Balance, Integrative and Infusion

Bio-magnetics and Nutrition

New Patient Health History

First Name:________________________ Last Name:________________

Today's Date:__________________ Date of Birth:________________

What brings you in today for bio-magnetics and/or Nutrition:

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Do you have a pacemaker? _______ Are you pregnant? ___________

Please list all surgeries you have had:

Surgery	Date

Please list all medications or supplements you are currently taking:

____

____

Do you have any known allergies to foods or medications? If yes, please list:

____

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____

Do you have any metal in your body? Rods, plates, piercings? If yes, where is it located?

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____

Have you had any significant traumas or injuries as a child?

____

Do you have any children? Describe their birth. Natural, complications?

____

Did your mother have you naturally? Were there any complications?

____

Do you smoke? ________ If yes how much? ____________Cigarettes or vape? ______________

Do you use recreational drugs? _________

Do you drink alcohol? _______ If yes, how much and how often?

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Is there anything else you can think of that is important for your health that you would like to discuss? (Ex: feeling sad, lonely, depressed, food issues, eating disorder, lack of sleep or overstressed)

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