Name: _____ Date: _____

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

Yes	No	Medical Doctor	Yes	No	Psychiatrist/Psychologist
Yes	No	Chiropractor	Yes	No	Osteopath

Have you ever been diagnosed with any of the following?

Yes	No	Cancer . . . If yes, describe what kind: _____
Yes	No	Heart Problems
Yes	No	High Blood Pressure
Yes	No	Asthma or other respiratory problems
Yes	No	Chemical Dependency
Yes	No	Thyroid Problems
Yes	No	Diabetes
Yes	No	Neurological Disorder
Yes	No	Rheumatoid Arthritis
Yes	No	Other Arthritic Condition
Yes	No	Depression
Yes	No	Stroke
Yes	No	Kidney Disease
Yes	No	Anemia
Yes	No	Pregnancy - Currently
Yes	No	Allergies. . . Please describe: _____
Yes	No	Other Illness or Injury _____
Yes	No	Surgery. . . .If yes, please describe: _____

For Office Use

_____

_____

What type of prescription or over the counter medications are you currently taking?

_____

Have you recently noticed any of the following?

Yes	No	Unexplained weight loss or gain
Yes	No	Nausea or vomiting
Yes	No	Fatigue
Yes	No	Weakness
Yes	No	Fever/chills/sweats
Yes	No	Numbness or Tingling
Yes	No	Dizziness

For Office Use

Do you do any of the following?

Yes	No	Smoke. . . . If yes, how much? _____
Yes	No	Drink alcohol. . . . . If yes, how much_____
Yes	No	Recreational Drugs
Yes	No	Exercise. . . . . If yes, what type and how often_____
Yes	No	Other leisure or recreational activities?. . . . .If yes, what type and how often?

_____