BIO BALANCE HEALTH

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Pre- Appointment Form

Please fill out this form as completely and honestly as you can. There is absolutely no judgement in any areas, and it is confidential. This information helps me to understand you and create the best plan possible for you, while providing the support you need along the way. If there is any other information you would like to share, please do, there is space for this at the end of the form. I'm looking forward to meeting with you, and working together with you!

Name:

Address:

Phone Number:

Email:

May I text you regarding appointment reminders and event/promo info? Yes / No

Date of Birth & Age:

Height and Weight:

What are your reasons for your upcoming appointment? Any specific concerns?

Health Conditions and time of onset / and or diagnosis:

How do you generally feel on a scale of 1-10? (1- very poor, 10- excellent)

Paternal Health Conditions:

Father:

Grandfather:

Grandmother:

Maternal Health Conditions:

Mother:

Grandfather:

Grandmother:

Any other family history of illnesses (eg. siblings or aunts and uncles)?

Have you been hospitalized? Or had any surgeries? Please list event and date:

What do you normally eat for breakfast?

What do you normally eat for lunch?

What do you normally eat for supper?

Snacks? When do you snack?

What do you drink normally throughout the day and night?

Coffee or energy drinks _____/day

Alcohol drinks _____/day or _____/week

Do you now or have you ever used cannabis or nicotine? When? How often? Medicinally or Recreationally?

Cannabis:

Nicotine:

Have you used street drugs? Which ones / when?

Which prescribed medications do you currently take?

Have you taken any other prescribed medications in the past? If so, which ones?

Antibiotics?

Which supplements do you take currently?

Have you ever had a negative reaction to any drugs or supplements? Which ones/ when?

How many hours of sleep do you normally get? What time do you go to sleep and what time do you wake up? Do you have trouble falling asleep? Yes/no Staying asleep? Yes/no
How do you feel in the morning upon waking?

How often do you have a bowel movement? Do you strain to have a bowel movement?

Are you constipated? Have diarrhea or loose stools?

Do you have any known allergies or sensitivities?

Allergies:

Sensitivities:

How do you feel after you have eaten?

Do you experience bloating, indigestion or heart burn?

Tell me about your relationship with FOOD over the years, and now:

How active are you? Tell me about your exercise, mobility habits:

What do you do for fun or to relax?

Do you have any pets?

Have you been vaccinated? Which vaccines?

Have you had any dental work done? Any root canals? Missing teeth?

Are you in a relationship right now? How long _____ Is it healthy and supportive?

Do you have a good support circle?

How would you score your mental health on a scale of 1-10, 1 being very poor, 10 being very good _____ Would this score fluctuate each day? Yes/ no; if yes, tell me about the timing and triggers. Would this score fluctuate each month? Yes/ No; if yes, tell me about the timing and triggers.

What types of changes are you feeling like you are ready to make?

To your diet?

To your daily routine?

Do you prefer supplements to be in a pill form or liquid?

If you could choose to change one thing about your health – what would it be?

What do you feel is your biggest obstacle that is holding you back from achieving your health goals? Eg. Motivation, time, money, knowledge, direction...

FOR WOMEN:

How old were you when you started your first menstrual cycle?

Was it regular from the beginning?

Is it regular now? Yes/no Every _____ days Duration of bleeding _____days

Do you have PMS, cramps, heavy bleeding, spotting between periods?

When did menopause start? _____(age)

Tell me about any menopausal/ perimenopausal symptoms?

Do you have children? How many? How many Pregnancies?

Is there anything else you would like to add? Anything else I should know?