessions with negative thoughts
- ☐ delayed puberty
- ☐ dark or mauve-colored urine
- ☐ abnormal EEG
- ☐ delusional thoughts
- ☐ social isolation
- ☐ dry eyes and mouth
- ☐ poor short-term memory
- ☐ sensitivity to loud noises
- ☐ affinity for spicy and salty foods
- ☐ tendency to be overweight
- ☐ obsessive/compulsive tendencies
- ☐ extreme mood swings
- ☐ history of a reading disorder
- ☐ severe inner tension
- ☐ frequent infections
- ☐ premature graying of hair
- ☐ abnormal or absent menstrual periods
- ☐ poor muscle development
- ☐ “fruity” breath and/or body odour
- ☐ spleen-area pain
- ☐ severe anxiety
- ☐ very strong willed
- ☐ joint pains
- ☐ poor wound healing
- ☐ psoriasis
- ☐ tendency to stay up very late
- ☐ auditory hallucinations
- ☐ enjoys spicy foods
- ☐ artistic or musical ability

INITIAL CONSULTATION PATIENT QUESTIONNAIRE

Please circle 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