Doctor's Name	Referred By	Date File #:
	PATIENT HEALTH HISTO	ORY Re-evaluation: [ ]Yes
Please write legibly to avoid in	accuracies and delays when process	sing your information.
1. Name:	Gender: [ ]M, [ ]F Ag	ge: Height: Weight:
Cell Phone:	Home Phone	Birth Date
Email		::Fax:
2. Have you ever used: [ ]Chiro If yes, for which conditions? _ If no, would you like to hear a		al Medicine [ ]Acupuncture [ ]Homeopath
Other Complaints: Diagnosed Medical Conditions  4. Cause of Health Conditions: Has the accident been reported	:	Personal Injury [ ] Other:
Are you now or have you ever	been disabled? Yes No Date: _	Cause: Phone:
5. Pain Symptoms: a (In Order b	Began (Mo/Yr)_ Began (Mo/Yr)_	Previous Episodes (Mo/Yr) Previous Episodes (Mo/Yr) Previous Episodes (Mo/Yr)
N=Numbness, T=Tingling, B= List the frequency and severity Frequency: 1=20% of the time	y of your condition on a scale of 1 to 5: Severity:	ne, SB=Stabbing, SF=Stiffness, X=Scars
Location/Body Part a. b. c.	Frequency Severity Initial Caus	Yes No Yes No
Does it affect other areas of yo	ur body (please circle)? Yes No	0
7. Do you have, or have you ever Osteoarthritis Bone S Bulging Disc Tendor Herniated Disc Joint Se DDD Bursitis Stenosis Sprains	purs Non-union Fracture itis Avascular Necrosis eparations Post-herpetic neuralg Intercostal Neuralgia	Cartilage injury gia (Meniscus Tear, Chondromalacia a Patellar Syndrome)
Please describe:	ith (please check): Work Sleep  I it affect your quality of life?	p Other:

What seems to make it worse? What treatments have you tried?  10. If you are currently under the care of a health care practitioner for any conditions or injuries, please provide their: Name: Phone: Phone: Email:  Description of Treatment:  11. Please list any current therapies:  12. Please describe your lifestyle (please check): Appetite: Low Moderate High Exercise (please check): Appetite: Low Moderate High Exercise (please check): Appetite: Confice: Yes No Cups/Day Coffice: Yes No Cups/Day None Very Active Sodu: Yes No Cups/Day Artificial Swecteners: Yes No Moderate Cravings for Sulgar: Yes No Moderate  Sitess Level: High Moderate Low Alcohol: Yes No Glasses/Day Sinoking: Yes No Glasses/Day Active Sonoking: Yes No Glasses/Day Artificial Swecteners: Occupational Hazards:  Type of Exercise:  Occupational Hazards:  Type of Exercise:  Occupational Hazards:  Type of Exercise:  I J List vitamins or supplements taken in the last 2 months:  Anti-acids (please check): I J TUMS   Zantae   Other: Other Medications:  14. List prescribed and over-the-counter pharmaceutical medication taken in the last 2 months: Anti-acids (please check): I J TUMS   Zantae   Other: Other Medications:  15. Please describe your health history (please check). Now Past Adabalian  Altrigies Alergies Alergies Alergies Alergies Alergies Alergies Artificial Supplements Arthrifis   Epilepsy   Scholey Folium   Scholey Sonotion   Arthrifis   Epilepsy   Scholey Folium   S	What seems to make it worse	e?			
10. If you are currently under the care of a health eare practitioner for any conditions or injuries, please provide their: Name:	What treatments have you tri	ied?			
11. Please describe your lifestyle (please check):   Appetite: Low   Moderate   High   Exercise (please check):	10. If you are currently under the	e care of a health care practiti	oner for any conditions or inj	uries, please provide their:	
11. Please describe your lifestyle (please check):   Appetite: Low   Moderate   High   Exercise (please check):	Name:	Phone:	Email: _		
12. Please describe your lifestyle (please check):   Appetite: Low   Moderate   High   Exercise (please check):	Description of Treatment:				
12. Please describe your lifestyle (please check):   Appetite: Low   Moderate   High   Exercise (please check):	11. Please list any current therap	ies:			
Appetite: Low Moderate High Glasses/Day Coffee: Yes No Glasses/Day None Very Active Soda: Yes No Cups/Day None Very Active Soda: Yes No Cups/Day None Very Active Soda: Yes No Cups/Day Artificial Sweeteners: Yes No Light Elite Athlete Cravings for Sugar: Yes No Moderate Stress Level: High Moderate Low Alcohol: Yes No Glasses/Day Active Smoking: Yes No Glasses/Day Active Smoking: Yes No Glasses/Day Active Smoking: Yes No Times/Day Type of Exercise: Occupational Hazards: Frequency of Exercise: Occupational Hazards: Frequency of Exercise: Stress List vitamins or supplements taken in the last 2 months: Frequency of Exercise: Other Drugs: Julian Stress List vitamins or supplements taken in the last 2 months: Anti-acids (please check): JTUMS JZantac JOther: Other Medications: Julian Stress List Now Past Acid Reflux/Hear Bum Coronary attery disease High Cholesterol AlDS/HIV Bum Dishibitors (please check): Move Past AlDS/HIV Bum Dishibitors (please check): Blb Scoliosis Anemia Diabetes Influenza Sacroidosis Anemia Diabetes Influenza Sacroidosis Anemia Arthritis Epidepsy Kidney Failure overgrowth (SIBO) Anemia Blb Scoliosis Arthritis Epidepsy Kidney Failure Organows (SIBO) Anemia Fibrionylagia Migraines Typioli Disorders Typioli Disorders Hidronylagia Migraines Typioli Disorders Hidronylagia Migraines Typioli Disorders Typioli Disorders Home Acid Reflux/Hear Bum Gout Panceral Disease Scizures Pacenaker Ulcerative Colitis Chronic Bionchitis Heart Murmur Pheurisy UTI Heart Murmur Pheurisy UTI Heart Murmur Pheurisy UTI Heart Murmur Pheurish Pheurish Disorder High Blood Pressure Pasoriatis Crohn's Disease Colore Conserve Acid reflux/Heart bum Gout Spannal Acid reflux/Heart bum Gout Spannal Spann					
Thirst for Water: Yes No			Exercise (please	check):	
Coffee: Yes No	Thirst for Water: Yes	No Glasses/Day	•	,	
Artificial Sweeteners: Yes No Light Elite Athlete Cravings for Sugar: Yes No Moderate Stress Level: High Moderate Low Alcohol: Yes No Glasses/Day Active Smoking: Yes No Glasses/Day Active Smoking: Yes No Glasses/Day Active Smoking: Yes No Glasses/Day Type of Exercise: Occupational Hazards: Frequency of Exercise:  13. List vitamins or supplements taken in the last 2 months:  14. List prescribed and over-the-counter pharmaceutical medication taken in the last 2 months:  15. Please describe your health history (please check):   Prilosec   Pepcid   Prevacid   Other: Other Medications:  16. Please describe your health history (please check).  Now Past Now Past Now Past High Cholesterol Acid Reflux/Heart Burn Coronary artery disease Acid Reflux/Heart Burn Coronary artery disease Alcoholism Dabetes Influenza Sarcoidosis Alengies Diverticultis Ilia Alcoholism Dabetes Influenza Sarcoidosis Alenemia Drug Withdrawal Ilis Alenemia Drug Withdrawal Ilis Arthritis Fipilepsy Kidney Stones Arthritis Fipilepsy Kidney Fibrosis Samal intestinal bacterial overgrowth (SIBO) Arthritis Fipilepsy Kidney Fibrosiae Siziaure Overgrowth (SIBO) Arthritis Fibromyalgia Migraines Tuberculosis Brith Trauma Fibromyalgia Migraines Tuberculosis Brith Trauma Fibromyalgia Mugraines Tuberculosis Brith Trauma Fibromyalgia Mugraines Tuberculosis Cancer Goiler Pacemaker Ulcerst, Location: Cancer Goiler Pacemaker Ulcerst, Location: Cancer Goiler Pacemaker Ulcerst Colitis Crohn's Disease Cirirhosis Heavity Iligh Blood Pressure Persuatis Windige Persuatis Weneral Blood Corol Persuatis Weneral Blood Persuate Persuatis Weneral Blood Persuate Persuatis Weneral Disease Corogestive heart failure High Blood Pressure Persuatis Weneral Disease Digestive Tract Blooding Gloten Integer.  Acid reflux/Heart burn Gas Persuation, Now Past No	Coffee: Yes	No Cups/Day		Very Active	
Cravings for Sulgar: Yes No Moderate Stress Level: High Moderate Low Alcohol: Yes No Glasses/Day Active Smoking: Yes No Glasses/Day Active Smoking: Yes No Glasses/Day Type of Exercise: Occupational Hazards: Frequency of Exercise:  Occupational Hazards: Frequency of Exercise:  13. List vitamins or supplements taken in the last 2 months:  14. List prescribed and over-the-counter pharmaceutical medication taken in the last 2 months:  15. Please describe your health history (please check):   Prilosec   Pepcid   Prevacid   Other: Other Medications:  15. Please describe your health history (please check).  Now Past Acid Reflux/Heart Burn Coronary artery disease Alosholism Diabetes High Cholesterol Rheumatic Fever ALOS/HIV Cystic Fibrosis Hyperlipidemia Rheumatic Fever ALOS/HIV Cystic Fibrosis Hyperlipidemia Rheumatic Fever ALOS-HIV		No Cups/Day			
