Health Information

Full Name______________________________ Today's Date_________________________

Address____

Evening Phone ________________________ Daytime Phone________________________

E -mail________________________________

Date of Birth_____________ Age____ Occupation__________________________________

Married____ Single____ Divorced____ Co-habiting____ Widow(er)____

Primary Care Physician____

Major complaint(s):

____

____

____

Significant Medical History:

____

____

____

Family Medical History:

____

____

____

Do you take any: Medication (prescription or over-the-counter). Please list.

____

____

____

Have you been diagnosed with any of the following? Please check all those applicable.

__Heart Disease __High Blood Pressure __Chronic Pain __Cancer
__Diabetes __Arthritis __Depression __Hepatitis
__Epilepsy __Stroke __Anemia __Migraines __Asthma __Other (Please List)

____

____

Are you currently taking any vitamins or supplements? Please list.

____

____

How much caffeine do you drink?______________

How much water do you drink on an average day?________________

On average, how many alcoholic drinks to you drink per week? ___________-

Do you smoke?______

What is your most recent blood pressure reading, if you remember it:____/_____

Do you have high cholesterol? __________

Do you have any reason to believe you might be pregnant?_____________

Rate your energy level over all: Low 1 2 3 4 5 6 7 8 9 10 High