

Name: _____ Date: _____

Previous treatment for this complaint (include any doctors names, dates treated, test results, or home remedies: _____

(If you need more room; please write on back of sheet)

<i>X-rays, MRI's or CT's</i>	<i>Where Taken</i>	<i>Date</i>

Past Surgical History

<i>Surgery</i>	<i>Year</i>

Hospitalizations (other than surgery)

<i>Reason</i>	<i>Year</i>

Accidents/Injuries

<i>Accident/Injury</i>	<i>Year</i>

Current medications/supplements _____

Known allergies to medications/supplements _____

Exercise, type and frequency: _____

Describe your typical diet for

Breakfast: _____

Lunch: _____

Dinner: _____

How much of the following do you consume daily?

Water: _____ Milk: _____ Soda: _____ Coffee _____

Cigarettes: _____ Sweets: _____ Alcohol: _____ Tea _____

Abdominal gas frequently? _____ #of bowel movements daily? _____

List any recent travel: _____

Age of mattress: _____ Regular: _____ Waterbed _____ Fouton: _____ Sleep Position _____

Do you like your job? _____ How do you relieve stress? _____

Spiritual/Religious affiliation/Meditation/Prayer _____

List hobbies: _____

With whom do you live? _____

Estimate the stress in your life: _____ None _____ Mild _____ Moderate _____ Great

Date of last physical exam? _____

Have you ever had a professional massage, Polarity Therapy or craniosacral therapy? _____

Are you currently in psychotherapy? _____