Cravings for Salty Foods: Yes No Moderate Stress Level: High Moderate Low Alcohol: Yes No Glasses/Day Active Smoking: Yes No Times/Day Type of Exercise: Other Drugs: Occupational Hazards: Frequency of Exercise: Other Drugs: Occupational Hazards: Frequency of Exercise:  13. List vitamins or supplements taken in the last 2 months: Anti-acids (please check): [] TUMS [] Zantac [] Other: Proton Pump Inhibitors (please check): [] Prilosec [] Pepcid [] Prevacid [] Other: Other Medications:  15. Please describe your health history (please check). Now Past Now Past Now Past Now Past AlbS/HIV Cystic Fibrosis Hipperlipidemia Rheumatic Fever AlbS/HIV Cystic Fibrosis Influency Allergies Diverticulitis BIBD Scoliosis Anemia Drug Withdrawal IBS Scoliosis Anemia Drug Withdrawal IBS Scoliosis Appendicitis Emphysema Kidney Stones Small intestinal bacterial overgrowth (SIBO) Arteriosclerosis Eczema Asthma Frectile Dysfunction Meniere's Disease Scizuces Asthma Fibroliation Fatty Liver Mental Disorder Thyroid Disorders Heat Murmur Phenumonia Interstitial Cystitis Conceived Nother Describe Protatitis Protatis Veneral Disease Congestive heat failure High Blood Pressure Psoriasis Utilia Confort Disease Disease Congestive heat failure High Blood Pressure Psoriasis Other, Describe Disease Poor Disease Disease Disease Disease			Light	Elite Athlete	
Alcohol: Yes No Cigarettes/Day Type of Exercise:  Marijuana: Yes No Times/Day Type of Exercise:  Occupational Hazards: Frequency of Exercise:  13. List vitamins or supplements taken in the last 2 months:  Anti-acids (please check): [] TUMS [] Zantac [] Other:  Proton Pump Inhibitors (please check): [] Prilosec [] Pepcid [] Prevacid [] Other:  Other Medications:  15. Please describe your health history (please check).  Now Past Now Past Now Past Now Past High Cholesterol Rheumatic Fever Altoshift Alcoholism Diabetes Influenza Sarcoidosis  — Alcoholism Diabetes Influenza Sarcoidosis — Anemia Diabetes Influenza Sarcoidosis — Anemia Drug Withdrawal IBS Scalet Fever Appendicitis Emphysema Kidney Stones Small intestinal bacterial Arthritis Epilepsy Kidney Failure overgrowth (SIBO) Attribution Fexcures Exercise Seizures Seizures Seizures Bronziela Multiple Sclerosis Typhoid Fever Bronziela Multiple Sclerosis Typhoid Fever Disease Chicken Pox Hemia Pleurisy UTI Chronic kidney disaster and Multiple Sclerosis Typhoid Fever Ulcers, Location:  — Candida Gout Pancentairis Ulcers Chronic kidney disaster and Penemonia Interstital Cystitis Chronic kidney disaster Seizures Protoke Pancentaker Ulcerative Colliis Chronic kidney disaster and Penemonia Interstital Cystitis Ulcers, Location:  — Candida Gout Pancentairis Underson Disease Ulcers, Location: — Chronic Bronchitis Heart Murmur Pneumonia Interstitial Cystitis Ulcers, Cortion Seconds Distributed Penemonia Interstitial Cystitis United Discorder Penemaker Ulcerative Colliis Cronic kidney disease Hepatitis Prostatitis Vitiligo Cirrhosis Heart Murmur Pneumonia Interstitial Cystitis United Discorder Pancentifis Cortionic Kidney disease Hepatitis Prostatitis Vitiligo Cirrhosis Heart Murmur Pneumonia Interstitial Cystitis Vitiligo Cirrhosis Heart Murmur Pneumonia Discorder Pleurisy UTI Disease Congestive heart failure High Blood Pressure Psoriasis Mhooping Cough Cortionic Kidney disease Penemaker Ulcerative Colliis Cirrhosis Pleurisy UTI Disease Psoriatic Arbritis Vitiligo Cirrhos	Cravings for Sugar:	Yes No			
Alcohol: Yes No Cigarettes/Day Type of Exercise:  Marijuana: Yes No Times/Day Type of Exercise:  Occupational Hazards: Frequency of Exercise:  13. List vitamins or supplements taken in the last 2 months:  Anti-acids (please check): [] TUMS [] Zantac [] Other:  Proton Pump Inhibitors (please check): [] Prilosec [] Pepcid [] Prevacid [] Other:  Other Medications:  15. Please describe your health history (please check).  