

Balance Health & Wellness Center Progress Note

NAME _____

DATE _____

	<u>Same</u> <u>Better</u> <u>Worse</u>		<u>Same</u> <u>Better</u> <u>Worse</u>		<u>Same</u> <u>Better</u> <u>Worse</u>
Hot flashes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Depression	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Diarrhea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Night Sweats	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Insomnia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bloating	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sex Drive	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Joint Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Breasts tender	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Headaches	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Acne	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Body swelling	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Incontinence	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hair loss	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Irritability	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Constipation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rash	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Weight loss	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Muscle pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Weight Gain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Salt Craving	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anxiety	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Erectile function	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	PMS symptoms	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Heartburn	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sugar cravings	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Oily skin	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Foggy thinking	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Memory	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dry skin	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Irregular Period	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

ENERGY LEVEL: 8 am _____ Noon _____ 4 pm _____ 8 pm _____ (1 = low; 10 = high)

HOURS SLEEP/NIGHT: _____ **EXERCISE/WEEK:** _____

CURRENT STRESS LEVEL (1-10): _____ (1 = low; 10 = high)

CURRENT TYPICAL DAILY DIET (servings per day):

Fruits/Vegetables daily: _____ Breads/pastas daily: _____ Soda/coffee daily: _____

Meat/protein per day: _____ Sweets/Candy daily: _____ Organic? _____

NEW PROBLEMS AND CONCERNS:

SUPPLEMENTS YOU ARE TAKING:
