BRING BALANCE 2 U, Holistic Health Counseling

MEDICAL HISTORY

Date: ____

Name: ____

Male ______ Female _______

If Child, Parent's Name ____

Single _______Married ________ Separated _________ Divorce _______

Widow _______ Minor __________

Birth Date ____

Address ____

City ________________________________ State _______ Zip _________

Business Name and Business Address ______________________________

____

Occupation ____

Telephone ________________Cell ________________ Work ___________

Whom May We Thank for This Referral_______________________________

Physician's Name____

Bring Balance 2 U, Holistic Health Counseling
343 Manville Road, Pleasantville, NY 10570
andrea@bringbalance2u.com

Andrea Tortorella, HHC
914 960-1554
www.bringbalance2u.com

Physician's address ____

Circle Answers:

Have you ever had a serious illness or operation: Yes No

If so, explain:

Are you under a physician's care Yes No

When was your last complete physical exam? ____________________________

Are you presently taking medications? Yes No

If yes, what types:

Do you routinely take health-related supplements Yes No

Do you have any allergies Yes No

Are you allergic to any medications or supplements Yes No

Have you been treated for or been told you
Have a heart disease? Yes No

Do you have a pacemaker or artificial heart
Valve implant Yes No

Are you aware of any heart murmurs Yes No

Have you ever had rheumatic fever Yes No

Have you ever had surgery, radiation treatment Chemo therapy for tumor, growth or other Condition?	Yes	No
Do you have high or low blood pressure	Yes	No

Explain ____

Do you have inflammatory diseases such as arthritis or rheumatism?

	Yes	No
Do you have artificial joints/prothesis	Yes	No
Do you have any blood disorders, such as Leukemia, etc.	Yes	No
Do you have stomach problems?	Yes	No
Do you have kidney problems?	Yes	No
Do you have any liver problems?	Yes	No
Are you a DIABETIC	Yes	No
Do you have asthma	Yes	No
Do you have epilepsy or seizure disorders	Yes	No
Do you have any venereal diseases	Yes	No
Do you have HIV/AIDS	Yes	No
Have you ever had hepatitis	Yes	No
Do uou or have you had TB	Yes	No

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Do you smoke Yes No

Do you consume alcoholic beverages Yes No

Are you pregnant or suspect you are Yes No

Do you have any disease condition or
Problem not listed? Explain ___________________________________

Is ther anything else we should know about your health that we have not
Covered in this form?

Do you exercise regularly Yes No

I hereby authorize the consultant to perform the testing necessary for Metabolic Typing:

Signature
Date: ____

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