Now Past Now Past Now Past Now Past High Cholesterol Rheumatic Fever Altoshift Alcoholism Diabetes Influenza Sarcoidosis  — Alcoholism Diabetes Influenza Sarcoidosis — Anemia Diabetes Influenza Sarcoidosis — Anemia Drug Withdrawal IBS Scalet Fever Appendicitis Emphysema Kidney Stones Small intestinal bacterial Arthritis Epilepsy Kidney Failure overgrowth (SIBO) Attribution Fexcures Exercise Seizures Seizures Seizures Bronziela Multiple Sclerosis Typhoid Fever Bronziela Multiple Sclerosis Typhoid Fever Disease Chicken Pox Hemia Pleurisy UTI Chronic kidney disaster and Multiple Sclerosis Typhoid Fever Ulcers, Location:  — Candida Gout Pancentairis Ulcers Chronic kidney disaster and Penemonia Interstital Cystitis Chronic kidney disaster Seizures Protoke Pancentaker Ulcerative Colliis Chronic kidney disaster and Penemonia Interstital Cystitis Ulcers, Location:  — Candida Gout Pancentairis Underson Disease Ulcers, Location: — Chronic Bronchitis Heart Murmur Pneumonia Interstitial Cystitis Ulcers, Cortion Seconds Distributed Penemonia Interstitial Cystitis United Discorder Penemaker Ulcerative Colliis Cronic kidney disease Hepatitis Prostatitis Vitiligo Cirrhosis Heart Murmur Pneumonia Interstitial Cystitis United Discorder Pancentifis Cortionic Kidney disease Hepatitis Prostatitis Vitiligo Cirrhosis Heart Murmur Pneumonia Interstitial Cystitis Vitiligo Cirrhosis Heart Murmur Pneumonia Discorder Pleurisy UTI Disease Congestive heart failure High Blood Pressure Psoriasis Mhooping Cough Cortionic Kidney disease Penemaker Ulcerative Colliis Cirrhosis Pleurisy UTI Disease Psoriatic Arbritis Vitiligo Cirrhos	Cravings for Salty Foods:	Yes No	Moderate		
Alcohol: Yes No Cigarettes/Day Type of Exercise:  Marijuana: Yes No Times/Day Type of Exercise:  Occupational Hazards: Frequency of Exercise:  13. List vitamins or supplements taken in the last 2 months:  Anti-acids (please check): [] TUMS [] Zantac [] Other:  Proton Pump Inhibitors (please check): [] Prilosec [] Pepcid [] Prevacid [] Other:  Other Medications:  15. Please describe your health history (please check).  Now Past Now Past Now Past Now Past High Cholesterol Rheumatic Fever Altoshift Alcoholism Diabetes Influenza Sarcoidosis  — Alcoholism Diabetes Influenza Sarcoidosis — Anemia Diabetes Influenza Sarcoidosis — Anemia Drug Withdrawal IBS Scalet Fever Appendicitis Emphysema Kidney Stones Small intestinal bacterial Arthritis Epilepsy Kidney Failure overgrowth (SIBO) Attribution Fexcures Exercise Seizures Seizures Seizures Bronziela Multiple Sclerosis Typhoid Fever Bronziela Multiple Sclerosis Typhoid Fever Disease Chicken Pox Hemia Pleurisy UTI Chronic kidney disaster and Multiple Sclerosis Typhoid Fever Ulcers, Location:  — Candida Gout Pancentairis Ulcers Chronic kidney disaster and Penemonia Interstital Cystitis Chronic kidney disaster Seizures Protoke Pancentaker Ulcerative Colliis Chronic kidney disaster and Penemonia Interstital Cystitis Ulcers, Location:  — Candida Gout Pancentairis Underson Disease Ulcers, Location: — Chronic Bronchitis Heart Murmur Pneumonia Interstitial Cystitis Ulcers, Cortion Seconds Distributed Penemonia Interstitial Cystitis United Discorder Penemaker Ulcerative Colliis Cronic kidney disease Hepatitis Prostatitis Vitiligo Cirrhosis Heart Murmur Pneumonia Interstitial Cystitis United Discorder Pancentifis Cortionic Kidney disease Hepatitis Prostatitis Vitiligo Cirrhosis Heart Murmur Pneumonia Interstitial Cystitis Vitiligo Cirrhosis Heart Murmur Pneumonia Discorder Pleurisy UTI Disease Congestive heart failure High Blood Pressure Psoriasis Mhooping Cough Cortionic Kidney disease Penemaker Ulcerative Colliis Cirrhosis Pleurisy UTI Disease Psoriatic Arbritis Vitiligo Cirrhos	Stress Level: High	Moderate Low			
Smoking: Yes No	Alcohol: Yes No	Glasses/Day	Active		
Occupational Hazards:    13. List vitamins or supplements taken in the last 2 months:   14. List prescribed and over-the-counter pharmaceutical medication taken in the last 2 months:   15. Anti-acids (please check): [] TUMS [] Zantac [] Other:   16. Proton Pump Inhibitors (please check): [] Prilosec [] Pepcid [] Prevacid [] Other:   17. Other Medications:   18. Please describe your health history (please check).   18. Now Past Now	Smoking: Yes No	Cigarettes/Day			
Secupational Hazards:   Frequency of Exercise:			Type of Exercis	se:	
13. List vitamins or supplements taken in the last 2 months:   Anti-acids (please check):     TUMS     Zantac     Other:     Proton Pump Inhibitors (please check):     Prilosec     Pepcid       Prevacid     Other:     Other Medications:     Other Medications:	Other Drugs :				
14. List prescribed and over-the-counter pharmaceutical medication taken in the last 2 months:   Anti-acids (please check): [] TUMS [] Zantac [] Other:				xercise:	
