

Please read entire form over before filling out. You may use a pencil. Leave blank if you do not know or, if a question does not apply to you. Feel free to use the back of page, if required.

1. **Generally, how are you feeling?**

2. **What are you doing for your health? Circle any that apply.**

Exercise	Chiropractor	Relaxation Therapies
Vitamins	Minerals	Herbs
Medications	Diet	Medical Doctor
Yoga	Meditation	Other. Please List

3. **When did you last see your medical Doctor?**

4. **What did he/she find?**

5. **Doctor's Name.** _____

6. **Have you been medically diagnosed as having any concerns/illnesses? State diagnoses and dates. Use additional sheet if required.**

Date: _____ Diagnosis: _____

Date: _____ Diagnosis: _____

Date: _____ Diagnosis: _____

7. **Have you ever had any serious accidents? What & When?**

8. **Are you or have you taken any medication? Answer Yes or No & Use sheet provided to list medications.**

9. **Have you ever had any serious illnesses? IE. Scarlet Fever, Tuberculosis, Pneumonia etc.**

10. **Do you sleep well?** _____

11. **How is your blood pressure?** _____

What is your Blood Type? _____

12. **How is you spine?**_____

13. **Additional factors that you feel have contributed to you present concerns are:**

14. **Is there anything else about your health you would like to disclose?**

16. **Main Objective of Consultation** i.e., weight loss, assessment of nutritional deficiencies/toxicities, menopause, diet & lifestyle assessment. Please state:

17. Genetic Predisposition: Illnesses/ Diseases Maternal Paternal
Mark (x) if Applicable

Heart Disease:

Cancer: Type:

Arthritis:

Osteoporosis:

Gastrointestinal Disorders
I.e., Crohn's Colitis, Ulcers
Irritable Bowel Syndrome

Cognitive/Psychiatric
Neurological Disorders:

Diabetes:

Allergies:

Other:

18. Other Information you feel is important: Use additional sheet if required.

Complete mailing Address: NAME: _____

ADDRESS: _____

Phone Number:

Date of Birth:

