BALANCE + FLOW PHYSIO
INTEGRATIVE PHYSICAL THERAPY SERVICES

Name: _____ Date: _____/_____/_____

I am here today because: _____

I am happiest when I participate in these activities: _____

What is it you want to do that you can't do now?_____

General Health:

Please indicate if you have been diagnosed with or have a history of the following?

Anxiety	Yes	No
Arthritis	Yes	No
AIDS/HIV	Yes	No
Allergies	Yes	No
Cancer	Yes	No
Concussion	Yes	No
Crohn's Disease	Yes	No
Change in Appetite	Yes	No
Change in Weight	Yes	No
Depression	Yes	No
Diabetes	Yes	No
Ehlers Danlos Syndrome	Yes	No
Epilepsy/Seizures	Yes	No
Fibromyalgia	Yes	No
Head Injury	Yes	No
Heart Problems	Yes	No
High Blood Pressure	Yes	No
Indigestion	Yes	No
IBS	Yes	No
Kidney Problems	Yes	No
Multiple sclerosis	Yes	No
Metal Implants	Yes	No
Nausea	Yes	No
Osteoporosis	Yes	No
Osteopenia	Yes	No
Parkinson's Disease	Yes	No
Pregnant (currently)	Yes	No
Problems with Hearing	Yes	No
Problems with Vision	Yes	No
Rheumatoid Arthritis	Yes	No
Thyroid Problems	Yes	No
TMJ/Jaw Pain	Yes	No
Sensitivity to Smell	Yes	No
Sensitivity to Sound	Yes	No
Sensitivity to Light	Yes	No
SIBO	Yes	No
Stroke	Yes	No

Neck/Jaw/Head:

Do you experience facial pain?	Yes	No
Do you feel a click of pop when you open or close your mouth?	Yes	No
Do you experience weekly headaches?	Yes	No
Do you wake up with a dry mouth?	Yes	No
Do you feel pain in the front of your ear, or ear "fullness" or "ringing"?	Yes	No
Do you feel tension at the base of your skull when you turn your head in the upright position?	Yes	No

Breathing:

Do you snore?	Yes	No
Do you have difficulty breathing with simple activity, i.e. going up steps?	Yes	No
Do you still feel tired after a full night of sleep?	Yes	No
Do you have asthma?	Yes	No
Do you use an inhaler?	Yes	No
Do you have to sleep in an upright position?	Yes	No
Do you clench or grind your teeth?	Yes	No
Have you been diagnosed with sleep apnea?	Yes	No

Lumbo/Pelvic:

Do you ever experience small amounts of urine leakage when you cough, sneeze. laugh, lift, or exercise?	Yes	No
Do you experience frequent trips to the bathroom that disrupt your day or do you plan trips out based on where the bathrooms are?	Yes	No
Do you experience pain, discomfort or pressure in your pelvic area when sitting or standing for prolonged periods of time?	Yes	No
Do you frequently strain to have a bowel movement or to empty your bladder?	Yes	No

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Please indicate (circle) your level of discomfort:

0= None 5= Moderate 10= Extreme

At worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Since the onset of you symptoms are you getting:

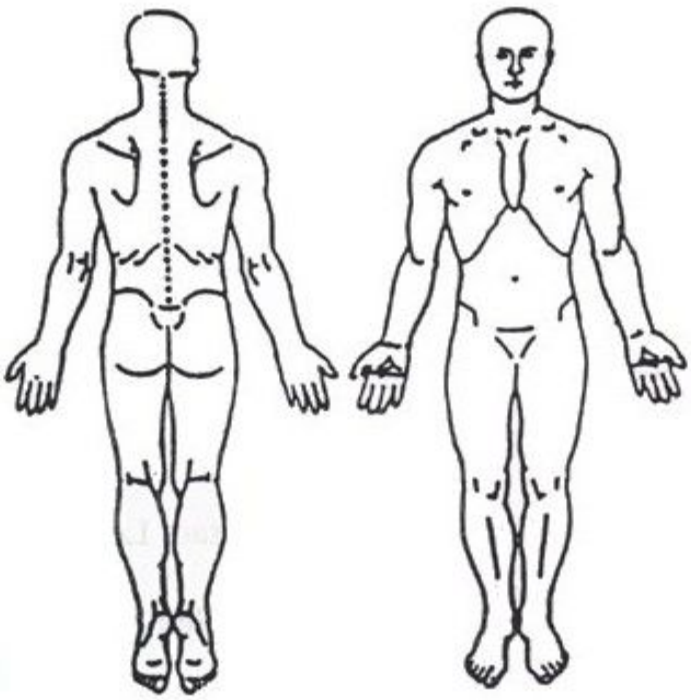
Better Worse No change

Describe your symptoms:

Burning Sharp Dull/Achy

Throbbing Shooting Numbness/Tingling

Please indicate on the picture the location of your issue(s) Shade or circle where appropriate



Please indicate (circle) if you have you had any of the following performed:

X-ray	PET Scan	Angiogram	Cardiac Stress Test
MRI	Ultrasound	ECG	EMG/Nerve Conduction
CT Scan	Bone Scan	CRP Test	Vestibular/Balance Testing

Please list any previous therapy or current treatment for your condition(s):
_____

_____

Please list any past/relevant surgeries: _____

_____

Please list any prescription or over-the-counter medications you are currently taking:
_____

_____

Please list any other problem or issue that has not been addressed: _____

_____

Signature: ____