

Do you have pain/problems in any of the following regions?
face / jaw / neck / back / shoulder / elbow / wrist / hand / hip / ankle / foot

Do you have any of the following?
headaches / pms / cancer / diabetes / arthritis / allergies / tendonitis
hearing aid / ringing in ears / contact lenses / osteoporosis / sleep problems
skin sensitivity / digestive issues / urinary issues / menstrual issues
constipation / diarrhea / artificial arms or legs / high blood pressure /
high cholesterol / sense of humor

Any family history of: Cancer/Heart Disease/Arthritis/Osteoporosis/Stroke

Are you pregnant? Y / N / N/A

Any past surgeries of note? _____

Any past auto injuries? _____

Any other relevant injuries? _____

How old is your mattress? _____ How many pillows do you use? _____

Do you sleep on your: side / back / stomach

What is your current exercise program? _____

Do you smoke? Y/N How often: _____

Drink alcohol Y/N How often: _____

Drink caffeine? Y/N How often: _____

Please list all prescription and over the counter meds you currently take:

Please list all vitamins and supplements you currently take:

Do you have prior experience with: Chiropractic Massage Acupuncture

Have you received any previous treatment for your issue(s): Y / N

If yes, please explain: _____

What is your motivation level on a scale of 1-10 (0=none, 10=extremely)

in receiving nutritional or home exercise info relative to your condition? _____

Is there anything else not contained in this form that needs to be discussed?

Signature: _____ Date: _____