Health History and Questionnaire

Please print clearly:	
Name	
Address	
	Occupation
Date of Birth	Age
Email	
Have you ever had any energ	y work before? (circle) Y N
What is the present condition	of your Health?
	octor?
Any possibility of pregnancy?	(circle) Y N
	in any other therapies besides conventional
Are you taking any medication	ns? (circle) Y N
If so, list them.	
Do you have any chronic heal If so, explain.	,

Please check any medical conditions I should be aware of. Also include any recent rashes, bruises, bumps, breaks, sprains, fractures, or illnesses. A partial list follows but is not meant to be all-inclusive.

O ADHD O Aids O Heart disease O Autism O Herpes O Allergies (List below) O Amalgam (Silver Fillings) O Asthma O Cancer/Malignancy O Chronic Pain O Headaches O Heart disease O Herpes O Mental Illness O Learning Disorders O Migraines O PMS/Troublesome cycles O Reproductive issues or concerns	O ADD	O Food Sensitivities
Aidis Autism Altergies (List below) Allergies (List below) Amalgam (Silver Fillings) Asthma A	O Addiction(s)	○ Fractures/Breaks
O Autism O Allergies (List below) O Allergies (List below) O Amalgam (Silver Fillings) O Asthma O Cancer/Malignancy O Chronic Pain O Contacts O Dentures O Depression O Epilepsy O Fluid Retention Explain any of the above and add anything you feel is of importance which has not been addressed above: Name/Phone # of primary care physician Signature (Guardian if under age 18) Mental Illness Migraines PMS/Troublesome cycles Migraines M	O ADHD	O Headaches
O Allergies (List below)	O Aids	O Heart disease
O Allergies (List below)	○ Autism	O Herpes
O Amalgam (Silver Fillings) O Asthma O Migraines O Cancer/Malignancy O Chronic Pain O Contacts O Dentures O Depression O Epilepsy O Fluid Retention Explain any of the above and add anything you feel is of importance which has not been addressed above: Name/Phone # of primary care physician Signature (Guardian if under age 18) Date	O Allergies (List below)	
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O Chronic Pain O Contacts O Dentures O Depression O Epilepsy O Fluid Retention Explain any of the above and add anything you feel is of importance which has not been addressed above: Name/Phone # of primary care physician Signature (Guardian if under age 18) Date	O Cancer/Malignancy	<u> </u>
O Contacts O Dentures O Depression O Epilepsy O Fluid Retention Explain any of the above and add anything you feel is of importance which has not been addressed above: Name/Phone # of primary care physician Signature (Guardian if under age 18) Date	O Chronic Pain	The state of the s
O Depression O Epilepsy O Fluid Retention Explain any of the above and add anything you feel is of importance which has not been addressed above: Name/Phone # of primary care physician Signature (Guardian if under age 18) Date	O Contacts	
O Depression O Epilepsy O Fluid Retention Explain any of the above and add anything you feel is of importance which has not been addressed above: Name/Phone # of primary care physician Signature (Guardian if under age 18) Date	O Dentures	O Surgeries
O Epilepsy O Fluid Retention Explain any of the above and add anything you feel is of importance which has not been addressed above: Name/Phone # of primary care physician Signature (Guardian if under age 18) Date		_
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Name/Phone # of primary care physician	Explain any of the above and add a	anything you leer is of importance which has
Name/Phone # of primary care physician	not been addressed above:	
Signature (Guardian if under age 18) Date		
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Signature (Guardian if under age 18) Date		
	Name/Phone # of primary care phy	rsician
	Signature (Guardian if under ad	e 18) Date
Were you referred by anyone? If so, who	(250,000,000,000,000,000,000,000,000,000,	24.0
Were you referred by anyone? If so, who		
	Were you referred by anyone? If so	o, who