

NAME: _____ HEIGHT: _____ WEIGHT: _____

Date of Onset: _____ Symptoms / Condition: _____

PLEASE CIRCLE IF APPLICABLE

Do you have: PAIN NUMBNESS TINGLING SWELLING

Are symptoms: CONTINUOUS INTERMITTENT

Have you experience any: WEAKNESS WEIGHT GAIN/LOSS FEVER/SWEATS FATIGUE

Do symptoms wake you at night: YES NO What time of day is worse: AM PM

What makes symptoms worse: _____

What makes symptoms better: _____

What tests have been done: MRI X-RAY OTHER: _____

Have you seen any specialists in the past three months: MEDICAL DOCTOR DENTIST OSTEOPATH
CHIROPRACTOR PHYSICAL THERAPIST

Why was the practitioner seen: _____

Any diagnosed medical condition ie: HEART DISEASE CANCER DIABETES HEPATITIS

Other: _____ Date: _____

Please list all previous injuries & surgeries w/ approximate dates: _____

Please list all prescription & non-prescription medications you have taken recently: _____

When is your next doctor's appointment: _____

How is your general health: EXCELLENT GOOD FAIR POOR

Are you currently exercising: YES NO How Often: _____

Please indicate your consumption of the following and amount per day: ALCOHOL / TYPE _____

COFFEE / CAFFEINATED BEVERAGES _____ CIGARETTES / TOBACCO PRODUCTS _____

Please draw in the location of your symptoms: