Health History

Birth Type (check box)

- ☐ Short ☐ Long ☐ Difficult
- ☐ Natural ☐ Forceps ☐ Don't Know
- ☐ Home ☐ Hospital Birth Weight

List medications

In the past 24 months have you experienced:

- ☐ Recurring Fever ☐ Weight Loss
- ☐ Anxiety/Tension ☐ Depression
- ☐ Family Dislocation ☐ Job Loss
- ☐ Night Pain ☐ Hypertension
- ☐ Blackouts

List significant falls or other accidents (please describe)

List operations/hospitalisations/serious illnesses

Is there a family or self history of:

- ☐ Stroke ☐ Obesity ☐ Osteoporosis
- ☐ Cancer ☐ Alzheimer's ☐ Eating Disorder
- ☐ Heart Disease ☐ Diabetes ☐ Immune Deficiency

Are you experiencing any of the following?

*Mark the appropriate box(es) with **O** (Occasionally), **F** (Frequently), **C** (Constantly)*

☐ Nervousness	☐ Chronic cough	☐ Indigestion	☐ Sexual disorder
☐ Chronic irritability	☐ Asthma	☐ Ulcer	☐ Lower back pain
☐ Insomnia	☐ Food allergies	☐ Heartburn	☐ Buttock pain
☐ Scalp ache	☐ General swelling	☐ Mid-back pain	☐ Hip joint stiffness
☐ Head/Face pain	☐ Neck pain	☐ Rib pain	☐ Leg pain
☐ Headache	☐ Shoulder pain	☐ Constipation	☐ Leg weakness
☐ Dizziness	☐ Arm/Elbow pain	☐ Diorrhea	☐ Knee problems
☐ Nausea/Vomiting	☐ Arm weakness	☐ Abdominal pain	☐ Calf cramping
☐ Loss of concentration	☐ Pins & Needles	☐ Kidney disorder	☐ Ankle/Foot swelling
☐ Eye disorder	☐ Finger numbness	☐ Urinary problems	☐ Foot/Toe numbness
☐ Sinisitus	☐ Blood pressure	☐ Menstrual disorder	☐ Skin problems
☐ Hay Fever	☐ Chest pain	☐ Testicle pain	☐ Hand/Wrist pain
☐ Loss of taste/smell	☐ Shortness of breath	☐ Impotency	☐ Other

Financial Responsibility

I acknowledge that payment is due on the day of consultation unless prior arrangement has been approved.

SIGNATURE _____ DATE _____