

**1. What is your:** Height \_\_\_\_\_ Weight \_\_\_\_\_ Race/Ethnicity \_\_\_\_\_  
 Occupation \_\_\_\_\_ Preferred Language \_\_\_\_\_

**2. How would you rate your Health?** ? Excellent ? Very Good ? Good ? Fair ? Poor

**3. What type of exercise do you do?** ? Strenuous ? Moderate ? Light ? None

**4. Indicate if you have any immediate family members with any of the following:**

? Rheumatoid Arthritis ? Diabetes ? Lupus ? None  
 ? Heart Problems ? Cancer ? ALS ? Other \_\_\_\_\_

**5. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

Past	Present	Past	Present	Past	Present
?	? Headaches	?	? Dizziness	?	? Diabetes
?	? Neck Pain	?	? High Blood Pressure	?	? Excessive Thirst
?	? Upper Back Pain	?	? Heart Attack	?	? Frequent Urination
?	? Mid Back Pain	?	? Chest Pains	?	? Smoking _____ packs per week
?	? Low Back Pain	?	? Stroke	?	? Drug/Alcohol Dependence
?	? Shoulder Pain	?	? Angina	?	? Allergies
?	? Elbow/Upper Arm Pain	?	? Kidney Stones	?	? Depression
?	? Wrist Pain	?	? Kidney Disorders	?	? Systemic Lupus
?	? Hand Pain	?	? Bladder Infection	?	? Epilepsy
?	? Hip Pain	?	? Painful Urination	?	? Dermatitis/Eczema/Rash
?	? Upper Leg Pain	?	? Loss of Bladder Control	?	? HIV/AIDS
?	? Knee Pain	?	? Prostate Problems	?	? Asthma
?	? Ankle/Foot Pain	?	? Abnormal Wt Gain/Loss	<b>For Females Only</b>	
?	? Jaw Pain	?	? Loss of Appetite	?	? Birth Control
?	? Joint Pain/Stiffness	?	? Abdominal Pain	?	? Hormonal Replacement
?	? Arthritis	?	? Ulcer	?	? Pregnancy
?	? Rheumatoid Arthritis	?	? Hepatitis	?	? Dysmenorrhea (cramps)
?	? General Fatigue	?	? Liver/GallBladder Disord.	?	? Endometriosis
?	? Muscular Incoordination	?	? Cancer	?	? Menopause Symptoms
?	? Visual Disturbances	?	? Tumor		
?	? Chronic Sinusitis	?	? Other: _____		

**6. List all prescription or over-the-counter medications you are currently taking:**

\_\_\_\_\_

**7. List all of the supplements you are currently taking:**

\_\_\_\_\_

**8. List all surgical procedures you have had:**

\_\_\_\_\_

**9. Have you ever been hospitalized?** ? No ? Yes

If yes, explain \_\_\_\_\_

**10. Have you had significant past trauma?** ? No ? Yes

If yes, explain \_\_\_\_\_