F. Present Health: Are you presently affected by . . . . .

Circle: O-occasional F-frequent C-constant

Muscle & Joint
O F C arthritis
O F C bursitis
O F C backache
O F C neck pain
O F C headaches
O F C pain between shoulders
O F C hernia
O F C spinal curvature
O F C faulty posture

Pain or Numbness in:
O F C shoulders
O F C arms
O F C hands
O F C tailbone
O F C hips
O F C legs
O F C knees
O F C ankles
O F C feet

Respiratory
O F C chronic cough
O F C spitting up phlegm
O F C chest pain
O F C difficult breathing
O F C wheezing

Urinary
O F C painful urination
O F C getting up at night to urinate
O F C blood in urine
O F C frequent urination
O F C bed wetting
O F C prostate trouble

Eyes, Ears, Nose, Throat
O F C deafness
O F C earache
O F C ear discharge
O F C ear noises
O F C nosebleeds
O F C sore throat
O F C hoarseness
O F C hay fever
O F C asthma
O F C tonsillitis
O F C sinus trouble
O F C enlarged glands
O F C enlarged thyroid
O F C eye pain
O F C blurring of vision

Cardiovascular
O F C rapid heart beat
O F C slow heart beat
O F C high blood pressure
O F C pain over heart
O F C swelling of ankles
O F C previous heart attack
O F C hardening of arteries

Female Only
Y N painful menstruation
Y N excessive flow
Y N irregular cycle
Y N cramps
Y N backache
Y N abnormal discharge
Y N passed menopause
Y N Are you pregnant? due date___________
Y N birth control pill
Date of last menstrual period
____

Gastrointestinal
O F C excessive hunger
O F C excessive thirst
O F C poor appetite
O F C stomach pain
O F C liver trouble
O F C gall bladder trouble
O F C colitis
O F C hemorrhoids
O F C difficult digestion
O F C burping or gas
O F C nausea or vomiting
O F C heartburn/indigestion
O F C constipation
O F C diarrhea

General Symptoms
O F C chills
O F C dizziness
O F C fever
O F C sweats
O F C fainting
O F C convulsions
O F C allergy
O F C skin problems
O F C bleeding tendency
O F C easy bruising
O F C colds/flu
O F C tremors
O F C weight loss
O F C loss of sleep
O F C loss of concentration
O F C depression
O F C decreased energy/fatigue

G. Family Health Conditions: (Please √)

___ aneurysm/stroke
___ arthritis
___ cancer
___ migraines
___ heart disease
___ other major conditions: ______________________
___ high blood pressure
___ back/disc problems

H. Past Health: Have you suffered from any of the following conditions?

(Please ✓)

__ AIDS (HIV+)
__ Allergies
__ Appendicitis
__ Alcoholism
__ Arthritis
__ Anemia
__ Asthma
__ Blood Pressure Problems
__ Prostate Problems
__ Stroke/Aneurysm
__ Cancer
__ Colitis
__ Diabetes
__ Drug Dependency
__ Eczema
__ Epileptic Seizures
__ Pneumonia
__ Kidney Disease
__ Gout
__ Heart Disease
__ Lung Disease
__ Migraines
__ Multiple Sclerosis
__ Emotional Disorder
__ Thyroid Problems
__ Tuberculosis
__ Ulcers
__ Psoriasis

Major Accidents/Falls/Hospitalizations ____
____
____

Person Responsible for Payment: ______________________________ **Signature:** ____________________