If yes, please explain below:

Medications (list all medications you are taking regularly. Include strength and directions. Include over the counter, herbal, and natural remedies)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Have You Ever Been Diagnosed to Have: (check all that apply)				
Head Injuries ◯	Heart Disease ◯	Ulcers ◯	Anemia ◯	Psychological Issues ◯
Convulsions ◯	Heart Murmur ◯	Digestive Disorder ◯	Bleeding Disorder ◯	Frequent Infections ◯
Asthma ◯	Vision Issues ◯	Rectal, Hemorrhoidal Issue ◯	Rheumatism, Arthritis ◯	Chronic Pain Syndrome ◯
Sinus Issues ◯	Pneumonia, Pleurisy ◯	Kidney Disease ◯	Gout ◯	Exposure to Chemicals ◯
Stroke/Paralysis ◯	TB/Lung Disease ◯	Kidney Stones ◯	Back Trouble ◯	Deformity, Amputation ◯
Seizure/Epilepsy ◯	Hernia ◯	Diabetes ◯	Pre-Diabetes ◯	Bone or Joint Disease ◯
Heart Attack/Angina◯	Jaundice/Hepatitis ◯	Varicose Veins ◯	High Cholesterol ◯	High/Low Blood Pressure ◯
Hearing Issues ◯	Emphysema ◯	Liver Disease ◯	Thyroid Disease ◯	Scars/Identifying Marks ◯
STD ◯	Cancer (type) ◯	Late Mentrual ◯	Womb/Ovary Issues ◯	Female Only (please circle response) Currently Pregnant **Yes** **No** Breastfeeding **Yes** **No**
Prior Work Comp/Auto/Sport Injury or Other ◯ ***If 'Yes', Please Specify:***				

Do you have allergies? (example: medications, shellfish, latex…etc) Circle YES or NO. If yes, please explain:

Allergic to: _____ Reaction: _____
Allergic to: _____ Reaction: _____
Allergic to: _____ Reaction: _____

Have you had any surgeries? Circle YES or NO. If yes, please explain:

Type of Surgery: _____ Date: _____ Name of Surgeon: _____
Type of Surgery: _____ Date: _____ Name of Surgeon: _____

Have you ever been hospitalized? Circle YES or NO. If yes, please explain:

→ _____

Family History

Have your Mother/Father, Grandmother/Grandfather, Aunt(s)/Uncle(s), Brother(s)/Sister(s) been diagnosed with the following?

If so, please specify who

Diabetes ◯:	Kidney Disease ◯:	High Blood Pressure ◯:
Cancer (type) ◯:	Stroke ◯:	Other ◯:

Social History

Drink any Alcohol: **Yes** **No** **Occasionally** **Rarely** Quit (if so, please specify when): _____
Recreational Drugs: **Yes** **No** (if yes, please specify. For example, Marijuana, Cocaine, Meth, Heroin, etc.) →
_____
Quit? (if so, please specify when): _____