

HEALTH RECORD -Please print

Blood type, if you know it. _____

Reason for appointment _____

How are you feeling? _____

What are your major concerns? _____

If pain, where is it located _____

What are you doing for your health? **Circle what applies:** exercise, yoga, diet, herbs, vitamins, minerals, meditation, relaxation techniques, chiropractor, M.D., medication, Naturopath, massage therapy

Other _____

When did you last see this therapist? _____

What were their findings? _____

Are you taking any medication? Yes/no

What? _____

Why? _____ How often? _____

Have you ever had any accidents? Yes/no

What? _____

When? _____

Have you ever had surgery? Yes/no

What? _____

When? _____

Have you ever had any serious illness or diseases? _____

What? _____

When? _____

How is your blood pressure? _____

Please rate the following to do with your present condition and lifestyle: 0-5, zero-not a problem, five-most aggravating.

Fatigue__overwork__stress__relationships__nerves__worries__finances__

home__job__food__drugs__alcohol__weather__allergies__chemicals/fumes__

Do you smoke? Yes/no How many a day? _____

Do you drink alcohol? Yes/No How many a day? _____

Do you drink soft drinks? Yes/No How many a day? _____

Do you drink tea? Yes/No What kind(s)? _____

Do you drink coffee? Yes/No How many a day? _____ How do you take it? _____

Do you drink milk? Yes/No How many a day? _____

Do you drink water? Yes/No How many 8oz. a day _____

Do you eat bread? Yes/No What? _____

Do you eat fruit? Yes/No What? _____

Do you eat vegetables? Yes/No What? _____

Do you eat meat? Yes/No What? _____

Do you eat junk foods Yes/No What? _____

Mother's health history _____

Father's health history _____

Brother's/Sister's health history _____

What do you do for fun? _____

Is there anything else about your health you would like to tell me? _____

