CONFIDENTIAL CASE HISTORY

(PLEASE PRINT LEGIBLY)

Name: ____ Sex: Female or Male Date: _____________

Street: ____ City/State/Zip: _________________________________

Phone: C: (___)________________ H: (___)___________________ W: (___)________________________________

Email:____

Would you like to receive our newsletter? ___Yes ___No

DOB: ________________ Age: ________ Ht:_______ Wt:________ Blood Type: O A B AB

Marital Status: M D S W

Emergency Contact/ #____

Partner's Name____

Children's' Name/Ages: ____

Occupation: ____

Occupational Stressors (Chemical, Physical, Structural, Psych): ____

List all know Allergies:

____

____

Recent Exams (give dates): Physical _______________________________ Eye ______________________________

Dental ____________________ Ob/Gyn ________________________ Specialist _________________________

Referred to our office by? ____

Please list 5 major health concerns in your order of importance:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Name: ______________________________

List ALL medications (prescriptions and over-the-counter) you take. (Use additional page if necessary.)

Name of Prescription/OTC	Dosage	How long have you taken this and for what condition?
____________________	__________	____
____________________	__________	____
____________________	__________	____

List ALL nutritional supplements you now take. (Use additional page if necessary.)

Name of Supplements	Dosage	How long have you taken this and for what condition?
____________________	__________	____
____________________	__________	____
____________________	__________	____

List ALL prior surgeries, hospitalizations, injuries, fractures, dislocations, and illnesses.

Doctor Name	Date	Treatments / Procedures	Results
________________	____/____/____	______________________________	______________________
________________	____/____/____	______________________________	______________________
________________	____/____/____	______________________________	______________________

Please check all of the following conditions you have experienced in your lifetime.

I Cancer I Stroke I Mumps I Measles I Kidney infection I Goiter
I Hepatitis I Diabetes I Anemia I Ulcers I ADD/ADHD I Heart disease
I Pneumonia I Alcoholism I Chicken Pox I Gout I Depression I Chronic Fatigue
I Seizures I Asthma I Fibromyalgia I Appendicitis I Thyroid disease I Parkinson's
I Epilepsy I Allergies I Alzheimer's I MS I Gall Bladder Inflammation

Please check all of the following conditions your family has experienced.

Father:	I Cancer	I Stroke	I Heart Disease	I Diabetes	I Parkinson's	I Alzheimer's	I MS
Mother:	I Cancer	I Stroke	I Heart Disease	I Diabetes	I Parkinson's	I Alzheimer's	I MS
Sisters:	I Cancer	I Stroke	I Heart Disease	I Diabetes	I Parkinson's	I Alzheimer's	I MS
Brothers:	I Cancer	I Stroke	I Heart Disease	I Diabetes	I Parkinson's	I Alzheimer's	I MS
Grandmother (M):	I Cancer	I Stroke	I Heart Disease	I Diabetes	I Parkinson's	I Alzheimer's	I MS
Grandfather (M):	I Cancer	I Stroke	I Heart Disease	I Diabetes	I Parkinson's	I Alzheimer's	I MS
Grandmother (P):	I Cancer	I Stroke	I Heart Disease	I Diabetes	I Parkinson's	I Alzheimer's	I MS
Grandfather (P):	I Cancer	I Stroke	I Heart Disease	I Diabetes	I Parkinson's	I Alzheimer's	I MS

List any other health concerns not listed:

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____
____
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Name: ______________________________

Disclaimer for Ballard Nutrition, LLC

I understand that Ballard Nutrition will provide me with professional nutritional analysis, therapy, and support for the purpose of enhancing health. I understand that Nutrition Therapy is not intended as a diagnosis, treatment, prescription or cure for any disease, mental or physical, and is not intended as a substitute for regular medical care.

No medical procedures are performed and no medications are prescribed with Nutrition Therapy. I understand that Pamela Ballard is a Master Nutrition Therapist, Registered Alternative Health Practitioner and Wellness Coach. I agree to pay Ballard Nutrition rates, which are outlined in her fee schedule. Ballard Nutrition, LLC does not accept health care insurance.

I have informed Ballard Nutrition, LLC of all my known physical and medical conditions, as well as any medications and supplements I am taking and will keep Pamela informed of any health changes. This statement is being signed voluntarily.

Date: _

Signature: _

Name: _
(Please print)

Thank you for your cooperation.
All information contained on this form will be kept strictly confidential.

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