Balanced Health Healing Center

16350 Blanco Rd. Ste 110B
San Antonio, TX 78232
Office: (210) 764-2121
Fax: (210) 579-6932

MEDICAL HISTORY

Who are you here to see? Please circle one: Kay Spears Carolina Villarreal Ana Primera
Who were you referred by? : _____
What is your preferred method of contact? Please circle one: Text Email Phone Call

Name: _____Date: _____
Street Address: _____ City _____ State: ___ ZIP: _____ Home phone_____ Cell phone_____ Work Phone_____
Height _____ Weight _____ Blood Type_____
Marital Status_____ Occupation _____
Date of Birth _____ Age_____ Sex _____ # of Children _____
Email address: _____

Reason for today's office visit:

_____

List current health problems for which you are being treated:

_____

What types of therapies have you tried for these problems or to improve your health over-all?:

- _ Diet modification
- _ Fasting
- _ Vitamins/minerals
- _ Herbs
- _ Homeopathy
- _ Chiropractic
- _ Acupuncture
- _ Conventional medications
- _ Other

Do you experience any of these general symptoms EVERY DAY?

- _ Debilitating fatigue
- _ Shortness of breath
- _ Insomnia
- _ Constipation
- _ Depression
- _ Chronic pain
- _ Panic attacks
- _ Nausea
- _ Fecal incontinence
- _ Bleeding
- _ Disinterest in sex
- _ Headaches
- _ Vomiting
- _ Urinary incontinence
- _ Discharge
- _ Disinterest in eating
- _ Itching/rash
- _ Diarrhea
- _ Low grade fever
- _ Dizziness

Current medications (prescription or over-the-counter):

_____

Laboratory procedures performed: (e.g. stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome: _____

Major hospitalizations, surgeries, injuries: _____

Please list all procedures, complications (if any) and dates: Year Surgery, illness or injury

_____

_____

Outcome _____

Rate your level of stress with 1 being the least stressed and 10 being the most stressed: _____

Identify the major causes of stress (e.g. changes in job, work, residence or finances, legal problems)

_____

Do you consider yourself: ____ underweight ____overweight ____ just right

My goal weight is _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g. pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g. fireman, etc.)_____

What are your current health goals: _____

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Medical History
__arthritis
__allergies/hay fever
__asthma
__alcoholism
__Alzheimer's disease
__Autoimmune disease
__Blood pressure problems
__Bronchitis
__Cancer
__Chronic fatigue syndrome
__Carpal tunnel syndrome
__Cholesterol, elevated
__Circulatory problems
__Colitis
__Dental problems
__Depression
__Diabetes
__Diverticular disease
__Drug addiction
__Eating addiction
__Epilepsy
__Emphysema
__Eyes, ear, nose, throat, problems
__Environmental sensitivities
__Fibromyalgia
__Food intolerance
__Gastroesophageal reflux disease
__Genetic disorder
__Glaucoma
__Gout
__Heart disease
__Infection, chronic
__Inflammatory bowel disease
__Irritable bowel syndrome
__Kidney/bladder disease
__Learning disabilities
__Liver/gallbladder disease (stones)
__Mental illness
__Mental retardation
__Migraine headaches
__Neurological problems (Parkinson's, paralysis)
__Sinus problems
__Stroke
__Thyroid trouble
__Obesity
__Osteoporosis
__Pneumonia
__Sexually transmitted diseases
__Seasonal affective disorder
__Skin problems
__Tuberculosis
__Ulcer
__Urinary tract infection
__Varicose veins
Other_____

Medical (Men)
__Benign prostatic hyperplasia
__Prostate cancer
__Decreased sex drive
__Infertility
__Sexually transmitted disease

Medical (Women)
__Menstrual irregularities
__Endometriosis
__Infertility
__Fibrocystic breasts
__Fibroids/ovarian cysts
__Premenstrual syndrome (PMS)
__Breast cancer
__Pelvic inflammatory disease
__Vaginal infections
__Decreased sex drive
__Sexually transmitted disease
Other_____
Date of last OB/GYN exam _____
PAP Exam_____
# of children _____
# of pregnancies_____
C-section_____
Age of first period_____
Date of last menstrual cycle_____
Length of cycle _____days
Interval of time between cycles _____days
Any recent changes in normal menstrual flow (i.e. heavier, scanty)_____
__Surgical menopause
__Menopause

