



ASULA  
back·body·balance

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## Balance Form

Please take a moment to complete this new patient paperwork regarding balance related issues such as hormone testing and nutritional consultation.

This form will be used in conjunction with other materials to evaluate medical and lifestyle factors affecting your state of wellness.

Name:		Date:		
Address:				
City:		State:	Zip:	
Home Phone:		Work phone		
E-mail:				
Age:	Birth date:	Sex: M F	Status: M S W D	No. Children:
Occupation:		Employer:		Years Employed:
Spouse's Name:		Occupation:	Employer:	
What is your major complaint?				
Other complaints?				
What are your overall health goals?				
How long has it been since you really felt good?				

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Asula Chiropractic & Wellness Center to release my personal medical information to me.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight:	Height:	Blood Pressure (if known):	% Body Fat (if known):
1. Are you presently taking any medications, nutritional supplements or vitamins?			
If yes, for how long?			
2. In the past, have you used birth control pills and/or antibiotics?			
If yes, for how long?			
3. If you have fillings, please list material(s) used:			
4. How much sleep do you get each night on average?			
5. Diet: What do you typically eat for:			
Breakfast:			Time:
Lunch:			Time:
Dinner:			Time:
Snacks:			Time:
6. Do you have any food allergies, sensitivities or restrictions?			
7. Smoke cigarettes? # per day:		Other tobacco? # per day:	
Exposed to second hand smoke or pollution:		Chemicals used at work or during hobbies:	
Alcohol	Wine # glasses/day/week:	Liquor # ounces/day/week:	Beer # glasses/day/week:
Caffeine	Coffee cups per day:	Tea cups/day:	Soda cans/day:
Chocolate or other sweets, ounces/day/week:			
Water	Glasses/day:	Bottled or Filtered?	
Exercise	Type:	Frequency:	
8. Please list foods you tend to overeat or crave (sweets, breads, fatty foods, meats, milk, etc.):			

9. Are there foods you eat on a daily basis, or almost daily basis?						
Do you "miss" these foods if you do not eat them?						
10. Write briefly about your weight gain/loss history:						
a. What do you feel triggered your weight fluctuation? (circle)	Heredity	Stress	Eating habits	Boredom		
b. Was you weight gain/loss: (circle)	Sudden	Gradual	Problem since childhood			
c. What methods have you tried to lose/gain weight?						
11. How is your energy level? (circle)		Very Low	Low	Average	Excellent	Highs &Lows
a. Are there times in the day that you feel best?				b. Worst?		
12. Are you happy in your life right now?						
13. What are your main sources of stress?						
14. How do you deal with stress?						

15. Please answer the following questions Yes or No (circle).

If I'm feeling down, a snack makes me feel better.	Yes	No
I sometimes have a hard time going to sleep without a bedtime snack.	Yes	No
I get tired and/or hungry in the mid-afternoon.	Yes	No
I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert.	Yes	No
Now and then I think I am a secret eater.	Yes	No
At a restaurant, I almost always eat too much bread before the meal is served.	Yes	No
I have difficulty concentration, or frequent fuzzy or spacey thinking patterns.	Yes	No
I experience cravings for sugar, breads, pasta and baked goods.	Yes	No
I feel shaky if I don't eat on time or if I don't snack.	Yes	No
I often find myself irritable or angry.	Yes	No

16. Please list close relatives that have Diabetes, Heart Disease, Cancer, Blood Pressure, Circulatory Problems, Stroke, Osteoporosis, Arthritis, Rheumatoid arthritis, Lupus, Mental Illness of Depression, Auto-immune Disorders, Asthma, Allergies, Alcoholism, Drug Abuse, or Obesity:

17. Symptoms: (circle) those you PRESENTLY have (last few weeks). Underline those you have had PREVIOUSLY.

GENERAL

Headache  
Fever  
Chills or Sweats  
Fainting or Dizziness  
Imbalance  
Seizures or Epilepsy  
Sleeping Difficulties  
Quality of Sleep  
Sleep\_\_\_\_\_hrs/night  
Fatigue or Feel Run-Down  
Hypoglycemia  
Nervousness/Anxiety  
Panic Attacks/Phobias  
Depression  
Mental Disorder  
Alcohol/Drug Problems  
Diabetes  
Neuralgia  
Anemia  
Cancer  
Memory Loss  
Weight Loss\_\_\_\_\_lbs  
Weight Gain\_\_\_\_\_lbs

EAR, NOSE & THROAT

Eye Strain/Pain  
Failing Vision  
Blurred Vision  
Glaucoma  
Sensitivity to Light  
Hearing Problems  
Ear Noises  
Ear Infections  
Sinus Infections  
Frequent Colds  
Nose Bleeds  
Sore Throat  
Thyroid Conditions  
Mouth Sores  
Gum Disease  
Teeth Grinding  
Jaw Pain  
Tonsillitis  
Enlarged Glands  
Hay Fever  
Allergies

SKIN

Rashes  
Skin Eruptions  
Eczema  
Itching  
Bruise Easily  
Dark Circles Under Eyes  
Boils  
Moles  
Varicose Veins  
Hair Loss

