

Please mark any of the following that you now have or have had.

**Musculoskeletal**

- Bone or Joint Disease
- Tendonitis/Bursitis
- Arthritis/Gout
- Sprains/Strains
- Low Back/Hip/Leg Pain
- Neck/shoulder/Arm Pain
- Jaw Pain/TMJ
- Lupus
- Osteoporosis
- Other \_\_\_\_\_

**Skin**

- Allergies
- Rashes
- Athletes Foot
- Herpes/cold Sore
- Other \_\_\_\_\_

**Nervous System**

- Shingles
- Numbness/tingling
- Trigeminal Neuralgia
- Bell's Palsy
- Pinched Nerve
- Epilepsy
- Other \_\_\_\_\_

**Miscellaneous (currently)**

- Contact Lenses
- Infection
- Inflammation/Swelling
- Fever
- Other \_\_\_\_\_

**Circulatory**

- Stroke
- Heart Condition
- Phlebitis/Varicose Veins
- Blood Clots
- High/Low Blood Pressure (please circle)
- Lymphedema
- Thrombosis/Embolism
- Pacemaker
- Other \_\_\_\_\_

**Digestive**

- Constipation
- Gas/Bloating
- Diverticulitis
- Irritable Bowel Syndrome
- Ulcers
- Other \_\_\_\_\_

**Respiratory**

- Breathing Difficulty/Asthma
- Emphysema
- Allergies Bees, Latex, \_\_\_\_\_
- Sinus Problems
- Other \_\_\_\_\_

**Reproductive**

- Pregnant: Stage
- Ovarian/Menstrual
- PMS
- Prostate
- Other \_\_\_\_\_

**Infectious Disease**

- Hepatitis
- Other \_\_\_\_\_
- HIV Positive

**Other**

- Cancer/Tumors
  - Kidney/Bladder Ailment
  - Diabetes
  - Drug/Alcohol/Caffeine and/or Tobacco Use (circle) Frequency \_\_\_\_\_
  - Chronic Pain
  - Chronic Fatigue
  - Fibromyalgia
  - Sleep Disorders
  - Migraines/Headaches
  - Anxiety/Stress Syndrome
  - Any condition that affects your immune system
- Please explain: \_\_\_\_\_
- \_\_\_\_\_

**Medications**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Any additional client/patient remarks and/or comments:**

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**How did you hear about us?**

\_\_\_ M.D. \_\_\_ Referral \_\_\_ Friend \_\_\_ Phone Book \_\_\_ Website \_\_\_ Other \_\_\_\_\_

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_