Your Health History

Medical Conditions

__Diabetes __Severe headaches __Digestive Disorder
__ Back Pain __ High Blood Pressure __Stroke __ Cancer __Kidney Disease
__ Neck Pain __ Heart Disease __ Arthritis __ Skin Disorder __Psychiatric Illness

If yes to Diabetes, is it: ❑Type I or ❑Type II? Was your blood lab-work test for hemoglobin A1c 9.0% or above? ❑Yes ❑No ❑Not sure
If yes to High Blood Pressure, do you take medication? ❑Yes ❑No *Medication:* _____

Past Surgical History

__ Back surgery __ Appendectomy __ Pacemaker __ Carpal tunnel surgery
__ Neck surgery __ Heart Surgery __ Brain surgery __ Shoulder surgery
__ Prostate surgery __ Hysterectomy __ Gall bladder __ Joint replacement_____
__ Other: _____ *(Knee, hip or other?)*

Family Medical History *Has your mother, father, sister, brother or child ever had:*

Cancer __ yes __no Relationship _____ Diabetes __yes __no Relationship_____
Heart Disease __ yes __no Relationship _____ Migraines __yes __no Relationship _____
Stroke __ yes __no Relationship _____ Mental Illness __ yes __no Relationship _____
High Blood Pressure __ yes __no Relationship _____ ____ ***I do not know of any family medical history***

Social History

Tobacco History: ❑ Never smoked ❑Former Smoker ❑Current smoker How often do you smoke? __Every day __Sometimes
If you smoke, what is your level of interest in quitting smoking? ❑0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No Interest ***Very Interested***

Do you drink caffeinated coffee, tea or soda? How much/ often_____
Do you drink alcohol (beer, wine, liquor)? ___ Never ___Rarely ___Occasionally ___Frequently What type? _____
Do you use illegal / recreational drugs? ___ Never ___Rarely ___Occasionally ___Frequently What type? _____
Do you get adequate sleep? __ Never __Rarely __Sometimes __Most of the time __ Always
Do you exercise? ___Not at all ___Occasionally ___Regularly What type(s) of exercise? _____
Recreational activities: __Walking __Golf __Running __Tennis __Swimming __Boating Other: _____
How often do you use pain relieving drugs, either over-the-counter or prescription? ___ Never ___Rarely ___Occasionally ___Frequently
What is your "healthy eating" level? __Very healthy __Somewhat healthy __Not very healthy __Unhealthy
Are you experiencing unusual stress? __Yes ___No Major stressor: _____

Allergies __Eggs __Soy __Seafood __Sulfites __Milk __Peanut __Wheat/ Gluten Other: _____

Medication allergies? __Yes __No Please list: _____

Your Medications *(If you have a list, please let us copy it for your records.)*

Please list your current medications, including prescriptions, over-the-counter, vitamins and supplements:

_____

_____

_____

Have you ever taken corticosteroids (e.g., Prednisone, steroid injections)? __Yes __No How recently? _____

For what condition(s)? _____