



Lifestyle and History

Name _____ Today's Date _____ Age _____

Why are you here? _____

Major Health Issues of Mother: _____

Major Health Issues of Father: _____

Some questions may be duplicated, please answer ALL questions to the best of your ability.

CHECK if occasional, CIRCLE if frequent or severe

Head and Neck

- Frequent headaches
- Neck pain/ tightness
- Blurred vision
- Migraines
- Dental problems
- Dizziness

Nervous System

- Difficulty relaxing
- Difficulty sleeping
- Nervousness
- Cold hands or feet

Digestive

- Hemorrhoids
- Bloating stomach

- Constipation
- Diarrhea
- Acid reflux

Skin

- Bruise easily
- Open cuts/sores
- Skin allergies
- Tender areas
- Varicose veins
- Night sweats

Cardiovascular

- Chest pain
- High blood pressure
- Low blood pressure
- Swelling in feet/ankles

- Phlebitis/thrombosis

Respiratory

- Sinus problems
- Asthma / bronchitis
- Allergies
- Easily out of breath

Females Genito/Urinary

- Lump/pain in breast
- Menstrual problems

Male Genito/Urinary

- Painful/slow urination
- Nighttime urinary frequency

Any other problems or concerns: _____

If Diagnosed by Doctor: CHECK if treated in the past and CIRCLE if current diagnosis

- | | |
|---|---|
| <input type="checkbox"/> Vascular, Circulatory Disease, Arteries, Veins | <input type="checkbox"/> Sensory Disorder (eyes, ears, taste, feel, or smell) |
| <input type="checkbox"/> Infections or History of Infections | <input type="checkbox"/> Sensitivity to Humidity, Hot or Cold |
| <input type="checkbox"/> Cancer, Tumors, or other Degenerative Disease | <input type="checkbox"/> Cognitive or Memory Disorders |
| <input type="checkbox"/> Dietary Disorders, or Absorption Disorders | <input type="checkbox"/> Arthritis / Rheumatism |
| <input type="checkbox"/> Drug or Alcohol Addiction or Toxic Exposure | <input type="checkbox"/> Kidneys/bladder/prostate |
| <input type="checkbox"/> Congenital or Inherited Birth Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies or Tendency to Allergic Responses | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Any serious Trauma or Injury in History | <input type="checkbox"/> Diabetes/Hyperglycemia |
| <input type="checkbox"/> Endocrine, Glandular, or Hormonal Disorders | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Mental or Emotional Disorders | <input type="checkbox"/> Epilepsy/Seizures |
| | <input type="checkbox"/> Hernia/rupture |
| | <input type="checkbox"/> Ulcer/colitis/ Diverticulitis |
| | <input type="checkbox"/> AIDS/HIV Positive |
| | <input type="checkbox"/> Learning Disability / ADD/ ADHD |
| | <input type="checkbox"/> Schizophrenia/Bipolar/Psychosis |

Surgeries? _____

Where on body? _____

When? _____

Broken bones/severe sprains: _____

Where on body? _____

Organs removed? _____

Teeth Extractions / root canals? _____

Ever been hospitalized? For: _____

Ever been in an Accident? Describe _____

Life Style Profile – Check ALL that Apply

- | | |
|--|---|
| <input type="checkbox"/> Organs removed? How many? _____ | <input type="checkbox"/> Use Alcohol? Estimate # of servings per week _____ |
| <input type="checkbox"/> Use prescription medications? How many? _____ | <input type="checkbox"/> Use Caffeine? Estimate # of servings per week _____ |
| <input type="checkbox"/> Use tobacco? How much? | <input type="checkbox"/> Exposed to known serious toxins or poisons? How many and what? _____ |
| <input type="checkbox"/> Use steroids in past year? How many? _____ | <input type="checkbox"/> Major infections in your life? How many? _____ |
| <input type="checkbox"/> Number of Amalgam fillings | <input type="checkbox"/> Major injuries in your life? How many? _____ |
| <input type="checkbox"/> Use recreational drugs? Times of use in past 30 days? _____ | <input type="checkbox"/> How many glasses of water do you drink a day? _____ |
| <input type="checkbox"/> Debilitating allergies? To what? | <input type="checkbox"/> Do you feel overweight? How many lbs? _____ |
| <input type="checkbox"/> Emotional / Mental conditions? How many? _____ | <input type="checkbox"/> Suffer from motion sickness? Often? |
| <input type="checkbox"/> Accept responsibility for your health? Estimate 0-10 high _____ | <input type="checkbox"/> Personality is Introverted (I) or Extroverted (E) _____ |
| <input type="checkbox"/> Estimate percent of fat in daily diet (20-30% = norm) _____ | <input type="checkbox"/> Hand dominance Left (write L) or Right (write R) _____ |
| <input type="checkbox"/> Personal Stress? Estimate 0-10 high | <input type="checkbox"/> Sleeping difficulty, going to sleep or waking frequently |
| <input type="checkbox"/> Eat Sweets? Estimate # per day _____ | |
| <input type="checkbox"/> Exercise weekly? How many 15 min. session per week? _____ | |
| <input type="checkbox"/> Nutritional supplements, herbs etc | |

Drugs /Prescriptions Used (now or in the past)

- | | | |
|--|---|---|
| <input type="checkbox"/> Pain Medication | <input type="checkbox"/> Anti-convulsant | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Anti-depressants | <input type="checkbox"/> Liver |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Anti-psychotic | <input type="checkbox"/> Heart Medication |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Birth Control | <input type="checkbox"/> Cancer drugs | <input type="checkbox"/> Digestive |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Diabetic |

Others

- | | | |
|--|---|--|
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Radiation | <input type="checkbox"/> Reduce weight |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Muscle relaxant | <input type="checkbox"/> Mood regulator | |

Toxic Exposures

- | | | |
|--|---|--|
| <input type="checkbox"/> Beauty Salon Toxins | <input type="checkbox"/> Radiation Exposure | <input type="checkbox"/> Herbicides/Insecticides |
| <input type="checkbox"/> Industrial Toxins | <input type="checkbox"/> Food Additives | <input type="checkbox"/> Air/Water Pollution |
| <input type="checkbox"/> Asbestos/Fiberglass | <input type="checkbox"/> Chlorine or Fluorine | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Heavy Metals | | |

Details of Stress You Experience

Are you the primary caregiver to someone else? If yes, what's relation and age? _____

Have you recently lost a job / changed careers? _____

Have you had a recent change in major relationship/partnership? _____

Have you recently had an experience which you feel you had no control over? _____

What movements cause/aggravate pain?

- | | | |
|-----------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Bending | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Other |
| <input type="checkbox"/> Stooping | <input type="checkbox"/> Lifting | |

On a level of 1-10 (10 being the worst) , what is your level of pain (circle)

1 2 3 4 5 6 7 8 9 10

On the figures below, **use X** to show areas where you experience muscle or joint pain/stiffness. Use **O** for spasm or **Dots** for numbness. Draw any scars (with a line).