Anti-acids (please check): [] TUMS [] Zantac [] Other:  Proton Pump Inhibitors (please check): [] Prilosec [] Pepcid [] Prevacid [] Other:  Other Medications:    15. Please describe your health history (please check).	13. List vitamins or supplements	taken in the last 2 months:			
Acid Reflux/Heart Burn					
AlDS/HIV Cystic Fibrosis Hyperlipidemia Rheumatoid Arthritis Alcoholism Diabetes Influenza Sarcoidosis Allergies Diverticulitis JBD Scoliosis Anemia Drug Withdrawal IBS Scarlet Fever Appendicitis Emphysema Kidney Stones Small intestinal bacterial Arthritis Epilepsy Kidney Failure overgrowth (SIBO) Arteriosclerosis Ezema Lyme Disease Seizures Asthma Erectile Dysfunction Meniere's Disease Scizures Asthma Erectile Dysfunction Meniere's Disease Stroke Atrial Fibrillation Fatty Liver Mental Disorder Thyroid Disorders Birth Trauma Fibromyalgia Migraines Tuberculosis Bronchiectasis Fibroid Multiple Sclerosis Typhoid Fever Breast Lump Gallbladder Stones Ovarian Cyst Ulcers, Location: Cancer Goiter Pacemaker Ulcerative Colitis Candida Gout Pancreatitis Crohn's Disease Chicken Pox Hernia Pleurisy UTI Chronic Bronchitis Heart Murmur Pneumonia Interstitial Cystitis Chronic kidney disease Hepatitis Prostatitis Vitiligo Cirrhosis Heart Murmur Psoriatic arthritis Venereal Disease Congestive heart failure High Blood Pressure Psoriatic arthritis Venereal Disease COPD Pulmonary fibrosis Other, Describe  Diegetive Tract Bloating Gluten Intolerance Difficulty Swallowing Poor Digestion Hicups Chemical Sensitivities Constipation	Now Past	Now Past	Now Past	Now Past	
Alcoholism Diabetes Influenza Sarcoidosis Allergies Diverticulitis IBD Scoliosis Anemia Drug Withdrawal IBS Scarlet Fever Appendicitis Emphysema Kidney Stones Small intestinal bacterial Arthritis Epilepsy Kidney Failure overgrowth (SIBO) Arthritis Epilepsy Skidney Failure Overgrowth (SIBO) Arthritis Overgrowth (SIBO	Acid Reflux/Heart Burr	Coronary artery disease	High Cholesterol	Rheumatic Fever	
Anemia Drug Withdrawal IBS Scarlet Fever  Appendicitis Emphysema Kidney Stones Small intestinal bacterial  Arthritis Epilepsy Kidney Failure overgrowth (SIBO)  Arteriosclerosis Eczema Lyme Disease Seizures  Asthma Erectile Dysfunction Meniere's Disease Stroke  Artial Fibrillation Fatty Liver Mental Disorder Thyroid Disorders  Birth Trauma Fibromyalgia Migraines Tuberculosis  Bronchiectasis Fibroid Multiple Sclerosis Typhoid Fever  Breast Lump Gallbladder Stones Ovarian Cyst Ulcers, Location:  Cancer Goiter Pacemaker Ulcerative Colitis  Candida Gout Pancreatitis Crohn's Disease  Chicken Pox Hernia Pleurisy UTI  Chronic Bronchitis Heart Murmur Pneumonia Interstitial Cystitis  Congestive heart failure High Blood Pressure Psoriatic arthritis Venereal Disease  COPD Pulmonary fibrosis Other, Describe  Digestive Tract Bloating Gas Food Allergies Diarrhea  Poor Digestion Hiccups Chemical Sensitivities Constipation	Alcoholism	Cystic Fibrosis	Hyperlipidemia	Rneumatoid Arthritis	
Anemia Drug Withdrawal IBS Scarlet Fever Appendicitis Emphysema Kidney Stones Small intestinal bacterial overgrowth (SIBO) Arthritis Epilepsy Kidney Failure overgrowth (SIBO) Arteriosclerosis Eczema Lyme Disease Seizures Asthma Ercetile Dysfunction Meniere's Disease Stroke Atrial Fibrillation Fatty Liver Mental Disorder Thyroid Disorders Birth Trauma Fibromyalgia Migraines Tuberculosis Bronchiectasis Fibroid Multiple Sclerosis Typhoid Fever Breast Lump Gallbladder Stones Ovarian Cyst Ulcers, Location: Cancer Goiter Pacemaker Ulcerative Colitis Candida Gout Pancreatitis Crohn's Disease Chronic Bronchitis Heart Murmur Pneumonia Interstitial Cystitis Chronic kidney disease Hepatitis Prostatitis Vitiligo Cirrhosis Herpes Psoriatic arthritis Venereal Disease Congestive heart failure High Blood Pressure Psoriasis Whooping Cough COPD Pulmonary fibrosis Diarrhea Poor Digestion Hiccups Chemical Sensitivities Constipation		Diverticulitis	IBD	Scoliosis	
Appendicitis Emphysema Kidney Stones Small intestinal bacterial Arthritis Epilepsy Kidney Failure overgrowth (SIBO)  Arteriosclerosis Eczema Lyme Disease Seizures  Asthma Erectile Dysfunction Meniere's Disease Stroke  Atrial Fibrillation Fatty Liver Mental Disorder Thyroid Disorders  Birth Trauma Fibromyalgia Migraines Tuberculosis  Bronchiectasis Fibroid Multiple Sclerosis Typhoid Fever  Breast Lump Gallbladder Stones Ovarian Cyst Ulcers, Location:  Cancer Goiter Pacemaker Ulcerative Colitis  Candida Gout Pancreatitis Crohn's Disease  Chicken Pox Hernia Pleurisy UTI  Chronic Bronchitis Heart Murmur Pneumonia Interstitial Cystitis  Chronic kidney disease Hepatitis Prostatitis Vitiligo  Cirrhosis Herpes Psoriasis Whooping Cough  COPD Pulmonary fibrosis Other, Describe  16. Please use the point scales to rate your symptoms over the past 3 months.  1 = Occasional, Not Severe 2 = Occasional, Severe 3 = Frequent, Not Severe 4 = Frequent, Severe  Digestive Tract Bloating Gluten Intolerance Difficulty Swallowing  Poor Digestion Hiccups Chemical Sensitivities Constipation					
Arteriosclerosis Eczema Lyme Disease Seizures  Asthma Erectile Dysfunction Meniere's Disease Stroke  Atrial Fibrillation Fatty Liver Mental Disorder Thyroid Disorders  Birth Trauma Fibromyalgia Migraines Tuberculosis  Bronchiectasis Fibroid Multiple Sclerosis Typhoid Fever  Breast Lump Gallbladder Stones Ovarian Cyst Ulcers, Location:  Cancer Goiter Pacemaker Ulcerative Colitis  Candida Gout Pancreatitis Crohn's Disease  Chicken Pox Hernia Pleurisy UTI  Chronic Bronchitis Heart Murmur Pneumonia Interstitial Cystitis  Chronic kidney disease Hepatitis Prostatitis Vitiligo  Cirrhosis Herpes Psoriatic arthritis Venereal Disease  Congestive heart failure High Blood Pressure Psoriasis Whooping Cough  COPD Pulmonary fibrosis Other, Describe  16. Please use the point scales to rate your symptoms over the past 3 months.  1 = Occasional, Not Severe 2 = Occasional, Severe 3 = Frequent, Not Severe 4 = Frequent, Severe  Digestive Tract Bloating Gluten Intolerance Difficulty Swallowing Acid reflux/Heart burn Gas Food Allergies Diarrhea  Poor Digestion Hiccups Chemical Sensitivities Constipation					
Asthma Erectile Dysfunction Meniere's Disease Stroke  Atrial Fibrillation Fatty Liver Mental Disorder Thyroid Disorders  Birth Trauma Fibromyalgia Migraines Tuberculosis  Bronchiectasis Fibroid Multiple Sclerosis Typhoid Fever  Breast Lump Gallbladder Stones Ovarian Cyst Ulcers, Location:  Cancer Goiter Pacemaker Ulcerative Colitis  Candida Gout Pancreatitis Crohn's Disease  Chicken Pox Hernia Pleurisy UTI  Chronic Bronchitis Heart Murmur Pneumonia Interstitial Cystitis  Chronic kidney disease Hepatitis Prostatitis Vitiligo  Cirrhosis Herpes Psoriatic arthritis Venereal Disease  Congestive heart failure High Blood Pressure Psoriasis Whooping Cough  COPD Pulmonary fibrosis Other, Describe  16. Please use the point scales to rate your symptoms over the past 3 months.  1 = Occasional, Not Severe 2 = Occasional, Severe 3 = Frequent, Not Severe 4 = Frequent, Severe  Digestive Tract Bloating Gluten Intolerance Difficulty Swallowing  Acid reflux/Heart burn Gas Food Allergies Diarrhea  Poor Digestion Hiccups Chemical Sensitivities Constipation					
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Birth Trauma Fibromyalgia Migraines Tuberculosis Bronchiectasis Fibroid Multiple Sclerosis Typhoid Fever Breast Lump Gallbladder Stones Ovarian Cyst Ulcers, Location: Cancer Goiter Pacemaker Ulcerative Colitis Candida Gout Pancreatitis Crohn's Disease Chicken Pox Hernia Pleurisy UTI Chronic Bronchitis Heart Murmur Pneumonia Interstitial Cystitis Chronic kidney disease Hepatitis Prostatitis Vitiligo Cirrhosis Herpes Psoriatic arthritis Venereal Disease Congestive heart failure High Blood Pressure Psoriasis Whooping Cough COPD Pulmonary fibrosis Other, Describe  16. Please use the point scales to rate your symptoms over the past 3 months.  1 = Occasional, Not Severe 2 = Occasional, Severe 3 = Frequent, Not Severe 4 = Frequent, Severe  Digestive Tract Bloating Gluten Intolerance Difficulty Swallowing Acid reflux/Heart burn Gas Food Allergies Diarrhea Poor Digestion Hiccups Chemical Sensitivities Constipation					
Breast Lump Gallbladder Stones Ovarian Cyst Ulcers, Location:  Cancer Goiter Pacemaker Ulcerative Colitis  Candida Gout Pancreatitis Crohn's Disease  Chicken Pox Hernia Pleurisy UTI  Chronic Bronchitis Heart Murmur Pneumonia Interstitial Cystitis  Chronic kidney disease Hepatitis Prostatitis Vitiligo  Cirrhosis Herpes Psoriatic arthritis Venereal Disease  Congestive heart failure High Blood Pressure Psoriasis Whooping Cough  COPD Pulmonary fibrosis Other, Describe  16. Please use the point scales to rate your symptoms over the past 3 months.  1 = Occasional, Not Severe 2 = Occasional, Severe 3 = Frequent, Not Severe 4 = Frequent, Severe  Digestive Tract Bloating Gluten Intolerance Difficulty Swallowing  Acid reflux/Heart burn Gas Food Allergies Diarrhea  Poor Digestion Hiccups Chemical Sensitivities Constipation			~ ~		
Cancer					
Candida					
Chicken Pox					
Chronic kidney disease Hepatitis Prostatitis Venereal Disease Cirrhosis Herpes Psoriatic arthritis Whooping Cough Congestive heart failure High Blood Pressure Psoriasis Other, Describe  16. Please use the point scales to rate your symptoms over the past 3 months.  1 = Occasional, Not Severe 2 = Occasional, Severe 3 = Frequent, Not Severe 4 = Frequent, Severe  Digestive Tract Bloating Gluten Intolerance Difficulty Swallowing Acid reflux/Heart burn Gas Food Allergies Diarrhea Poor Digestion Hiccups Chemical Sensitivities Constipation					
Cirrhosis		Heart Murmur			
Congestive heart failureHigh Blood PressurePsoriasisWhooping Cough					
COPDPulmonary fibrosisOther, Describe  16. Please use the point scales to rate your symptoms over the past 3 months.  1 = Occasional, Not Severe 2 = Occasional, Severe 3 = Frequent, Not Severe 4 = Frequent, Severe  Digestive TractBloatingGluten IntoleranceDifficulty SwallowingAcid reflux/Heart burnGasFood AllergiesDiarrhea					
Digestive Tract     Bloating     Gluten Intolerance     Digestive Tract       Acid reflux/Heart burn     Gas     Food Allergies     Diarrhea       Poor Digestion     Hiccups     Chemical Sensitivities     Constipation					
Digestive TractBloatingGluten IntoleranceDifficulty SwallowingAcid reflux/Heart burnGasFood AllergiesDiarrheaPoor DigestionHiccupsChemical SensitivitiesConstipation	16. Please use the point scales to rate your symptoms over the past 3 months.				
Acid reflux/Heart burn Gas Food Allergies Diarrhea Poor Digestion Hiccups Chemical Sensitivities Constipation	1 = Occasional, Not Severe 2 = Occasional, Severe 3 = Frequent, Not Severe 4 = Frequent, Severe				
Poor Digestion Hiccups Chemical Sensitivities Constipation					
				Diarrhea	
		Hiccups	Chemical Sensitivities	Constination	

Blood in Stool	Craving Certain Foods	Numbness	Wakes Up Frequently
Mucous in Stool	Describe:	Tics	Morning Shakiness
Black Stool	Excessive Weight	Foot Neuropathy	Cannot Wake Up in Morning
Stomach Pains/Cramps	Loss of Taste	E 9 A 41 14	N
Abdominal Pain	Compulsive Eating	Energy & Activity	Mouth & Throat
Abdominal Spasms	Poor Appetite	Apathy, Lethargy Attention Deficit	Chronic CoughingGagging, Often Clearing Throat
Lack of Bowel Control	Heavy Appetite	Attention Deficit Fatigue	Sore Throat, Hoarse, Voice Loss
Itchy Anus	Strongly Like Cold Drinks	Lack of Strength	Swollen/Discolored Tongue/Lips
Rectal Pain	Strongly Like Hot Drinks	Body Heaviness	Sores on Lips or Tongue
Hemorrhoids	Water Retention	Body Ticaviness Hyperactivity	Soles on Elps of Tollgue Canker Sores
Anal Fissures	Musculoskeletal	Restlessness	Itching on Roof of Mouth
Bowel Movements:	Muscle Pains	Shortness of Breath	Dry Mouth
Frequency:	Muscle Cramps	Stuttering or Stammering	Excessive Saliva
Texture/Form	Pains or Aches in Joints	Slurred Speech	Recurrent Sore Throat
Color	Stiffness/Limited Range of Motion	Started Speech	Excessive Phlegm
Odor	Pains or Aches in Muscles	Ears	Color:
General	Feeling of Weakness/Tiredness	Itchy Ears	Swollen Glands
Sweat Easily	Swollen Tender Joints	Ear Aches, Ear Infections	Lumps in Throat
Night Sweats	Pain in Legs	Drainage from Ears	Enlarged Thyroid
Gallbladder Trouble	Hip Tightness/Coldness/Pain	Hearing Loss	Teeth Problem
Cold Hands or Feet	Rib Pain	Reddening of the Ears	Gum Problem
Poor Circulation	Neck/Shoulder Pain	Ringing in the Ears	Grinding Teeth
Spitting Blood	Upper Back Pain	Headaches	
Fever	Back Pain	Concussions	Skin & Hair
Chills	Lower Back Pain	Nose	Acne
Muscle Cramps	Sciatic Pain	Stuffy Nose	Itching
Lower Extremity Edema	Cardiovascular	Dryness Inside the Nose	Hives
Vertigo or Dizziness	Heart Murmur	Chronically Red,	Rash
Bleed or Bruise EasilyFrequent Illness	Heart Palpitations	Inflamed Nose	Eczema Dry Skin
Seasonal Allergy	Irregular or Skipping Heartbeat	Sinus Problem	Ulcerations
Seasonal Affergy Addicted to Drugs	Rapid or Pounding Heartbeat	Hay Fever	Hair Loss
Addicted to Brugs Addicted to Smoking	Chest Pain	Sneezing Attacks	Dandruff
Peculiar Taste:	Difficulty Breathing	Excessive Mucous Formation	—Flushing or Hot Flashes
Describe:	High Blood Pressure	Back Dripping	Change in Hair/Skin Texture
·	Low Blood Pressure	Nose Bleeding	Loss in Pigmentation
Respiratory	Blood Clots	TC	Skin Fungal Infections
Tight Chest	Anemia	Eyes	-
Shortness of Breath Difficulty Breathing	FaintingTachycardia	Glasses/Contacts	For Women Only
When Lying Down		Watery or Itchy EyesRed, Swollen or Sticky Eyelids	Age Menstrual Cycle Began:
Itching Inside the Chest	Emotions	Red, Swohen of Sticky Eyends Bags/Dark Circles Under Eyes	
Wheezing	Mood Swings	Poor Vision	Length of Cycle (Day 1 - Day 1):
Persistent Cough	Anxious, Fear, Nervous	Blurred or Tunnel Vision	- CF1
Coughing Blood	Angry Irritable, Aggressive	Sensitive to Sunlight	Duration of Flow:
Cough: Wet / Dry, Thick / Thin	Easily Stressed	Eye Strain	Dark Color Flow
Color of Phlegm	Argumentative	Eye Buum Eye Pain	Clots in Flow
Other Lung Problems	Frustrated, Cries Easily	Red Eyes	Excessive Flow
_	Depression	Itchy Eyes	Irregular Cycle
Urinary	Abuse Survivor	Easily Fatigued Eyes	Painful Period
Bedwetting	Considered/Attempted Suicide	—Spots in Eyes	Painful Intercourse
Blood in Urine	Seeing a Therapist	Night Blindness	Excessive Vaginal Discharge Menopause Symptoms
Lack of Bladder Control	Obsessive Behavior	Glaucoma	Lump in Breast
Pain During Urination	Compulsive Thoughts	Cataract	Vaginal Dryness
Frequent/urgent urination	Uncontrollable Urges		Vaginal Dryness Vaginal Sores
Incomplete Urination	Mind	Head	Vaginal Soles Vaginal Odor
Difficulty Urination	Poor Memory	Headaches	Vaginal Odor Vaginal Discharge Color:
Wake to Urinate	Difficulty Completing Projects	Migraines	. agmai Distinigo Coloi.
Prostate Problem	Difficulty with Mathematics	Faintness	# of Pregnancies:
Genital Itch or Discharge	Underachiever	Dizziness	# of Live Births:
— Premature Ejaculation	Poor/Short Attention Span	Facial Flushing	# of Premature Births:
— Recurrent Bladder Infections	Confusion	Facial Pain	Age at Menopause:
—Impotence	Easily Distracted	TMJ	Date Last Period Began:
— Increased Libido	Difficulty Making Decisions	Sleep	
— Decreased Libido	Learning Disability	Insomnia	Any Other Symptoms:
Weight & Eating	Neurological	Sleep Disorder	
Recent Weight Loss	NeurologicalSeizures	Difficulty Falling Asleep	
Recent Weight Gain	SCIZUICS	Difficulty Staying Asleep	
Binge Eating/Drinking			

17. Operations and Procedures			
Date	Date	Date	
Vaccinations	Tubes in Ears	Sinus	Other:
Tonsillectomy	Appendectomy	Hernia	<b>Date:</b>
Gallbladder	Gynecological	Thyroid	
Back Operation	Rectal Surgery	Stomach	
List and date any accidents or falls	(please check):		
[ ] Car, [ ] Recreati	on, [ ] Sports	, [ ] School	, [ ] Other
List any broken bones:			ate:
Have you ever had spinal taps or s	pinal injections (please check)?	Yes No Da	ate:
Have you ever lost consciousness	(please check)? Yes No	Why?	
Have you ever had X-ray taken?	Yes No Date:	By Whon	n?
Do you suffer from any condition	other than that for which you are	now consulting us?	
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and me. The heath care provider's guarantee reimbursement. Direct peredited to my account upon receip responsibility and I agree to make suspend or terminate my care and party collection become necessary	s office will prepare necessary paragramments made from the insurance of and any balances due will be many payments for these services to the treatment, any fees for services reprovides to pay all fees involved as provider to examine and treat many fees for services respectively.	perwork to assist me in the ce company to the health car by responsibility. All service he health care provider's off endered will be immediated in collections of the accounty condition as deemed app	ces rendered to me are my personal ice. I also understand that if I y due and payable. Should third at.  ropriate through the use of
Patient's / Guardian's Sign	ature:		Date: