

Medical History for _____
Patient Name (please print)

	YES	NO
Are you in generally good health?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had recent surgery or hospitalization? If so, please specify; _____ .	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking any medications? Please include Over-the-Counter medications and Vitamins.	<input type="checkbox"/>	<input type="checkbox"/>

Have you had recent tests such as x-ray, MRI, Scans? _____ .	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken steroids (i.e. cortisone, prednisone)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently seeing any of the following?		
Medical Doctor	<input type="checkbox"/>	<input type="checkbox"/>
Osteopath	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatrist/Psychologist	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractor	<input type="checkbox"/>	<input type="checkbox"/>
.		
Do you have or have you ever been diagnosed as having any of the following:		
Cancer: kind: _____ .	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency (e.g. alcoholism)	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other Arthritic Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Other _____ .	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently lost or gained more than 10 pounds?	<input type="checkbox"/>	<input type="checkbox"/>
Are you experiencing any bowel/bladder irregularity?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience any numbness/tingling in your buttock or genital region?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any numbness/tingling in BOTH hands or feet at the same time?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience any weakness in your legs or balance problems during walking?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any dizziness related to moving your head or neck?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience blurred vision, nausea, or difficultly breathing?	<input type="checkbox"/>	<input type="checkbox"/>
How would you rate your stress level? _____		
How much caffeine containing beverages do you drink per day? _____		
How many packs of cigarettes do you smoke per day? _____		
How many days per week do you drink alcohol? _____		