

Confidential Health History Information

Please PRINT carefully, all information must be completed and signature is required.

Name: _____ Date: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Phone: Home _____ Work _____ Cell _____
Email: _____ Date Of Birth: _____
Age: _____ If referred, whom may we thank? _____
Is your condition due to an accident or illness? _____ Health Care Provider: _____

Health History:

What are the 3 main reasons you are here today?

- 1.
- 2.
- 3.

Please describe the symptoms that alerted you to the conditions described above. Please include anything you have observed which makes the conditions better or worse.

How long have you had the conditions?

Please list any major injuries, accidents, or surgeries in your past, including the dates.

Please indicate If Any of the Following Apply to You

<input type="checkbox"/> Breast Augmentation	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Surgery	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Sprains	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Seizures
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Accident	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Whiplash	<input type="checkbox"/> Allergies	<input type="checkbox"/> Colitis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Headaches	<input type="checkbox"/> Migraines	<input type="checkbox"/> Stroke
<input type="checkbox"/> Nervous Tension	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> HIV/Aids
<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Prosthetics	<input type="checkbox"/> Cancer
<input type="checkbox"/> Heart Problems/Attack	<input type="checkbox"/> Disk Problems	<input type="checkbox"/> Wear Contacts	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Decreased Range of Motion	<input type="checkbox"/> Arthritis/Bursitis		

Please list any alternatives you are currently using for any of your conditions:

Are you currently under a doctor's care? Y__ N__ If yes please explain:

Are you currently taking any medications? Please include nutritional. If so, what and what for?