



## Impact of Symptoms

How is this symptom/condition interfering with your life? (Check all that apply)

- Work
- Sleep
- Energy
- Relationships
- Exercise
- Recreation
- Attitude
- Productivity
- Daily Routine
- Other \_\_\_\_\_

## Health History

Please check the box beside any condition that you have or have had in the past:

- AIDS/HIV
- Depression
- Diabetes
- Alcoholism
- Gout
- Digestive issues (Constipation/Diarrhea/IBS)
- Fatigue
- Stroke
- Shoulder/Elbow/Wrist/Hand issues
- Jaw pain/TMJ issues
- Hepatitis
- Headaches/Migraines
- Loss of memory
- Ankle swelling
- Hormone imbalance (Thyroid, etc.)
- Asthma
- Immune issues
- Hip/Knee/Ankle/Foot issues
- Back pain
- Lymphatic issues
- Multiple sclerosis
- Heart Issues
- Neck pain
- Reproductive issues
- Cancer
- Ringing in ears
- Scoliosis
- Circulation issues
- Shortness of breath
- Dizziness/Loss of balance/Vertigo
- Childhood illness
- Chronic cough
- Urinary issues (overactive bladder / other: \_\_\_\_\_)
- Osteoporosis
- ADD/ADHD
- Coughing up blood
- Blood in stool
- Yeast infections
- Abnormal blood pressure
- Anxiety
- Arteriosclerosis
- Losing weight without trying
- Menstrual issues
- Arthritis
- Pain that wakes you up at night
- Chest pain
- Scoliosis
- Heart burn/acid reflux/GERD
- Sinus issues
- High blood pressure
- Allergies: Circle one: seasonal / food / other
- Fibromyalgia
- Menopause
- Parkinson's
- Loss of sex drive
- Impotence
- Overweight
- Sleep problems
- Plantar Fasciitis
- Loss of smell, taste, hearing, sight
- Sciatica
- History of Cancer
- Recent bowl/bladder changes
- Other \_\_\_\_\_

## Injuries/Surgeries (Please provide date)

List all past motor vehicle accidents \_\_\_\_\_

List any injuries / traumas (as child or adult) \_\_\_\_\_

Broken bones / dislocations \_\_\_\_\_

List all past surgeries \_\_\_\_\_

## Children & Pregnancy

How many children do you have? \_\_\_\_\_ Are you currently pregnant?  No  Yes, I am due \_\_\_\_\_

Children's ages \_\_\_\_\_ Health concerns regarding this pregnancy \_\_\_\_\_

Children's health concerns \_\_\_\_\_ Number of past pregnancies \_\_\_\_\_

# Stress Test

## Physical Stress:

Check box applicable (past or present):

- Birth traumas (as a mother or child)
- Sitting on a wallet for years
- Sleeping position – stomach
- Extensive computer work
- Carrying heavy purse/backpack/child
- Repetitive lifting/bending
- Continuous hours sitting/standing
- Minimal/no exercise

## Chemical Stress

- Environment (i.e. pollution)
- Smoker
- Second hand smoke
- Poor diet
- Excessive caffeine
- Excessive sugar
- Artificial sweeteners
- Prescription drugs
- Over-the-counter drugs(i.e. Tylenol, Motrin)

## Emotional Stress

- Relationships
- Career
- Children
- Suppressed feelings
- Sickness or loss of loved one

Which do you feel is your primary stress?

Physical

Chemical

Emotional

Please Explain: \_\_\_\_\_  
\_\_\_\_\_

# Allergies, Medications, Supplements

ALLERGIES

MEDICATIONS (and reason for taking them)

SUPPLEMENTS

\_\_\_\_\_  
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The statements made on this form are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE