Health History

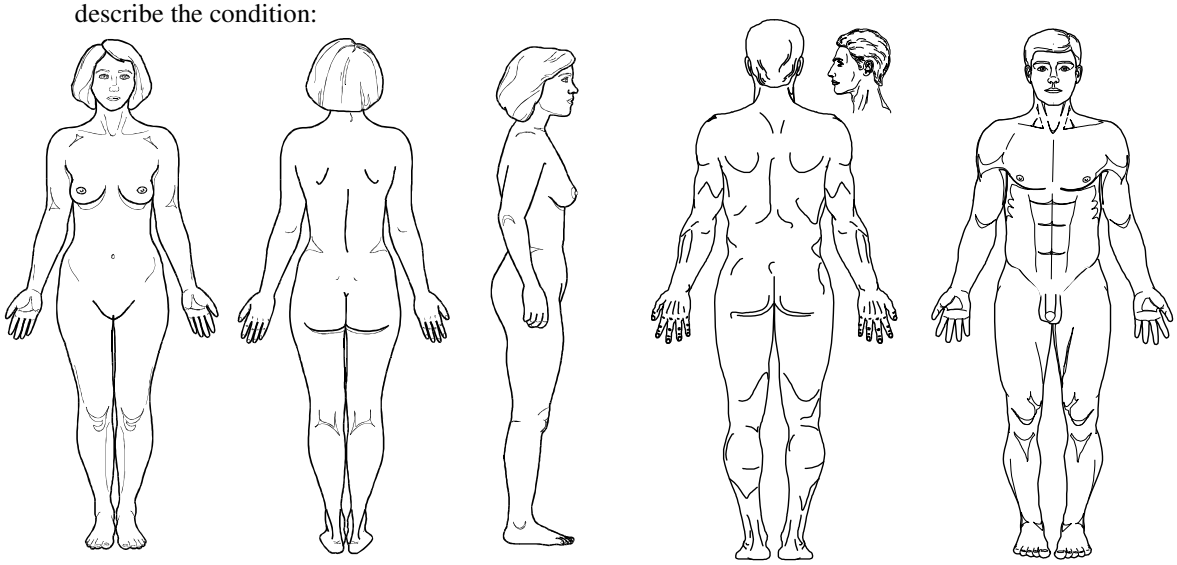
Name: _____ DoB:_____

Last, First, MI

Check all that apply:

Prescribed blood thinners?	☐ Yes ☐ No	Venereal Disease?	☐ Yes ☐ No
Prescribed painkillers?	☐ Yes ☐ No	Cancer?	☐ Yes ☐ No
Do you have a pacemaker?	☐ Yes ☐ No	Diabetes?	☐ Yes ☐ No
Women: Are you pregnant?	☐ Yes ☐ No	HIV/AIDS?	☐ Yes ☐ No
Liver Disease?	☐ Yes ☐ No	Hepatitis?	☐ Yes ☐ No
Kidney Disease?	☐ Yes ☐ No	Other: _____	

1. What is your primary complaint? _____
2. Other health concerns: _____
3. How long have you had this condition? _____
4. What was happening in your life at the time of onset? _____
5. What aggravates your condition? _____
6. Is this condition getting worse? ☐Yes ☐No ☐Constant ☐Comes and goes
7. List previous diagnoses and treatments you have received for present condition: _____
   _____
8. List any surgical operations and dates: _____
9. List all pharmaceutical drugs you are currently taking: _____
   _____
10. List other supplements you are taking: _____
    _____
11. List any known medications that produce allergic reactions:
    _____
12. Mark areas on the figures below where your problems are located. Please add any notes to further describe the condition:



Practitioner Notes (Office use only):

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