2325 W North Avenue, Chicago, IL 60647
Phone: 312-626-0313 | Fax: 312-957-4862
Email: hello@balancedflow.today
Website: balancedflow.today

DEMOGRAPHICS

Name ____________________ Date of Birth ____________________

Address ____________________ City ________ State ________ Zip ________

Phone ____________________ Email ____________________

Marital Status ____________ Occupation ____________ Date of Last Physical Exam ____________

Primary Care Provider / Other Providers Seen in Past year ____________________

Emergency Contact / Relation ____________________ Phone ____________________

HEALTH HISTORY

Are you Currently Pregnant? No ☐ Yes ☐ Due Date: ____________________

Personal	Family	*(Please Check all that apply)*	Personal	Family	*(Please Check all that apply)*
☐	☐	High Cholesterol	☐	☐	High Blood Pressure
☐	☐	Diabetes	☐	☐	Heart Disease
☐	☐	Obstructive Sleep Apnea	☐	☐	Depression
☐	☐	Insomnia	☐	☐	Stroke
☐	☐	Arthritis	☐	☐	Cancer
☐	☐	Osteoporosis	☐	☐	Thyroid Disorder
☐	☐	Gout	☐	☐	Anxiety
☐	☐	Kidney Disease	☐	☐	Migraine Headache

Other: ____________________

Previous Surgeries: ____________________

Current medications, supplements & over the counter medications:

____

LIFESTYLE ASSESMENT

Overall Health

Please Circle your current overall Level of Health 0 1 2 3 4 5 6 7 8 9 10
Poor Excellent

Sleep

Over the last ***TWO WEEKS,*** how many hours of sleep did you average in a 24-hour period?

☐ Less than 4 hours ☐ 4-5 hours ☐ 6 hours ☐ 7-8 hours ☐ 9 or more hours

Over the last ***TWO WEEKS***, how often did you feel tired or have difficulty staying awake during routine tasks?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Weight Management

What do you think about your current weight?

☐ I want to gain a lot of weight ☐ I want to gain a little weight ☐ I am happy with my weight

☐ I want to lose a little weight ☐ I want to lose lot of weight. Desired Weight: ____________________

Nutrition

Over the last ***TWO WEEKS***, how often have you eaten fast food, sugary drinks (e.g., soda, sports drinks, juice) or packaged foods (e.g., chips, candy, crackers, cookies)?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

ON AN AVERAGE DAY, how many servings of whole fruits & vegetables do you eat (1 serving is about a handful & does not include fruit juice)?

☐ Less than 2 servings ☐ 2-3 servings ☐ 4-5 servings ☐ More than 5 servings

Exercise

Over the last ***TWO WEEKS,*** how many days did you exercise at a moderate to strenuous intensity (e.g., brisk walking or enough movement to break a sweat)?

☐ Less than 1 time per week ☐ 1-2 times per week ☐ 3-4 times per week ☐ 5 or more times per week

Sexual Health

Do you experience pain or discomfort during sexual activities?

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Are you able to achieve and maintain an erection (for males) or experience arousal (for females) when desired?

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Over the last 4 weeks, how would you rate your level of sexual desire or libido on a scare from 1-10, with 1 being low and 10 being high? _______________

Mental Health

Over the past TWO WEEKS, how often have you ….	Not at all	Several days	More than half the days	Nearly every day
Felt like your life had purpose or meaning?	☐	☐	☐	☐
Connected with any support network (e.g., community, Spiritual, friends/family, nature, yoga, or meditation)?	☐	☐	☐	☐
Been bothered by little interest or pleasure in doing things?	☐	☐	☐	☐
Been bothered by feeling down, depressed, or hopeless?	☐	☐	☐	☐
Been bothered by feeling nervous, anxious or on edge?	☐	☐	☐	☐
Been bothered by worrying too much about different things?	☐	☐	☐	☐

Smoking/Substance Use

Have you used any of the following substances in the past year?

NICOTINE (cigarettes, e-cigarettes/vaping, cigars) ☐ Yes ☐ No

If you marked YES, how many do you usually have? _________________ a day

If you marked YES, circle what level of concern you have regarding nicotine?

0 1 2 3 4 5

no concern high concern

ALCOHOL (beer, wine, liquor) ☐ Yes ☐ No

If you marked YES, how much alcohol do you usually have? ______________ a day

If you marked YES, circle what level of concern you have regarding your alcohol use?

0 1 2 3 4 5

no concern high concern

RECREATIONAL DRUGS ☐ Yes ☐ No

If you marked YES, how much do you usually have? ______________ a day

If you marked YES, circle what level of concern you have regarding your recreational drug use?

0 1 2 3 4 5

no concern high concern

Balanced Flow Wellness | 2325 W North Avenue, Chicago, IL 60647 | P: 312-626-0313
F: 312-957-4862 | hello@balancedflow.today | balancedflowwellness.today

MAIN CONCERNS

Please rank the top THREE areas you desire to change in order to improve your current overall LEVEL OF HEALTH (1 being the most motivated)

Sleep __________ Nutrition __________ Exercise __________ Mental Health __________

Substance Abuse __________ Sexual Health __________ Weight Management __________

List any other concers: ____

____

What would be different or better without these problems?

- ☐ Stress
- ☐ Sleep
- ☐ Mood
- ☐ Energy
- ☐ Work
- ☐ Relationships
- ☐ Self-esteem
- ☐ Outlook
- ☐ Activities
- ☐ Confidence
- ☐ Family

What have you tried doing to resolve this problem the did NOT work?

____

____

Describe how you would like to feel, look, and perform 3 years from now:

____

____

____

Rate on a scale from 1 to 10 (10 being the highest and 1 being the lowest)

__________ How important is it for you to resolve your health concerns?

__________ How willing are you to make the appropriate lifestyle changes that may be necessary to achieve your goals

____________________________________ ____________________

Patient Signature **Date**

Balanced Flow Wellness | 2325 W North Avenue, Chicago, IL 60647 | P: 312-626-0313
F: 312-957-4862 | hello@balancedflow.today | balancedflowwellness.today