Do you have a particular position for watching television? ☐ Yes ☐ No

Comments: _____

I wear: ☐ glasses ☐ bifocals ☐ contact lenses

AUTOMOBILE ACCIDENTS:

Have you, (even as a passenger, even if you do not think you were hurt), been involved in a vehicular collision, or near collision? ☐ Yes ☐ No

Please list approximate dates and severity (Mild, Moderate or Extreme):

Automobile: _____

Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: _____

MEDICAL TREATMENT:

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, what was actually done to you? _____

Have you had surgery? _____

Do you still have all of your body parts? _____

Have you had: ☐ spinal tap ☐ spinal injections ☐ physiotherapy ☐ neck collar ☐ spinal brace ☐ traction ☐ heel lift

☐ radiation treatments ☐ corrective shoes or bars on shoes ☐ extensive diagnostic x-rays ☐ acupuncture ☐ chemotherapy

☐ transfusion ☐ body part in a cast or immobilized ☐ other _____

Comments: _____

CHEMICAL HISTORY DURING YOUR BIRTH:

Was your mother regularly taking any drug immediately prior to, or during her pregnancy with you? ☐ Alcohol ☐ Smoking

Other: _____

Was her labor chemically induced or altered? ☐ Yes ☐ No

Was your mother: ☐ conscious ☐ semiconscious ☐ unconscious during your delivery

Any other chemical stress that your mother may have been subject to: _____

GENERAL CHEMICAL STRESS:

Are you now taking any drug (prescription or over-the-counter) regularly? Please list drugs, when prescribed and reasons for taking them: _____

_____

Are these drugs being prescribed by a physician? ☐ Yes ☐ No Last visit: _____

If you were previously taking any medication regularly, please list and describe reasons: _____

_____

Do you or did you work with any chemicals, fumes, dust, powder, smoke for prolonged periods? ☐ Yes ☐ No

Please describe: _____

Please grade any dietary selection that is appropriate for you using the following scale:

O – Do not consume this
M – Consume this monthly
FM – Consume a few times per month (less than weekly)
FD – Consume this a few times per day
W – Consume this weekly
FW – Consume this a few times per week
D – Consume this daily

_____ Alcohol	_____ Eggs	_____ Poultry	_____ Fruit
_____ Coffee/Tea	_____ Cooked, Canned Vegetables	_____ Fish	
_____ Tobacco	_____ Refined Sugar	_____ Raw Vegetables	
_____ Fried Foods	_____ Beef	_____ Fasting	
_____ Whole Grains	_____ Soda	_____ Weight Control Diet	
_____ Dairy (milk products)	_____ Artificial Sweeteners	_____ Organic Foods	