Family Health History (Parents & Siblings)
__Arthritis
__Asthma
__Alcoholism
__Alzheimer's Disease
__Cancer
__Depression
__Diabetes
__Drug addiction
__Eating Disorder
__Drug addiction
__Eating disorder
__Genetic disorder
__Glaucoma
__Heart disease
__Infertility
__Learning disabilities
__Mental illness
__Mental retardation
__Migraine headaches
__Neurological disorders (Parkinson's, paralysis)
__Obesity
__Osteoporosis
__Stroke
__Suicide
Other _____

Health Habits
__Cigarettes: #/day_____
__Cigars: #day_____
__Wine: #glasses/day ___
__Liquor: #ounces/day___
__Beer: #glasses/day____
__Coffee:#6oz cups/day__
__Tea:#6 oz cups/day____
__Soda w/caffeine:#/day__
__Water:#glasses/day____

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Exercise
__5-7 days per week
__3-4 days per week
__1-2 days per week
__45 min or more per Workout
__30-45 min per workout
__Less than 30 minutes
__Walk: # days/wk____
__Run, jog, other aerobic #days/week _____
__Weights:#days/wk ____
__Stretch:#days/wk ____
Other_____

Nutrition and Diet
__Mixed food diet (animal and vegetable sources)
__Vegetarian
__Vegan
__Salt restriction
__Starch/carb restriction
__The Zone Diet
__Total calorie restriction
Specific food restrictions: i.e., dairy, wheat, soy, egg, gluten.
_____

Food Frequency
Number of servings/day:
Fruits _____
Dark green vegetables____
Yellow/orange _____
Grains (unprocessed) ____
Beans, peas, legumes____
Dairy, eggs _____
Meat, poultry, fish_____

Eating Habits
__Skip meals; which ones _____
__One meal/day
__Two meals/day
__Three meals/day
__Graze (small, frequent meals)
__Generally eat on the run
__Eat constantly whether hungry or not

Current Supplements
__Multivitamin/multimineral
__Vitamin C
__Vitamin E
__EPA/DHA
__Evening Primrose/GLA
__Calcium
__Magnesium
__Minerals, describe _____
__Zinc
__Probiotics (acidophilus)
__Digestive enzymes
__Amino acids
__CoQ10
__Antioxidants
__Herbs
__Homeopathy
__Protein shakes
__Liquid meals (Ensure)
Other_____

I Would Like To:
ENERGY – VITALITY
__Feel more vital
__Have more energy
__Have more endurance
__Be less tired after lunch
__Sleep better
__Be free of pain
__Get fewer colds and flu
__Get rid of allergies
__Not be dependent on over-the-counter medications
__Stop using laxatives and stool softeners
__Improve sex drive
BODY COMPOSITION
__Lose weight
__Burn more body fat
__Be stronger
__Have better muscle tone
__Be more flexible

STRESS
__Learn how to reduce stress
__Think more clearly and be more focused
__Improve memory
__Be less depressed
__Be less moody
__Be less indecisive
__Feel more motivated

LIFE ENRICHMENT
__ Reduce my risk of degenerative disease
__Slow down accelerated aging
__Maintain a healthier life for a longer time
__Change from “treating illness” to creating a wellness lifestyle

Making Lifestyle Changes
__ I am comfortable with making large changes quickly
__ I prefer to make small changes at first
__ I am willing to change my diet immediately if it will make me feel better
__ I prefer to make small changes in my diet each week
__ I have taken supplements before and am comfortable taking a variety of items/day.
__ I would prefer to start with just a few items
__ I can easily work the cost of supplements and office visits into my budget and want to start with the fastest program possible
__ My budget will allow me to spend $200 - $400 per month on supplements and office visits
__ I need to keep the cost below $200 each month

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ADRENAL FATIGUE QUICK CHECK

Name: _____
Date: _____

Rate the following from 0 to 5, with 0 being no problem and 5 being a severe problem.

_ Difficulty getting up in the morning
_ Continuing fatigue, not relieved by sleep and rest
_ Lethargy, lack of energy to do normal daily activities
_ Sugar cravings
_ Salt cravings
_ Allergies
_ Digestion problems
_ Increased effort needed for everyday tasks
_ Decreased interest in sex
_ Decreased ability to handle stress
_ Don't really wake up until after 10:00 A.M.
_ Afternoon low between 3:00 P.M. and 4:00 P.M.
_ Feel better after supper
_ Get a "second wind" in the evening, and stay up late
_ Decreased ability to get things done; less productive
_ Increased time needed to recover from illness, injury or traumas
_ Light-headed or dizzy when standing up quickly
_ Low mood
_ Less enjoyment or happiness with life
_ Increased PMS
_ Symptoms worsen if meals are skipped or inadequate
_ Thoughts are less focused; brain fog
_ Memory is poorer
_ Decreased tolerance for stress, noise, disorder
_ Have to keep moving; if I stop, I get tired
_ Feeling overwhelmed by all that needs to be done
_ It takes all my energy to do what I have to. There's none left over for anything or anyone else.

TOTAL_____

==========

20-40 suggests mild adrenal stress.
40-70 suggests moderate adrenal fatigue
Over 70 suggests significant adrenal fatigue problems

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METABOLIC SCREENING QUESTIONNAIRE

Name: _____
Date: _____

Rate each of the following symptoms based upon your typical health profile:

POINT SCALE:
0 = Never or almost never have the symptom
1 = occasionally have it, effect not severe
2 = occasionally have it, effect is severe
3 = frequently have it, effect not severe
4 = frequently have it, effect is severe

HEAD
____ Headaches
____ Faintness
____ Dizziness
____ Insomnia
____ TOTAL

NOSE
____ Stuffy nose
____ Sinus problems
____ Hay fever
____ Sneezing attacks
____ Excessive mucus
____ TOTAL

LUNGS
____ Chest congestion
____ Asthma, bronchitis
____ Shortness of breath
____ Difficulty breathing
____ TOTAL

ENERGY/ACTIVITY
____ Fatigue
____ Apathy, lethargy
____ Hyperactivity
____ Restlessness
____ TOTAL

EMOTIONS
____ Mood swings
____ Anxiety, fear, nervousness
____ Anger irritability, aggressiveness
____ Depression
____ TOTAL

EYES
____ Watery or itchy eyes
____ Swollen, reddened or sticky eyelid
____ Bags or dark circles under eyes
____ Blurred or tunnel vision
(Does not include near or far-sighted)
____ TOTAL

MOUTH/THROAT
____ Chronic coughing
____ Gagging, frequent need to clear throat
____ Sore throat, hoarseness, loss of voice
____ TOTAL

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Statement of Commitment:

I fully understand that a healthy lifestyle requires commitment and dedication, and change doesn't happen overnight. I choose to improve my health by assuming greater self-responsibility to reduce or eliminate unhealthy behaviors that are contrary to my well-being. The Surgeon General (1990) estimated that 7 out of 10 of the leading causes of death in America are related to lifestyle habits. I will commit to Kay's recommendations for the agreed upon time frame and make my health my priority.

No Guarantees:

I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any treatments/recommendations I receive.

Cancellation Policy:

Beginning February 1st, 2016 we will be assessing a $55.00 cancellation/no show fee. If you need to cancel or reschedule an appointment please provide a 24-hour notice so that I can offer that time to other clients. If you do not provide at least a 24-hour notice you will be charged the $55.00 cancellation/ no show fee.

Thank you so much for your time for we know it is very valuable.

Payment Policy:

- Payment in full is required when services are rendered. Credit cards and checks accepted.
- Payment plans can be arranged only in extreme circumstances.

Name: _____

Date: _____

Signature: _____

Please fax or bring form filled out to your first appointment. Thank you!