DATE: Please list any major health occurrences including: surgeries, hospitalizations, medical studies, etc.

1. _____
2. _____
3. _____
4. _____
5. _____

O = Occasional F = Frequent C = Constant

O F C

Muscle / Joint

- ☐☐☐ Arthritis
- ☐☐☐ Bursitis
- ☐☐☐ Foot trouble
- ☐☐☐ Hernia
- ☐☐☐ Low back pain
- ☐☐☐ Lumbago
- ☐☐☐ Neck pain, stiffness
- ☐☐☐ Pain between shoulders

General

- ☐☐☐ Allergy
- ☐☐☐ Chills
- ☐☐☐ Convulsions
- ☐☐☐ Dizziness
- ☐☐☐ Fainting
- ☐☐☐ Fatigue
- ☐☐☐ Fever
- ☐☐☐ Headache
- ☐☐☐ Loss of sleep
- ☐☐☐ Loss of weight
- ☐☐☐ Nervousness, depression
- ☐☐☐ Neuralgia
- ☐☐☐ Numbness
- ☐☐☐ Sweats
- ☐☐☐ Tremors

Cardiovascular

- ☐☐☐ Hardening of arteries
- ☐☐☐ High blood pressure
- ☐☐☐ Low blood pressure
- ☐☐☐ Pain over heart
- ☐☐☐ Poor circulation
- ☐☐☐ Rapid heartbeat
- ☐☐☐ Slow heartbeat
- ☐☐☐ Swelling of ankles

Genitorinary

- ☐☐☐ Bed-wetting
- ☐☐☐ Bladder/kidney infection
- ☐☐☐ Blood in urine
- ☐☐☐ Frequent urination
- ☐☐☐ Lack of kidney control
- ☐☐☐ Painful urination
- ☐☐☐ Prostate trouble
- ☐☐☐ Puss in urine
- ☐☐☐ Low libido
- ☐☐☐ Sexual dysfunction

O F C

Eye, Ear, Nose & Throat

- ☐☐☐ Asthma
- ☐☐☐ Colds
- ☐☐☐ Crossed eyes
- ☐☐☐ Deafness
- ☐☐☐ Dental decay
- ☐☐☐ Earache
- ☐☐☐ Ear discharge
- ☐☐☐ Ear noise
- ☐☐☐ Enlarged glands
- ☐☐☐ Enlarged thryoid
- ☐☐☐ Eye pain
- ☐☐☐ Failing vision
- ☐☐☐ Far sightedness
- ☐☐☐ Gum trouble
- ☐☐☐ Hay fever
- ☐☐☐ Hoarseness
- ☐☐☐ Nasal obstruction
- ☐☐☐ Near sightedness
- ☐☐☐ Nose bleeds
- ☐☐☐ Sinus infection
- ☐☐☐ Sore throat
- ☐☐☐ Tonsillitis

Gastrointestinal

- ☐☐☐ Acid reflux/heartburn
- ☐☐☐ Belching or gas
- ☐☐☐ Colitis
- ☐☐☐ Colon trouble
- ☐☐☐ Constipation
- ☐☐☐ Diarrhea
- ☐☐☐ Difficult digestion
- ☐☐☐ Bloated abdomen
- ☐☐☐ Excessive hunger
- ☐☐☐ Gallbladder trouble
- ☐☐☐ Hemorrhoids
- ☐☐☐ Intestinal worms
- ☐☐☐ Jaundice
- ☐☐☐ Liver trouble
- ☐☐☐ Nausea
- ☐☐☐ Pain over stomach
- ☐☐☐ Poor appetite
- ☐☐☐ Vomiting
- ☐☐☐ Vomiting of blood

O F C

Skin

- ☐☐☐ Boils
- ☐☐☐ Bruise easily
- ☐☐☐ Dryness
- ☐☐☐ Eczema/psoriasis
- ☐☐☐ Hives or allergy
- ☐☐☐ Itching
- ☐☐☐ Skin eruptions (rash)
- ☐☐☐ Varicose veins

Pain or Numbness in

- ☐☐☐ Shoulders
- ☐☐☐ Arms
- ☐☐☐ Elbows
- ☐☐☐ Hands
- ☐☐☐ Hips
- ☐☐☐ Legs
- ☐☐☐ Knees
- ☐☐☐ Feet
- ☐☐☐ Painful tailbone
- ☐☐☐ Poor posture
- ☐☐☐ Sciatica
- ☐☐☐ Spinal curvature
- ☐☐☐ Swollen joints

Respiratory

- ☐☐☐ Chest pain
- ☐☐☐ Chronic cough
- ☐☐☐ Difficulty breathing
- ☐☐☐ Spitting up blood
- ☐☐☐ Spitting up phlegm
- ☐☐☐ Wheezing

Women Only

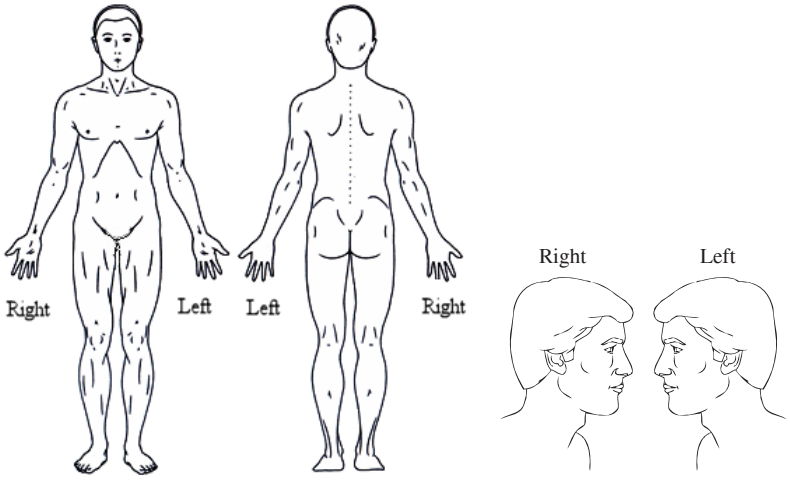
- ☐☐☐ Congested breasts
- ☐☐☐ Cramps or backache
- ☐☐☐ Excess menstrual flow
- ☐☐☐ Hot flashes
- ☐☐☐ Irregular cycle
- ☐☐☐ Lumps in breast
- ☐☐☐ Menopause
- ☐☐☐ Painful menstruation
- ☐☐☐ Vaginal discharge

Are you pregnant? ☐ Yes ☐ No
If yes, how many months? _____
How many children do you have? _____

Check any of the following conditions you current have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cholera
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diptheria
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ High cholesterol
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough
- ☐ Lymes

Please indicate any areas of body pain, stiffness or numbness.



Please list all your medications including pharmaceutical drugs, herbs, vitamins, minerals or other supplements.

MEDICATION	DOSE	MEDICATION	DOSE
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

HABITS:	None	Light	Mod	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

Please check any you are interested in:

- ☐ Acupuncture
- ☐ Manual Therapy including: massage, cupping, etc.
- ☐ Diet & Lifestyle Changes
- ☐ Nutritional Supplements & Herbs

THANK YOU.

Signature of patient or legal Representative: _____

Date: _____