

F. Present Health: Are you presently affected by

Circle: O-occasional F-frequent C-constant

Muscle & Joint

- F C arthritis
- F C bursitis
- F C backache
- F C neck pain
- F C headaches
- F C pain between shoulders
- F C hernia
- F C spinal curvature
- F C faulty posture

Pain or Numbness in:

- F C shoulders
- F C arms
- F C hands
- F C tailbone
- F C hips
- F C legs
- F C knees
- F C ankles
- F C feet

Respiratory

- F C chronic cough
- F C spitting up phlegm
- F C chest pain
- F C difficult breathing
- F C wheezing

Urinary

- F C painful urination
- F C getting up at night to urinate
- F C blood in urine
- F C frequent urination
- F C bed wetting
- F C prostate trouble

Eyes, Ears, Nose, Throat

- F C deafness
- F C earache
- F C ear discharge
- F C ear noises
- F C nosebleeds
- F C sore throat
- F C hoarseness
- F C hay fever
- F C asthma
- F C tonsillitis
- F C sinus trouble
- F C enlarged glands
- F C enlarged thyroid
- F C eye pain
- F C blurring of vision

Cardiovascular

- F C rapid heart beat
- F C slow heart beat
- F C high blood pressure
- F C pain over heart
- F C swelling of ankles
- F C previous heart attack
- F C hardening of arteries

Female Only

- Y N painful menstruation
- Y N excessive flow
- Y N irregular cycle
- Y N cramps
- Y N backache
- Y N abnormal discharge
- Y N passed menopause
- Y N Are you pregnant? due date _____
- Y N birth control pill
- Date of last menstrual period _____

Gastrointestinal

- F C excessive hunger
- F C excessive thirst
- F C poor appetite
- F C stomach pain
- F C liver trouble
- F C gall bladder trouble
- F C colitis
- F C hemorrhoids
- F C difficult digestion
- F C burping or gas
- F C nausea or vomiting
- F C heartburn/indigestion
- F C constipation
- F C diarrhea

General Symptoms

- F C chills
- F C dizziness
- F C fever
- F C sweats
- F C fainting
- F C convulsions
- F C allergy
- F C skin problems
- F C bleeding tendency
- F C easy bruising
- F C colds/flu
- F C tremors
- F C weight loss
- F C loss of sleep
- F C loss of concentration
- F C depression
- F C decreased energy/fatigue

G. Family Health Conditions: (Please ✓)

- | | | |
|--|--|--|
| <input type="checkbox"/> aneurysm/stroke | <input type="checkbox"/> migraines | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> heart disease | <input type="checkbox"/> back/disc problems |
| <input type="checkbox"/> cancer | <input type="checkbox"/> other major conditions: _____ | |

H. Past Health: Have you suffered from any of the following conditions?

(Please ✓)

- | | | |
|--|---|---|
| <input type="checkbox"/> AIDS (HIV+) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Colitis | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Dependency | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Emotional Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epileptic Seizures | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Gout | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Stroke/Aneurysm | | |

Major Accidents/Falls/Hospitalizations _____

Person Responsible for Payment: _____ Signature: _____