OMNI
BALANCED LIFE CENTER
Traditional & Holistic Therapeutic Services

Client Medical History
Confidential

General Information

Name:_____ Date:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Primary Phone: _____ Emergency contact: _____ Phone: _____
Home Phone:_____ Work Phone:_____ Other Phone:_____
Email address: _____
☐ Check here to be included on our email list and to receive periodic updates and newsletters via email.
Gender:_____ Age:_____ Date of Birth:_____
Marital Status:_____ Height:_____ Weight:_____ Occupation:_____

Primary Care Physician name & phone number_____
Date of last visit:_____ Reason:_____

How did you hear about us?

☐ Primary Care Physician ☐ Community Event ☐ Newspaper
☐ Yahoo! search ☐ Google.com search ☐ Facebook
☐ Seminar/Free talk ☐ Flyer ☐ Current Client
☐ Citysearch.com
☐ Other: _____ ☐ Friend/Relative: _____

Primary Reason for Visit:

_____
_____
_____

What do you think is the cause of this condition?

_____
_____

Does this condition interfere with your ☐Sleep ☐Work ☐Other: _____
How long have you had this condition?_____ Is it getting worse?_____
What seems to make it better? _____
What seems to make it worse? _____
Have you received treatment for this complaint? ☐ Yes ☐ No
If yes, what was done?_____
Did it help? ☐ Not at all ☐ Somewhat ☐ Very effective ☐ Not sure
Do you have any specific questions that you would like to discuss today?_____
_____
_____
_____

Family Health History

Place a mark to indicate if a *blood relative* has had any of the following:

☐ Alcoholism ☐ Cancer ☐ High Blood Pressure ☐ Vascular Disease
☐ Allergies ☐ Diabetes ☐ Seizures ☐ Other:
☐ Asthma ☐ Heart Disease ☐ Stroke _____

Client Name: _____

Personal Medical History

Place a mark to indicate if *you* have had any of the following:

☐ AIDS/HIV	☐ Diabetes	☐ Jaundice	☐ Obesity	☐ Thyroid Disorders
☐ Alcoholism	☐ Epilepsy	☐ Kidney Disease	☐ Pacemaker	☐ Tuberculosis
☐ Allergies	☐ Glaucoma	☐ Measles	☐ Pneumonia	☐ Typhoid Fever
☐ Asthma	☐ Heart Disease	☐ Meningitis	☐ Polio	☐ Ulcers
☐ Bleed Easily	☐ Hepatitis	☐ Mental Disorder	☐ Rheumatic Fever	☐ Stroke
☐ Cancer	☐ High Blood Pressure	☐ Migraines	☐ Scarlet Fever	☐ Vascular Disease
☐ Chicken Pox	☐ High Fevers	☐ Multiple Sclerosis	☐ Seizures	
☐ Colitis	☐ IBS	☐ Mumps	☐ Sexually Transmitted Disease	

Male

☐ Impotence ☐ Nocturnal emissions ☐ Premature ejaculation

Female

Age menses began: _____
Length of cycle (day 1 to day 1): _____
Duration of flow: _____
Number of pregnancies: _____
Number of live births: _____
Number of premature births: _____
Age at menopause: _____

☐ Vaginal discharge
☐ Irregular periods
☐ Painful periods
☐ Clots
☐ PMS
Date of last PAP: _____
Date last period began: _____

Are you pregnant, nursing, or attempting to become pregnant: ☐ Yes ☐ No

Additional Information

List any medications, vitamins, or supplements you are currently taking: _____

_____

_____

List illnesses *not requiring* surgery for which you have been hospitalized: _____

_____

List illnesses *requiring* surgery for which you have been hospitalized: _____

_____

List any other serious injuries, broken bones, scars, etc.: _____

_____

List allergies or sensitivity to any medicines or other substances: _____

_____

Body Systems Overview

Place a mark to indicate if *you* currently have or have a propensity towards any of the following:

LR/GB

☐ Anger/Irritability	☐ Depression	☐ PMS	☐ Stress – high
☐ Blurry vision/spots	☐ Gallbladder stones	☐ Rib pain/distension	☐ Temper – short
☐ Breast tenderness	☐ Headaches	☐ Stiff neck	☐ Tinnitus (high pitch)
☐ Brittle/coarse hair	☐ Menstrual Irregularities	☐ Stiff shoulders	☐ Ticks
☐ Brittle/coarse nails	☐ Migraines	☐ Spasms/muscle cramps	☐ Tremors

HT/SI

☐ Anemia	☐ Heart problems	☐ Mouth/tongue sores	☐ Restlessness
☐ Anxiety/dread	☐ Hot flashes	☐ Palpitations	☐ Speech disorders
☐ Dream disturbed sleep	☐ Insomnia	☐ Pacemaker	☐ Upper back pain
☐ Elbow/shoulder pain	☐ Lack of joy/humor	☐ Poor Circulation	☐ Urinary tract infections

Client Name: _____

Body Systems Overview (continued)

Place a mark to indicate if *you* currently have or have a propensity towards any of the following:

SP/ST

☐ Abdominal pain	☐ Diarrhea	☐ Heavy limbs	☐ Nausea/vomiting
☐ Belching	☐ Gastritis	☐ Indigestion	☐ Poor appetite
☐ Bloating	☐ Gas	☐ Low energy	☐ Poor concentration
☐ Bleed easily	☐ GERD/reflux	☐ Loose Stools	☐ Prolapse
☐ Bruise easily	☐ Hiccups	☐ Muscle weakness	☐ Worry/over-thinking

LU/LI

☐ Allergies	☐ Eczema/psoriasis/rash	☐ Shortness of breath	☐ Skin disorders
☐ Arm/shoulder pain	☐ Frequent "colds/flu"	☐ Sinus headaches	☐ Sweating (day)
☐ Asthma	☐ Grief/sadness	☐ Sinusitis	☐ Weak voice
☐ Constipation	☐ Mucus/phlegm (excess)	☐ Smelling difficulties	☐ Wheezing
☐ Cough	☐ Nasal problems	☐ Sneezing	

KD/BL

☐ Adrenal insufficiency	☐ Infertility/sterility	☐ Kidney disease	☐ Sore throat (chronic)
☐ Brittle bones	☐ Knee/ankle – pain/weakness	☐ Night sweats	☐ Tinnitus (low pitch)
☐ Dark/puffy around eyes	☐ Lack of stamina	☐ Poor dental health	☐ Urination (urgent/freq.)
☐ Depression/fear	☐ Lethargy/fatigue	☐ Poor memory	☐ Urination (nighttime)
☐ Edema/chronic swelling	☐ Loss/thinning hair	☐ Premature graying	☐ Water Retention
☐ Impotence/low libido	☐ Low back – pain/weakness	☐ Sciatica/lumbago	☐ Weak immunity

Do you require the use of a mobility assistive device? ☐ Yes ☐ No

If yes, please call our office before your appointment to insure proper arrangements are made.

Do you have a pacemaker or any other electrical devices in your body? ☐ Yes ☐ No

Are you pregnant, nursing, or attempting to become pregnant? ☐ Yes ☐ No

Please list foods generally included in your diet: _____

_____

_____

_____

Please list foods that you generally avoid: _____

_____

_____

Comments/Other Information _____

_____

_____

_____

All information, on all pages of this form, is correct to the best of my knowledge:

PATIENT SIGNATURE:
(Or Patient Representative)

Date: