

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

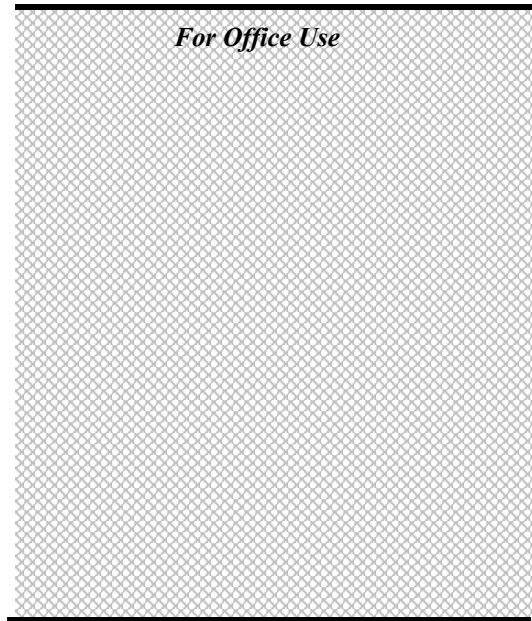
Condition Depression

Stroke

Kidney Disease

Anemia

Currently Pregnant



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

Fever/chills/sweats

Nausea or vomiting

Numbness or Tingling

Fatigue

Dizziness

Weakness

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?
