Please Check yes or no

I. Have you ever had or do you now have:			I. Have you ever had or do you now have:				
YES	**NO**	***(Please Check each item no blanks!)***	**CARDIOVASCULAR**	**YES**	**NO**	**OFTEN**	**SELDOM**
		1 Chronic or Frequent Colds	1 Shortness of Breath with Normal Activity				
		2 Sinusitis	2 Ankle Swelling				
		3 Heart Condition	3 High Blood Pressure				
		4 Stomach, Liver, or Intestinal Trouble	4 Rapid Heart Beat				
		5 Gall Bladder Trouble or Gall Stones	5 Irregular Heart Beat				
		6 Jaundice	6 Dizziness				
		7 Tumor, Growth Cyst, Cancer	7 Fainting Spells				
		8 Venereal Disease	8 Chest Pain or Pressure				
		9 Ear, Eye, Nose, Throat Trouble	9 Leg Cramps				
		10 Drug/Alcohol Abuse	**RESPIRATORY**				
II. Female Issues: A. Have you ever:			1 Cough				
		1 Been pregnant	2 Cough up Blood				
		2 Had Chronic yeast problems	3 Frequent Sore Throat				
		3 Been treated for female disorders	4 Hoarseness				
		4 Had painful menstruation	5 Frequent Sneezing				
		5 Had irregular menstruation	6 Hay Fever				
B. Complete the following:			7 Nose Bleeds				
		1 Age at onset of menstruation	8 Asthmatic Wheezing				
		2 Interval between periods	9 Pneumonia				
		3 Duration of periods	**GASTRO-INTESTINAL**				
		4 Date of last period	1 Indigestion				
Quantity: Normal ___ Excessive ___ Scanty ____			2 Abdominal Pain or Cramps				
MEDICATIONS CURRENTLY TAKING			3 Constipation				
Prescription's Name		**Reason for Medication**	4 Diarrhea				
			5 Increased Thirst				
			6 Decreased Appetite				
			7 Nausea and Vomiting				
			8 Undigested Food in Stool				
			9 Bloating After Eating				
			10 Excessive gas				
			11 Acid Reflux				
			12 Blood in Bowel Movement				

Please check all items. No blank spaces please!

SKIN	YES	NO	SELDOM	OFTEN
1 Ulcerations				
2 Itching				
3 Rash				
4 Psoriasis				
5 Long Term Dry Skin				
6 Frequent Boils				
GENITO-URINARY				
1 Frequent Urination				
2 Painful, Burning Urination				
3 Pain in the Testicle				
4 Bloody or other discharge				
5 Loss of Sexual Potency or Desire				
6 Cold Feeling in the Genital Area				
MUSCLE/SKELETAL				
1 Arthritis				
2 Rheumatoid Arthritis				
3 Muscle Pain or Cramps				
4 Painful Joints				
5 Lameness				
6 Backaches				
7 Back Pain				
MISCELLANEOUS				
1 Fever				
2 Chills				
3 Night Sweats				
4 Headaches				
5 Insomnia				
6 Nervousness				
7 Easy Fatigability				
8 Frequent Irritability				
9 Morning Tiredness				
10 Tremors or uncontrollable shaking				
11 Nightmares				

Please check yes or no

Do you have or have you had recently:	YES	NO	Is there a family history of:	YES	NO
1 Weight Loss: How Much? _____			1 Tuberculosis		
2 Weight Gain: How Much? _____			2 Diabetes		
3 Memory Loss			3 Cancer		
4 Difficulty Walking in the dark			4 Multiple Sclerosis		
5 Balance Problems			5 Chron's Syndrome		
6 Numbness & Tingling in the extremities			6 Irritable Bowl Syndrome		
7 Hearing Loss			7 Heart Trouble		
8 Ringing in the ears			8 High Blood Pressure		
9 Vision Change			9 Asthma, Hay Fever, Hives		
10 Double Vision			10 Glaucoma		
11 Earaches (Chronic during Childhood)			11 Stroke		
12 Running ears			12 Gout		
13 Tendency to bleed or bruise easily			13 Alzheimer's Disease		
14 Heat Intolerance			14 Down's Syndrome		
15 Cold Intolerance			15 Myasthenia Gravis		
16 Lymph node enlargement			16 Celia Sprue		

ARE YOU ALLERGIC TO ANY TYPE OF FOOD? IF SO, WHICH?	**Please list all operations & your age when each was performed**
HOW OFTEN DO YOU EXERCISE?	**NAME THE MOST RECENTLY SELF-HELP BOOK THAT YOU'VE READ**

PLEASE LIST ALL THE VITAMINS AND OTHER SUPPLEMENTS THAT YOU CURRENTLY TAKE	**WHICH OF THE FOLLOWING MODALITIES HAVE YOU BEEN TREATED WITH IN THE PAST?**			
	ACUPUNCTURE		MASSAGE	
	CHIROPRACTIC		HYPNOSIS	
	HERBAL MEDICINE		HOMEOPATHY	
	CHINESE HERBS		OTHER	