

HEALTH HISTORY

Please list any **medications and/or supplements** you are taking _____

Have you ever had any of the following diseases or medical conditions?

- | | | |
|-----------------------------|------------------------------------|----------------------------------|
| Y N High/Low Blood Pressure | Y N Fainting/Seizures/Epilepsy | Y N Ear Infections |
| Y N Heart Attack/Stroke | Y N Tuberculosis | Y N Enlarged Glands |
| Y N Heart Surgery | Y N Emphysema | Y N Difficulty Swallowing |
| Y N Heart Valve Problems | Y N Difficulty Breathing | Y N Jaw Pain/Ear Noises |
| Y N Heart Murmur | Y N Asthma | Y N Thyroid Condition |
| Y N Shortness of Breath | Y N Pneumonia/Pleurisy | Y N Recurring/Frequent Headaches |
| Y N Cancer | Y N Anemia | Y N Neck Pain |
| Y N Chemo/Radiation Therapy | Y N Shingles | Y N Back Pain |
| Y N HIV/AIDS | Y N Glaucoma | Y N Disc Injuries |
| Y N Venereal Disease | Y N Diabetes | Y N Arthritis |
| Y N Alcohol/Drug Abuse | Y N Rheumatic Fever | Y N Sinus Problems |
| Y N Hepatitis | Y N Bowel Disease | Y N Muscle Spasms |
| Y N Psychiatric/Depression | Y N Frequent Diarrhea/Constipation | Y N Broken/Dislocated Bones |
| Y N Recent Weight Loss | Y N Difficult/Excessive Urination | Y N Numb/Tingling Extremities |
| Y N Polio/Meningitis | Y N Kidney Problems | Y N Dizziness/Vertigo |

Please list any **serious medical conditions** you have ever had: _____

Please list any **allergies** you have: _____

List all previous **surgeries** with dates: _____

List any **past** serious accidents with dates: _____

Do you smoke? Y N How Much? _____

Do you have foot pain or flat feet? Y N Are you wearing: ___ Heel Lifts ___ Orthotics/Arch Supports

What is the age of your mattress? _____ Is it comfortable? Y N

Are you interested in Nutritional Testing to improve your overall health? Y N

For women:

Are you taking Birth Control? Y N

Are you **Pregnant**? Y N Are you presently Nursing? Y N

The patient is responsible for all costs and such payment is not contingent on payment by your insurance company, settlement, judgment or verdict by which he/she might eventually recover.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____