Name: _____ Date: _____

During the past three months, have you seen any of the following?

- ☐ Medical Doctor
- ☐ Chiropractor
- ☐ Psychiatrist/Psychologist
- ☐ Osteopath

Have you ever been diagnosed with any of the following?

- ☐ Cancer . . . If yes, describe what kind: __ _____
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Asthma or other respiratory problems
- ☐ Chemical Dependency
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Neurological Disorder
- ☐ Rheumatoid Arthritis
- ☐ Other Arthritic
- ☐ Condition Depression
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Anemia
- ☐ Currently Pregnant

For Office Use

- ☐ Allergies Please describe: _____
- ☐ Other Illness or Injury Please describe:_____
- ☐ Surgery Please describe:_____
- ☐ What type of prescription or over the counter medications are you currently taking?

_____

Have you recently noticed any of the following?

- ☐ Unexplained weight loss or gain
- ☐ Nausea or vomiting
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever/chills/sweats
- ☐ Numbness or Tingling
- ☐ Dizziness

Do you do any of the following?

- ☐ Smoke. . . . If yes, how much? _____
- ☐ Drink alcohol. . . . . If yes, how much_____
- ☐ Recreational Drugs
- ☐ Exercise. . . . . If yes, what type and how often_____
- ☐ Other leisure or recreational activities?. . . . .If yes, what type and how often?

_____