RESPIRATORY

Asthma  
Pneumonia  
Emphysema  
Tuberculosis  
Bronchitis  
Chronic Cough  
Spitting Blood/Phlegm  
Chest Pain  
Difficulty Breathing  
Shortness of Breath

CARDIOVASCULAR

Rapid/Slow/Irregular  
Heartbeat  
Blood Clots  
High or Low Blood Pressure  
High Cholesterol  
Pacemaker  
Hardening of Arteries  
Swelling of Ankles  
Poor Circulation  
Stroke/TIA

MUSCLE & JOINT

Stiff Neck  
Backache  
Arthritis  
Swollen Joints Bursitis  
Tendonitis  
Muscle or Joint Weakness or Pain  
Muscle Spasms or Cramps

Foot Trouble

Spinal Curvature  
Osteoporosis

GENITOURINARY

Frequent Urination  
Night Urination  
Blood/Pus in Urine  
Kidney Infection or Stones  
Bed Wetting or Incontinence  
Prostate Trouble  
Hernia  
STD  
Sexual Dysfunction

GASTROINTESTINAL

Trouble Swallowing  
Bad Breath or Body Odor  
Indigestion/Heartburn  
Nausea  
Poor Appetite  
Belching or Passing Gas  
Excessive Hunger  
Cravings  
Hypoglycemia  
Eating Disorder  
Vomiting Blood  
Pain Over Stomach  
Ulcers  
Distension of Abdomen  
Constipation  
Diarrhea  
Appendicitis  
Tiredness After Meals  
Gurgles in Stomach  
Alternation  
Constipation/Diarrhea  
Hemorrhoids  
Parasites  
Hepatitis  
Gall Bladder Trouble  
Bloating After Meals  
Liver Troubles  
Hard/Compact Stools

WOMENS ONLY

PMS  
Painful Menstrual Period  
Excessive Flow  
Bleeding Between Cycles  
Irregular Cycle  
Cramps or Backache  
Endometriosis  
Ovarian Cysts  
Uterine Fibroids  
Abnormal PAP  
Vaginal Discharge  
Breast Pain/ Tenderness  
Lumps in Breast  
Menopausal Symptoms  
Hot Flashes

IS YOUR LIFE:

Satisfactory  
Boring  
Demanding  
Unsatisfying

DO YOU WORRY OVER:

Home Life  
Marriage  
Children  
Job  
Finances

DO YOU OFTEN:

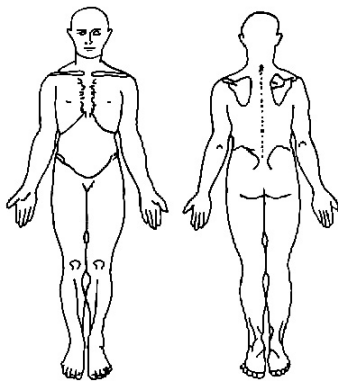
Feel Upset or Cry  
Feel anxiety or have Irrational Fears  
Feel Depressed  
Feel things always go wrong  
Feel Shy or Inferior  
Feel Angry

HAVE YOU:

Seriously considered Suicide  
Attempted Suicide  
Suffered Abuse (physical, sexual or emotional)

18. List any Auto Accidents you've been in:	
19. Surgeries, starting with most recent:	
20. Hospitalizations:	
21. Have you had any recurring infections or inflammations? (For example: bladder, ear, vaginal, sinusitis)	

Please Indicate Location of Pain.



Other than the health concerns already indicated, circle any of the following with which you would like to support.

- |                             |                         |                          |
|-----------------------------|-------------------------|--------------------------|
| ❖ Have more energy/Vitality | ❖ Slow Premature Ageing | ❖ Be Less Depressed      |
| ❖ Sleep Better              | ❖ Be Stronger           | ❖ Need fewer Drugs       |
| ❖ Be Less Tired             | ❖ Be more Flexible      | ❖ Be Less Moody          |
| ❖ Get Less Colds/ Flues     | ❖ Reduce Body Fat       | ❖ Think More Clearly     |
| ❖ Get Rid of Allergies      | ❖ Improve Skin          | ❖ Improve my Memory      |
| ❖ Have more sex drive       | ❖ Be Happier            | ❖ Learn to reduce stress |

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THIS FORM IS REQUIRED BY LAW AND SERVES TO PROTECT YOUR RIGHT TO PRIVACY.

Asula Chiropractic & Wellness Center protects the privacy of your personal and health information. Personal and health information includes both medical information and individual information, such as your name, address or telephone number. Asula Chiropractic and Wellness Center will not disclose this information without your authorization, except as permitted by law.

Our Notice of Privacy Practices provides information about how your protected health information may be used or disclosed. You have the right to request that we restrict how protected health information about you is used or disclosed. Please review the Notice of Privacy Practices before signing this consent.

By signing this form you consent to our use and disclosure of your protected health information as indicated in the Notice of Privacy Practices. Please note that your personal information is not shared with third parties such as financial, credit, or marketing companies. Use is restricted to procedures that are relevant to your care.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

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Print Name

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Signature

Date