

Medical History

Patient's Name _____ DOB _____ Date _____ File# _____

Four factors contribute to your state of health:

1. Neurological integrity of Mind / Body connection
2. Hormonal balance & Metabolic processing
3. Lifestyle activities & Nutrition
4. Genetic & Familial history

Please provide the following information of your grandparents, parents, or siblings.

Have any of them had the following? G P S

- | | |
|---|---|
| <input type="checkbox"/> Allergies / Asthma / Crohns | <input type="checkbox"/> Arthritis / Scoliosis / Spina Bifida |
| <input type="checkbox"/> Mental Illness / Social Dysfunctions | <input type="checkbox"/> Liver / Gall Bladder Disease |
| <input type="checkbox"/> Cerebral Vascular Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Kidney / Urinary Tract Dysfunctions |
| <input type="checkbox"/> Respiratory Disease / Emphysema | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Disease / Murmurs | <input type="checkbox"/> Cancer / AIDS / HIV |
| <input type="checkbox"/> Digestive Diseases / Ulcers / IBS | <input type="checkbox"/> Multiple Sclerosis / ALS |

<u>Do you take any of the following?</u>	<u>NO</u>	<u>YES</u>	<u>More Details of Type</u>	<u>How Long?</u>
Vitamin / Mineral Supplements				
Herbs / Laxatives				
Pain Meds / Muscle Relaxants				
Sedatives / Tranquilizers				
Birth Control Pills				
Hormone Replacement Therapy				
Blood Pressure Medicine				
Insulin				
Other Prescribed Medicine				
Over the Counter Products				
Recreational Drugs				
Tobacco				
Alcohol				
Coffee				
Diet soda / Artificial Sweeteners				
Electric Blanket / Magnets				
Cell Phone / Pager				