

HEALTH HISTORY

Please ✓ any of the following conditions that you are currently experiencing or have experienced in the last 6 months.

Please X any conditions you may have experienced anytime in the past prior to six months.

- | | | |
|--|--|--|
| <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Upper/mid back pain | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Regular colds/flu |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Nervous/anxiety | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Tired / fatigue | <input type="checkbox"/> Allergies | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Tension in body | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Numb/tingling in arms/hands | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Numb/tingling in legs/feet | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Muscle cramps/sprains | <input type="checkbox"/> Weight problems | <input type="checkbox"/> Depression |

Other conditions _____

Which of the above conditions is the worst _____

Describe severity of the condition _____

What treatments have you tried prior to today _____

List all surgery you have had and at what age _____

List all major fractures, falls or accidents over the last 10 years _____

List any other previous illness that has not been mentioned above _____

Are you pregnant or is there any possibility that you are pregnant _____

If applicable, at what stage in the pregnancy are you _____

LIFESTYLE

How many hours do you sleep each night _____ Time you retire _____ Time you rise _____

How often do you exercise Daily Twice or more daily Weekly Never

If applicable, what exercise do you do and the duration _____

Do you smoke Y/N _____ Number per day _____ How long have you smoked _____

What drugs (medical or recreational) are you currently taking (include dosage) _____

What vitamin or mineral supplements are you currently taking (include dosage) _____

Do you have any food allergies _____

Indicate your normal/general diet:

Meat & 3 veg Vegetarian Vegan High protein Macro

Wheat free Gluten free Dairy Free Other

Daily intakes of:

Sugar _____ Coffee _____ Tea _____ Alcohol _____ Water (ltr) _____

Additional diet information _____

