HEALTH REPORT

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We need your complete health report before we can be responsible for your case.
This is a medical history. We do not claim to treat or cure all your reported conditions.

NAME: _____ **DATE:** _____

Any major accident, injury or fall?
_____

Any joint pain (other than main complaint)?
_____

Numbness/tingling?
Where? _____

Arthritis (Osteoarthritis, Rheumatoid, Lupus, etc.)?
_____

TMJ/jaw pain? _____

Heart condition? _____

Blood pressure problems? _____

Circulation problems? _____

Had any strokes/TIA's? _____

Eyes, Ears, Nose, Throat problems? _____

Respiratory/Lung problems? _____

Stomach/Intestines/Bowel Problems? _____

Kidney/Bladder Problems? _____

Diabetes? _____ **Depression?** _____

Headaches? _____

Dizziness? _____ **Thyroid Condition?** _____

Are you pregnant? _____ **No. of Children** _____

HABITS:	None	Light	Mod.	Heavy
Alcohol	___	___	___	___
Caffeine	___	___	___	___
Tobacco	___	___	___	___
Exercise	___	___	___	___
Sleep	___	___	___	___
Appetite	___	___	___	___
Soft Drinks	___	___	___	___
Water	___	___	___	___
Sugar & Products	___	___	___	___
Dairy Foods	___	___	___	___

Y N Have you ever had cancer?
Y N Are you losing weight without trying?
Y N Does pain wake you up at night?
Y N Have you had a change in bowel or bladder habits?
Y N Have you had a sore that doesn't heal?
Y N Have you recently had any unusual bleeding or discharge?
Y N Do you have a thickening/lump in the breast or elsewhere?
Y N Do you have indigestion or difficulty swallowing?
Y N Have you had an obvious change in a wart or mole?
Y N Do you have a nagging cough or hoarseness?

Anything else the doctor should know about you?

_____
_____
_____
_____
_____
_____
_____