Please Indicate the conditions that you have experienced or experiencing

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis/Varicose veins
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease
- ☐ Dizziness/Vertigo
- ☐ Seizures

Is there any family history of any of the above? ☐ Yes ☐ No

Head and Neck

- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Hearing problems
- ☐ Hearing loss

Infectious Conditions

- ☐ Skin condition
  Describe:____________________
  ____
- ☐ Respiratory conditions
  Describe: ____________________
  ____
- ☐ Hepatitis ☐ A ☐ B ☐ C ☐ D ☐ E

Skin Conditions

- ☐ Eczema
- ☐ Psoriasis
- ☐ Rash
- ☐ Warts
- ☐ Open sores

Respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Shortness of breath

Is there any family history of any of the above? ☐ Yes ☐ No

Muscle/Joint

- ☐ Neck
- ☐ Spine
- ☐ Upper back
- ☐ Mid back
- ☐ Lower back
- ☐ Shoulders
- ☐ Elbow
- ☐ Wrist/Hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle/Foot
- ☐ Internal pins/Wires
- ☐ Artificial joints/Special equipments
  Describe:____________________
  ____

Women

- ☐ Pregnancy
  Due date:____________________
- ☐ Previous pregnancy complications:____________________
  ____
- ☐ Menopausal problems:__________
  ____
- ☐ Menstrual problems:__________
  ____
- ☐ Any gynecological conditions:____________________
  ____

Digestive

- ☐ Constipation
- ☐ Chrones disease
- ☐ Colitis
- ☐ Irritable bowel syndrome
- ☐ Ulcers

Other

- ☐ Loss of sensation
  Where? ____________________
  ____
- ☐ Diabetes
  Since when?______________
  Type ____________________
- ☐ Allergies
  What? ____________________
- ☐ Hypersensitivity
  What? ____________________
- ☐ Cancer
  Type/Location:__________
  ____
- ☐ Arthritis
  Type?____________________
  Family history? ☐ Yes ☐ No
- ☐ Nerve lesion
- ☐ Any Nerve related diseases
- ☐ Epilepsy
- ☐ Hemophilia
- ☐ Fibromyalgia
- ☐ Chronic fatigue
- ☐ Scoliosis
- ☐ Polio/Post polio
- ☐ Osteoporosis
- ☐ Gout
- ☐ Any other diseases
  Describe: ____________________
  ____
  ____

Overall, how is your general health? ____

Is there any additional information that you would like to provide?____
____
____
____
____

____ ____

Signature **Date**