

NAME _____

LIFESTYLES & HABITS

How many hours of television do you watch per day? <1 1-3 3-5 >5

Do you usually snack while watching television? Yes No

How many hours per day do you use a computer at home or work? <1 1-3 3-5 >5

How many hours per day do you ride in a car or other vehicle? <1 1-3 3-5 >5

How often do you exercise? daily 3 X's per wk 1 X per week I don't exercise

How long do your exercise workouts last? 30 min 1 hour > 1 hour NA

What are your exercise activities (mark all that apply) I don't exercise

walking swimming weight lifting stretching/flexibility yoga/pilates

resistance bands running/treadmill/rowing/climbing group exercise other _____

Do you take multi-vitamins? Yes No

List any other nutritional supplements you are currently taking.

Supplement	Reason	Supplement	Reason
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Do you use tobacco products? Yes No If yes, <1/2 pack daily 1 pack daily _____

How many servings of alcohol do you drink each week? 0 <1 1-3 3-5 >5

How many servings of coffee do you drink each week? 0 <1 1-3 3-5 >5

How many servings of soda do you drink each week? 0 <1 1-3 3-5 >5

FAMILY HISTORY

Please make the following conditions as they pertain to your immediate family.

Arthritis	<input type="checkbox"/> mother	<input type="checkbox"/> father	<input type="checkbox"/> brother	<input type="checkbox"/> sister
Back Pain	<input type="checkbox"/> mother	<input type="checkbox"/> father	<input type="checkbox"/> brother	<input type="checkbox"/> sister
Cancer	<input type="checkbox"/> mother	<input type="checkbox"/> father	<input type="checkbox"/> brother	<input type="checkbox"/> sister
Diabetes	<input type="checkbox"/> mother	<input type="checkbox"/> father	<input type="checkbox"/> brother	<input type="checkbox"/> sister
Headaches	<input type="checkbox"/> mother	<input type="checkbox"/> father	<input type="checkbox"/> brother	<input type="checkbox"/> sister
Heart problems	<input type="checkbox"/> mother	<input type="checkbox"/> father	<input type="checkbox"/> brother	<input type="checkbox"/> sister
Kidney problems	<input type="checkbox"/> mother	<input type="checkbox"/> father	<input type="checkbox"/> brother	<input type="checkbox"/> sister
Obesity	<input type="checkbox"/> mother	<input type="checkbox"/> father	<input type="checkbox"/> brother	<input type="checkbox"/> sister
Other (describe)	<input type="checkbox"/> mother	<input type="checkbox"/> father	<input type="checkbox"/> brother	<input type="checkbox"/> sister _____

HOSPITAL / MEDICINE

Have you had implant surgery? Yes No if yes, describe _____

Do you have a pacemaker? Yes No Have you ever had a lapse in memory? Yes No

Have you had knee or hip replacement surgery? Yes No If yes, R knee L knee R hip L hip

Do you have any other medical devices in your body? Yes No If yes, describe _____

Mark all of the following procedures as they pertain to you.

Vaccinations <input type="checkbox"/>	Tonsillectomy <input type="checkbox"/>	Gall bladder removed <input type="checkbox"/>	Other <input type="checkbox"/>
Back surgery <input type="checkbox"/>	Tubes in Ears <input type="checkbox"/>	Appendectomy <input type="checkbox"/>	_____
Female / Male surgery <input type="checkbox"/>	Rectal surgery <input type="checkbox"/>	Sinus surgery <input type="checkbox"/>	_____
Hernia surgery <input type="checkbox"/>	Thyroid surgery <input type="checkbox"/>	Stomach surgery <input type="checkbox"/>	_____

Please list any prescription or over-the-counter medications you are currently taking

Medication	reason	Medication	reason
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Have you ever had a spinal tap or spinal injections? Yes No

CONDITIONS: HAVE YOU EVER SUFFERED (CURRENTLY OR IN THE PAST) FROM ANY OF THESE CONDITIONS? (mark all that apply)

- | | | | | | | | |
|------------------|--------------------------|--------------------------|--------------------------|-----------------------|--------------------------|------------------------|--------------------------|
| Alcoholism | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | Influenza | <input type="checkbox"/> | Poor Posture | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> | Digestion Problems | <input type="checkbox"/> | Irregular Heart Beat | <input type="checkbox"/> | Prostate Problems | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | Irregular Cycle | <input type="checkbox"/> | Rheumatic fever | <input type="checkbox"/> |
| Appendicitis | <input type="checkbox"/> | Ears Ringing | <input type="checkbox"/> | Kidney Problems | <input type="checkbox"/> | Sciatica | <input type="checkbox"/> |
| Arteriosclerosis | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | Loss of Memory | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | Excessive Menstruation | <input type="checkbox"/> | Loss of Balance | <input type="checkbox"/> | Sinus problems | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Eye Pain or Difficulties | <input type="checkbox"/> | Loss of Smell / Taste | <input type="checkbox"/> | Sleep/Insomnia | <input type="checkbox"/> |
| Back Pain | <input type="checkbox"/> | Fatigue | <input type="checkbox"/> | Low Back Pain | <input type="checkbox"/> | Spinal Curvatures | <input type="checkbox"/> |
| Breast Lumps | <input type="checkbox"/> | Frequent Urination | <input type="checkbox"/> | Measles | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> | Goiter | <input type="checkbox"/> | Mental disorders | <input type="checkbox"/> | Swelling ankles/joints | <input type="checkbox"/> |
| Bruise Easily | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | Mumps | <input type="checkbox"/> | Thyroid Condition | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | Neck Pain / Stiffness | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Chest Pain | <input type="checkbox"/> | Hemorrhoids | <input type="checkbox"/> | Pacemaker | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> |
| Constipation | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | Pleurisy | <input type="checkbox"/> | Varicose Veins | <input type="checkbox"/> |
| Cramps | <input type="checkbox"/> | HIV Positive | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> |
| | | Hot Flashes | <input type="checkbox"/> | Polio | <input type="checkbox"/> | Whooping Cough | <input type="checkbox"/> |

SYSTEM REVIEW – GENERAL Please mark the following conditions that are CURRENTLY a cause of significant concern for you.

- | | | | | |
|--|------------------------------------|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> consistent fainting | <input type="checkbox"/> chills | <input type="checkbox"/> convulsions | <input type="checkbox"/> depression | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> loss of weight | <input type="checkbox"/> fatigue | <input type="checkbox"/> fever | <input type="checkbox"/> headaches | <input type="checkbox"/> loss of sleep |
| <input type="checkbox"/> weight gain | <input type="checkbox"/> neuralgia | <input type="checkbox"/> night sweats | <input type="checkbox"/> wheezing | <input type="checkbox"/> nervousness |

GASTRO-INTESTINAL

- | | | | | |
|--|-----------------------------------|---|--|---|
| <input type="checkbox"/> constipation | <input type="checkbox"/> diarrhea | <input type="checkbox"/> gall bladder prob. | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> jaundice |
| <input type="checkbox"/> liver problems | <input type="checkbox"/> nausea | <input type="checkbox"/> stomach pain | <input type="checkbox"/> poor appetite | <input type="checkbox"/> poor digestion |
| <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting | <input type="checkbox"/> vomiting blood | | |

EYE/EAR/NOSE/THROAT

- | | | | | |
|--|---|---|--------------------------------------|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> crossed eyes | <input type="checkbox"/> deafness | <input type="checkbox"/> earache | <input type="checkbox"/> ear discharge |
| <input type="checkbox"/> ear noises | <input type="checkbox"/> enlarged thyroid | <input type="checkbox"/> frequent colds | <input type="checkbox"/> hay fever | <input type="checkbox"/> hoarseness |
| <input type="checkbox"/> nasal obstruction | <input type="checkbox"/> nose bleeds | <input type="checkbox"/> pain in eyes | <input type="checkbox"/> poor vision | <input type="checkbox"/> sinusitis |
| <input type="checkbox"/> sore throat | <input type="checkbox"/> tonsillitis | | | |

RESPIRATORY

- | | | | | |
|-------------------------------------|--|---|---|--|
| <input type="checkbox"/> chest pain | <input type="checkbox"/> chronic cough | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> spitting blood | <input type="checkbox"/> spitting phlegm |
|-------------------------------------|--|---|---|--|

MUSCLES/JOINTS/BONES

- | | | | | |
|---|---|--|--|-------------------------------------|
| <input type="checkbox"/> backache | <input type="checkbox"/> foot problems | <input type="checkbox"/> pain/shoulder | <input type="checkbox"/> pain / tailbone | <input type="checkbox"/> stiff neck |
| <input type="checkbox"/> spinal curvature | <input type="checkbox"/> swollen joints | <input type="checkbox"/> tremors | <input type="checkbox"/> twitching | <input type="checkbox"/> weakness |

CARDIO-VASCULAR

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> ankle swelling | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> heart trouble | <input type="checkbox"/> pain over heart |
| <input type="checkbox"/> poor circulation | <input type="checkbox"/> rapid heart | <input type="checkbox"/> slow heart | <input type="checkbox"/> strokes | |

SKIN OR ALLERGIES

- | | | | | |
|--|----------------------------------|---------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> dryness | <input type="checkbox"/> eczema | <input type="checkbox"/> hives | <input type="checkbox"/> itching |
|--|----------------------------------|---------------------------------|--------------------------------|----------------------------------|