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 Dependance
?	?	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			**For Females Only**
?	?	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 ____