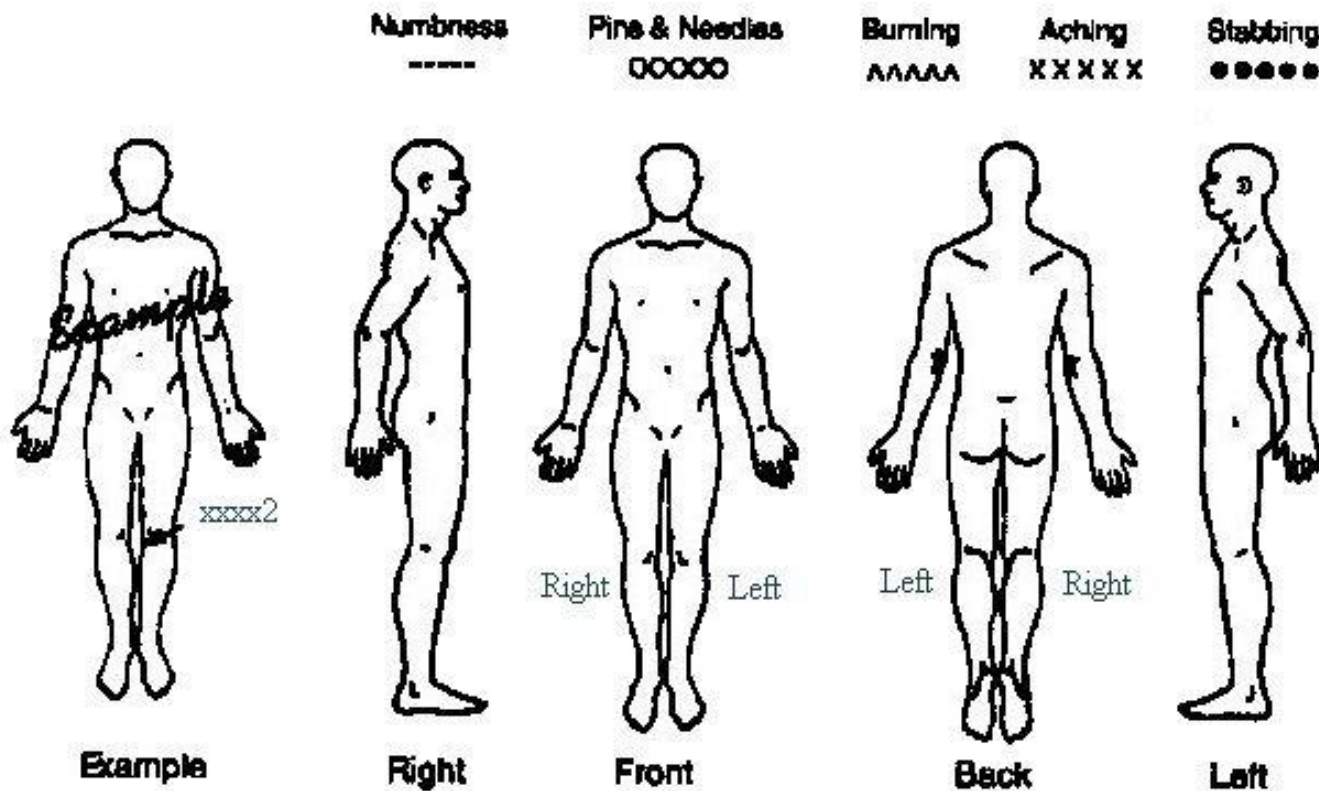


Medical History									
Have you ever suffered from:									
<input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Alcoholism <input type="checkbox"/> Allergies <input type="checkbox"/> Anemia Arteriosclerosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Back Pain <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cancer <input type="checkbox"/> Chest Pain <input type="checkbox"/> Cold Extremities Constipation <input type="checkbox"/> Cramps Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Digestion Problems <input type="checkbox"/> Dizziness <input type="checkbox"/> Deep Vein Thrombus <input type="checkbox"/> Ear ringing	<input type="checkbox"/> Easy Bruising <input type="checkbox"/> Excessive menstruation <input type="checkbox"/> Eye conditions <input type="checkbox"/> Fatigue <input type="checkbox"/> Frequent urination <input type="checkbox"/> Headache <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Irregular Cycle <input type="checkbox"/> Kidney Infection <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Loss of Smell <input type="checkbox"/> Loss of Taste <input type="checkbox"/> Neck Pain or stiffness	<input type="checkbox"/> Nervousness <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Poor posture <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Sciatica <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sinus Infection <input type="checkbox"/> Spinal Curvatures <input type="checkbox"/> Stroke <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Thyroid conditions <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Varicose veins <input type="checkbox"/> Other							
Have you been treated for any conditions in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If yes, please describe _____									
Date of last physical exam: / / Is there a chance that you are pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Have you had X-rays taken? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? _____									
Do you have an implanted pacemaker or AICD? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Medications you are taking and for what conditions: _____									
Vitamins, minerals, or herbs you are taking and for what condition _____									
Do you wear orthotics? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: _____									
Have you ever	No	Yes	Briefly explain						
Broken Bones?	<input type="checkbox"/>	<input type="checkbox"/>							
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>							
Been in an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>							
Had sprains/strains?	<input type="checkbox"/>	<input type="checkbox"/>							
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>							
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>							
Habits	None	Light	Moderate	Heavy		None	Light	Moderate	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Sweetener	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Medical History:									
Do you have a blood relative living or diseased with any of the following? Please check.									
<input type="checkbox"/> Arthritis <input type="checkbox"/> Back Pain <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Other (specify) _____									

Symptoms:	No	Yes
Do you experience pain every day?	<input type="checkbox"/>	<input type="checkbox"/>
Do your symptoms affect the quality of your life?	<input type="checkbox"/>	<input type="checkbox"/>
Does your pain wake you up at night?	<input type="checkbox"/>	<input type="checkbox"/>
Are your symptoms worse during certain times of the day?	<input type="checkbox"/>	<input type="checkbox"/>
What activities aggravate your symptoms?	<input type="checkbox"/>	<input type="checkbox"/>



Additional Comments: