Do you or any immediate family member have a history of:

	Myself		Relative	
Cancer	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
Depression	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Heart Disease	Yes	No	Yes	No
Tuberculosis	Yes	No	Yes	No
Stroke	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No
Osteoporosis	Yes	No	Yes	No
Scoliosis	Yes	No		
Ulcers	Yes	No		
Shortness of Breath	Yes	No		
Allergies	Yes	No		
Asthma	Yes	No		
Bronchitis	Yes	No		
Epilepsy	Yes	No		
Fibromyalgia	Yes	No		
Kidney disease/stones	Yes	No		
Polio	Yes	No		
Emphysema	Yes	No		
Anemia	Yes	No		
Rheumatic fever	Yes	No		
Thyroid disorder	Yes	No	hyper/hypo	
Falls/Balance problems	Yes	No		
Other:____________________	Yes	No		

Have you **recently** had:		
Nausea/Vomiting	Yes	No
Fever/Chills/Sweats	Yes	No
Unexplained weight changes	Yes	No
Numbness/Tingling	Yes	No
Muscular weakness	Yes	No
Fatigue	Yes	No
Fainting spells	Yes	No
Dizziness	Yes	No
Night pain	Yes	No
Bowel/Bladder changes	Yes	No
Headaches	Yes	No

Please estimate your stress level: (low) 0 1 2 3 4 5 6 7 8 9 10 (high)

List all previous injuries and surgeries with approximate dates:____

____

____

List all current medications (prescription and nonprescription) you are currently taking:______________________

____

Please indicate the amount you consume of the following:

Coffee/other caffeine beverages:___________________________

Alcohol and type:_______________________________________

Cigarettes/other tobacco products:__________________________

Illegal substances and type:_______________________________

Name:____________________________________Date of birth_____/_____/______Date:___________________