CONFIDENTIAL CLIENT QUESTIONNAIRE

FOR OFFICE USE ONLY
DATE SENT _____/_____/_____
DATE REC'D _____/_____/_____
IC TECH SCORE _____

GENERAL INFORMATION - PLEASE PRINT

DATE_____/____/_____

PATIENT NAME _____ HOME ADDRESS_____

CITY _____ STATE _____ ZIP CODE _____ HOW LONG?_____

E-mail address _____@_____ *We do not share your address.*

[redacted]

PREVIOUS ADDRESS IF LESS THAN 3 YEARS AT PRESENT

ADDRESS _____ CITY _____ STATE_____ ZIP CODE _____

BIRTH DATE _____/_____/_____ AGE_____ SEX M____ F____ MARITAL STATUS M___S___D___W___

YOUR EMPLOYER_____ CITY_____ YEARS WITH FIRM _____

OCCUPATION _____ SOCIAL SECURITY# _____/_____/_____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SPOUSE'S NAME_____BIRTH DATE ____/____/____ OCCUPATION_____

SPOUSE'S EMPLOYER _____ CITY_____ PHONE_____

YOUR MD__ _____ DATE OF LAST PHYSICAL _____

DENTIST _____ DATE OF LAST VISIT _____

DATE OF LAST CHIROPRACTIC ADJUSTMENT _____/_____/_____ GIVEN BY DR_____

WHO MAY WE CONTACT IN CASE OF EMERGENCY_____ PHONE _____

WHO MAY WE THANK FOR REFERRING YOU TO US? _____ PHONE _____

PLEASE FILL OUT THE FOLLOWING AS COMPLETELY AS YOU CAN. USE ADDITIONAL BLANK SHEETS. OBTAINING THE BEST HEALTH POSSIBLE IS A PROCESS THAT CAN ONLY OCCUR WITH YOUR PARTICIPATION. THE INFORMATION YOU PROVIDE WILL HELP YOUR DOCTOR MAKE INFORMED RECOMMENDATIONS. THANK YOU.

YOUR HEALTH HISTORY

GIVE THE PRIMARY REASON YOU ARE CONSULTING WITH OUR DOCTOR. BE SURE TO GIVE A DETAILED ACCOUNT INCLUDING WHEN AND WHY IT STARTED, WHAT HAS BEEN DONE TO DATE, THE RESULTS YOU HAVE HAD AND IF THE PROBLEM IS GETTING BETTER, WORSE OR IS THE SAME.

GIVE ANY SECONDARY HEALTH PROBLEMS YOU ARE EXPERIENCING. LIST THE MOST SEVERE FIRST.

LIST ALL NUTRITIONAL SUPPLEMENT PRODUCTS YOU ARE TAKING. INCLUDE THE NAME OF THE COMPANY, AMOUNT, WHY YOU ARE TAKING THEM AND HOW LONG YOU HAVE BEEN TAKING. WE ASK THAT YOU BRING ALL BOTTLES TO YOUR CONSULTATION.

NAME COMPANY AMOUNT WHY TAKING HOW LONG

LIST ALL DRUGS (PRESCRIPTION OR NOT) YOU ARE TAKING. INCLUDE THE REASON TAKEN, AMOUNT, LENGTH OF TIME TAKEN AND RESULTS. LIST ALL OTHER DRUGS YOU HAVE TAKEN IN THE PAST.

NAME AMOUNT WHY TAKING HOW LONG RESULTS

LIST ALL SURGERIES YOU HAVE HAD INCLUDING THE DATE, WHY IT WAS DONE AND THE RESULTS.

SURGERY DATE WHY DONE RESULTS

LIST ANY ALLERGIES YOU HAVE TO FOOD, DRUGS OR OTHER SUBSTANCES ALONG WITH THE SYMPTOMS THEY PRODUCE AND INDICATE HOW LONG YOU HAVE SUFFERED FROM EACH ITEM.

ALLERGY SYMPTOMS HOW LONG

ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. IF YOU DON'T KNOW THE ANSWER, LEAVE BLANK:

()YES ()NO MY MOTHER WAS HEALTHY WHILE PREGNANT WITH ME. IF NO,DESCRIBE_____

()YES ()NO WAS YOUR BIRTH NATURAL? IF NO, PLEASE CHECK ()ANESTHESIA ()FORCEPS ()C-SECTION

()YES ()NO WERE YOU BREAST FED FOR AT LEAST THE FIRST 6 MOS? _____

()YES ()NO WERE YOU FED ANYTHING OTHER THAN BREAST OR COW FORMULA MILK IN THE FIRST 6 MOS? LIST ITEMS _____

()YES ()NO WERE YOU A COLICKY BABY? UNTIL WHAT AGE?_____

()YES ()NO HAVE YOU BEEN TO OR LIVED IN A FOREIGN COUNTRY? LIST_____

()YES ()NO HAVE YOU EVER FAINTED OR HAD A CONVULSION? DESCRIBE_____

MARK ANY YOU HAVE HAD: ()MEASLES ()CHICKEN POX ()MUMPS ()GERMAN MEASLES ()HEPATITIS
()SCARLET FEVER ()RHEUMATIC FEVER ()LYMES DISEASE ()MONONUCLEOSIS
()HERPES ()SHINGLES ()VENEREAL DISASE ()HIV/AIDS

DIET HISTORY MARK EACH ONE USING A "0" OR NONE WHEN APPROPRIATE

GIVE THE AMOUNT OF EACH YOU CONSUME:

_____	OUNCES WATER	____DAY	____NOT DAILY
_____	OUNCES ALCOHOL	____DAY	____NOT DAILY
_____	OUNCES COFFEE/TEA	____DAY	____NOT DAILY
_____	OUNCES SODA	____DAY	____NOT DAILY
_____	OUNCES JUICE	____DAY	____NOT DAILY
_____	OTHER _____	____DAY	____NOT DAILY

LIST YOUR 10 MOST FAVORITE FOODS EATEN MOST FREQUENTLY. _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

GIVE PERCENTAGE FOR EACH OF THE FOLLOWING. Total for each line to equal 100%

WHERE DAILY DIET PREPARED: ____HOME _____RESTAURANT _____FAST FOOD _____VENDING MACHINE

HOW FOOD PREPARED: ____BAKED ____ROILED ___BOILED ____RIED ____STEAMED ____ MICROWAVE

FOOD PREPARED FROM:_____FRESH _____CANNED _____FROZEN _____PREPACKAGED

MY APPETITE IS: () NORMAL () EXCESSIVE () POOR () NONE

I CRAVE: () SWEETS () SALT () CHOCOLATE () WATER () DIRT () OTHER_____

TYPE OF WATER USED FOR DRINKING/COOKING: ()TAP OR CITY ()SPRING ()WELL ()RAIN
()BOTTLED DISTILLED ()BOTTLED FILTERED ()REVERSE OSMOSIS

IF PURCHASE WATER, IS IT IN: ()SOFT PLASTIC ()HARD PLASTIC ()GLASS

FOODS THAT DISAGREE WITH YOU: ()RAW VEGETABLES ()RAW FRUIT ()FATS ()FRIED
()MILK/DAIRY ()GREASY ()EGGS ()ONIONS
()HIGHLY SPICED ()BEANS

()CABBAGE ()SUGAR

()OTHER_____

WHAT SYMPTOMS DO YOU GET FROM FOODS THAT DISAGREE WITH YOU?_____

_____

DO YOU FAST? ()YES ()NO IF YES, HOW OFTEN AND HOW LONG?_____

HAVE YOU EVER DONE A DETOXIFICATION PROGRAM? ()YES ()NO EXPLAIN_____

CHECK ANY OF THE FOLLOWING DIETS YOU HAVE EVER TRIED?

() LOW CHOLESTEROL	() LOW SALT	() LOW PURINE	() ALL ENERGY
() LOW FAT	() DIABETIC	() RENAL/KIDNEY	() HIGH FIBER
() ULCER	() DIVERTICULITIS	() COMPLEX CARBOHYDRATE	() HIGH PROTEIN

() WEIGHT LOSS (LIST WHICH ONES)_____

HOW MANY DAYS A WEEK DO YOU EXERCISE?____HOW LONG EACH TIME?___ TYPE OF EXRCISE?_____

BOWEL HEALTH BM = BOWEL MOVEMENT OR STOOL

HOW MANY TIMES DO YOU HAVE A BM? _____ X A DAY _____X A WEEK

()YES ()NO DO YOU USE LAXATIVES? HOW OFTEN _____BRAND_____

()YES ()NO DO YOU GET THE URGE TO HAVE A BM? ()YES ()NO DO YOU HAVE PAIN WITH BM?

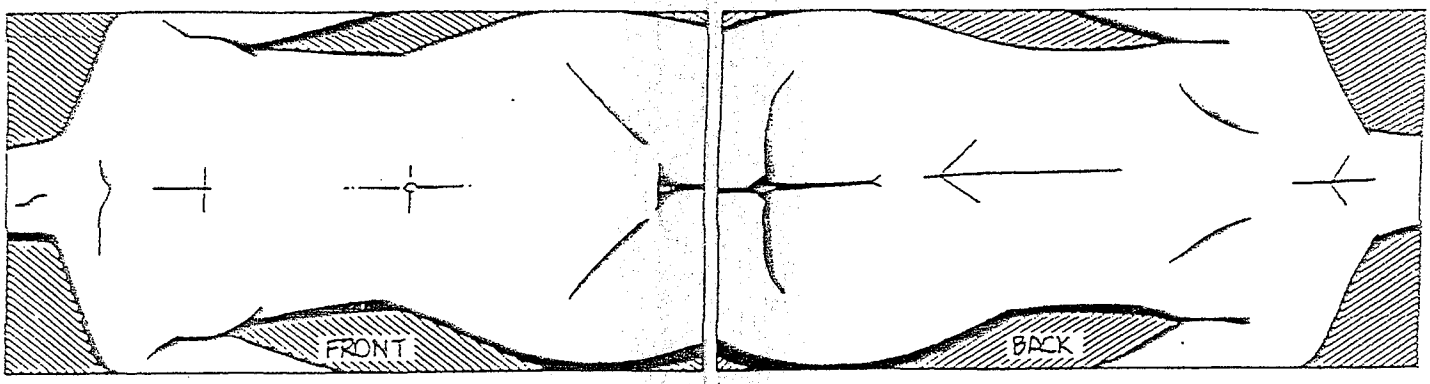
Answer key for the following tables: 0 = never 1 = rarely 2 = frequently 3 = always

STOOL SIZE	STOOL CONSISTENCY	STOOL COLOR
___2" wide & 6+" length	___Float like a submarine	___Med/dark brown
___1" wide & 4+" length	___Float on top of water	___Very dark/black
___Thin, long or narrow	___Sink to bottom	___Yellow/tan/clay
___Small, hard	___Loose but not watery	___Greenish
___Large, hard	___Diarrhea	___Blood is visible
___Difficult to pass	___Alternate hard/diarrhea	___Mucus in or around

()YES ()NO HAVE YOU EVER HAD WORMS OR PARASITES? HOW TREATED?_____

()YES ()NO DO YOU PRESENTLY HAVE RECTAL ITCHING? ()DAY ()NIGHT ()CONTINUOUSLY

DIGESTION MARK ANY AREAS OF DISTRESS ASSOCIATED WITH FOOD INTAKE ON THE DIAGRAMS



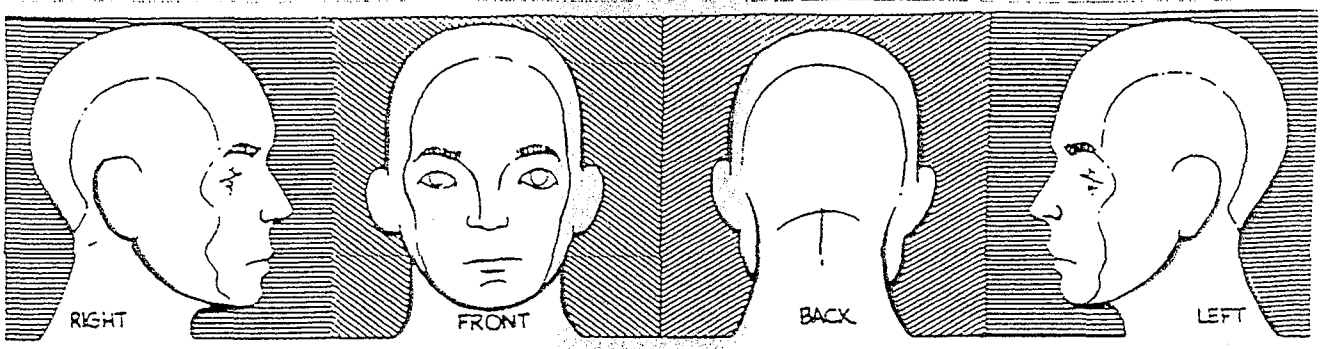
I GET PAIN/HEARTBURN: ()BEFORE EATING ()AFTER EATING ()WHEN LIE DOWN ()UPON ARISING

I HAVE: ()INDIGESTION ()BELCHING ()GERD ()INTESTINAL GAS ()BLOATING
()IMMEDIATELY AFTER EATING ()1 - 2 HOURS ()3 - 5 HOURS ()6 + HOURS
()NO ODOR ()SOME ODOR ()ODOR USUALLY ()FOWL SMELLING
()HIATAL HERNIA ()ESOPHAGEAL BURNING/REFLUX ()RAISE HEAD OF BED TO SLEEP

LIST ANY DRUGS (PERSCRIPTION OR OTC) OR NATURAL REMEDIES YOU TAKE FOR ANY STOMACH OR BOWEL SYMPTOMS

PRODUCT	DOSE	HOW FREQUENTLY	RESULTS

HEAD, MOUTH, THROAT MARK ANY AREAS OF HEADACHE OR PAIN MARK ALL THAT APPLY



MY TEETH ARE: ()GOOD ()SOME FILLINGS)BAD ()SOME MISSING ()ALL MISSING ()ROOT CANAL
I WEAR DENTURES: ()UPPER ()LOWER ()PARTIALS ()CROWNS ()MORE THAN 1 METAL TYPE IN MOUTH
MY BREATH IS: ()GOOD ()SLIGHT ODOR ()ODOR OFF/ON ()OFFENSIVE ODOR USUALLY
MY TONGUE IS: ()COVERED WITH SMALL TASTE BUDS ()SORE ()FURROWED ()COATED _____COLOR
MY TONGUE COLOR IS: ()PINK ()RED ()RED BLOTCHY ()PINK WITH RED TIP
MY TONSILS ARE: ()NORMAL ()REMOVED AT AGE ____ ()ENLARGED ()SPOTTED
MY SENSE OF TASTE IS: ()NORMAL ()POOR ()NO TASTE ()OVERSALT FOOD ()CANKER SORES

MY LIPS ARE: ()NORMAL ()DRY ()PEEL A LOT ()FEVER BLISTERS OFTEN ()CRACKED IN CORNERS

I GET HEADACHES: ()DAILY ()WEEKLY ()RARELY)NEVER
()WAKE UP WITH ()GET IN AM ()GET IN PM
()OF DIFFERENT TYPES ()WITH SOME FOODS OR DRINKS
()WITH AURA ()WITH NAUSEA/VOMITING

MUSCLE, LIGAMENT, JOINT, NERVES

I HAVE PAIN IN: ()NECK ()MID BACK ()LOW BACK
()HIP ()KNEE ()ANKLE ()FEET
()SHOULDER ()ELBOW ()WRIST ()HANDS
()OTHER_____

I GET: ()SWOLLEN JOINTS ()SORE JOINTS ()JOINTS POP OR CRACK ()JAW POPS
()LEG CRAMPS AT REST ()LEG CRAMPS WITH ACTIVITY ()WORSE AT NIGHT
()FOOT CRAMPS AT REST ()FOOT CRAMPS WITH ACTIVITY ()FLAT FEET ()BURNING FEET

()TINGLING IN FEET OR HANDS ()RESTLESS LEG SYNDROME

I HAVE: ()NERVOUS TIC OR TWITCHING - WHERE_____ ()BELL'S PALSY
()RINGING IN EARS () PARKINSON'S ()SCIATIC NEURITIS () MULTIPLE SCLEROSIS
()HAD SPINAL SURGERY - WHERE_____ RESULTS_____

HAIR, NAILS, SKIN

HAIR: ()COURSE ()FINE ()FALLS OUT EXCESSIVELY ()TURNED GREY AT AGE _____ ()OILY ()DRY
MALE BEARD: ()HEAVY ()LIGHT OR SPARSE ()NONE ETHNIC BACKGROUND_____
FEMALE: ()FACIAL HAIR ALWAYS ()FACIAL HAIR STARTED AT AGE__ ()HAIR ON ABDOMEN OR BREASTS

FINGER NAILS: ()NORMAL ()BRITTLE/BREAK EASILY ()SOFT ()RIDGED VERTICALLY ()WHITE SPOTS
()RIDGED HORIZONTALLY ()GROW FAST ()GROW SLOW ()SHAPED ODDLY ()HANGNAILS

SKIN: ()NORMAL ()OILY ()DRY ()FLAKY ()ACNE ()PSORIASIS ()BOILS
()SMALL BUMPS ON UPPER ARMS ()SKIN CANCER REMOVED ON_____
(DATE)
()ANTIBIOTICS FOR ACNE AT WHAT AGE _____ HOW LONG TAKEN _____

SPOTS ON SKIN: ()WARTS ()MOLES ()SMALL RED ()LARGE RED ()BROWN ()WHITE

HANDS AND FEET: ()DRY CRACKED OR BLEEDING AREAS ON ()HANDS ()HEELS ()FEET
()INGROWN TOENAILS ()FUNGUS ON FEET OR NAILS ()ATHLETE'S FOOT

CHEST AND HEART MARK ANY AREAS OF PAIN OR DISCOMFORT ON DIAGRAM

I HAVE CHEST PAIN THAT IS: ()SHARP ()DULL ()SEVERE
()RADIATES TO MY ARM, NECK, OR BACK
()WORSE AT REST ()WORSE ON EXERTION
()BETTER WITH EXERCISE ()NO CHANGE WITH EXERCISE

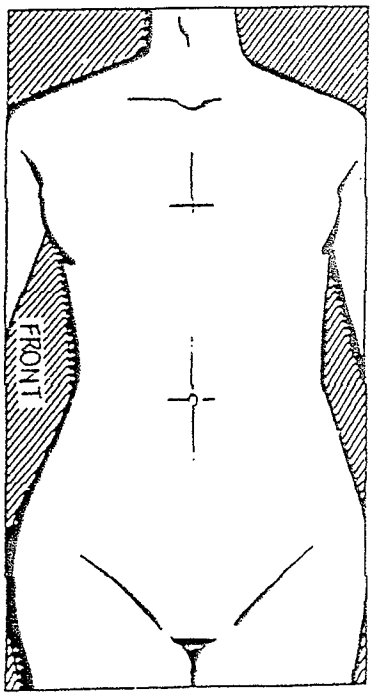
MY PULSE/ HEARTBEAT IS: ()TOO FAST ()TOO SLOW ()SKIPS BEATS

I HAVE: ()HIGH BLOOD PRESSURE ()LOW BLOOD PRESSURE
I AM: ()ON HBP MEDICINE ()ON DIURETICS

I HAVE HAD: ()HAD A HEART ATTACK ()HAD A STROKE
()ANGIOPLASTY ()BYPASS SURGERY

I HAVE BEEN TOLD I HAVE: ()HEART DISEASE ()LUNG DISEASE
()CLOGGED ARTERIES

I HAVE: ()VARICOSE VEINS ()SPIDER VEINS
()HEMORRHOIDS ()HAD VESSEL SURGERY



RESPIRATORY, LUNGS

I HAVE NASAL CONGESTION: ()DAILY ()SEVERAL TIMES A WEEK ()ONLY ON OCCASION

I HAVE NASAL DISCHARGE: ()DAILY ()SEVERAL TIMES A WEEK ()ONLY ON OCCASION
()CLEAR ()YELLOW ()GREEN ()BLOOD TINGED ()OTHER_____

I HAVE: ()NON-PRODUCTIVE COUGH {W/O MUCUS} ()PRODUCTIVE COUGH {WITH MUCUS}
()ALLERGIES TO _____ ()HOARSENESS OF VOICE ()POST-NASAL DRIP
()HAYFEVER ()ASTHMA ()WHEEZING ()SNORING

I HAVE/HAVE HAD: ()FREQUENT COLDS ()FLU ONCE OR MORE A YEAR
()PNEUMONIA ()SINUS INFECTIONS
()ANTIBIOTICS 3 OR MORE TIMES IN MY LIFE
()ALLERGIC TO _____

I TAKE: ()ALLERGY SHOTS ()ALLERGY MEDICINE ()DECONGESTANTS ()NASAL SPRAYS ()STEROIDS

I USE: ()CIGARETTES ___PACK/DAY ()SNUFF/CHEW ()CIGARS ()EXPOSED TO 2ND HAND SMOKE

I HAVE BEEN TOLD I HAVE: ()LUNG DISEASE _____ ()EMPHYSEMA ()COPD

EMOTIONAL, NERVOUS AND METABOLISM MARK ALL THAT APPLY

I AM/HAVE: ()NERVOUS ()ANXIOUS ()DEPRESSED ()SENSITIVE TO NOISE
()CONFUSED EASILY ()SLEEPY DURING DAY ()EXHAUSTED A LOT ()FATIGUE EASILY

()LOSS OF APPETITE ()RAGE ()FEARFUL ()HEAR VOICES
()WEAKNESS ()POOR MEMORY ()IRRITABILITY ()MORBID THOUGHTS

I AM/HAVE: ()SUSPICIONS OF OTHERS ()THOUGHTS OF SUICIDE ()QUICK MOOD CHANGES
()FEAR OF INSANITY ()FEAR SERIOUS DISEASE LIKE_____
()AVOID CROWDS ()FRIENDS AVOID ME ()HAVE HYPOGLYCEMIA OR LOW BLOOD SUGAR
()HAD GLUCOSE TOLERANCE TEST AND IT WAS ()POSITIVE ()NEGATIVE

I: ()TAKE DAYTIME NAPS ()DREAM TOO MUCH ()HAVE NO DREAMS AT ALL ()HAVE NIGHTMARES

I: ()WAKE UP TIRED ()AM COLD WHEN OTHER ARE COMFORTABLE ()FEEL TOO HOT
()HAVE COLD HANDS ()HAVE COLD FEET
()PERSPIRE TOO MUCH ()HAVE INADEQUATE PERSPIRATION WHEN EXERCISE

DO YOU FEEL WELL RESTED WHEN YOU WAKE UP IN THE MORNING ()YES ()NO

_____ RATE THE QUALITY OF YOUR SLEEP (1 BEING AWFUL AND 10 BEING GREAT)

FEMALE SPECIFIC

MY MENSTRUAL PERIODS ARE: AGE OF FIRST PERIOD____
()NORMAL ()PAINFUL FIRST DAY ()PAINFUL BEFORE AND DURING
()FLOW IS EXCESSIVE ()HAVE CLOTS OR HEMORRHAGE ()FLOW IS SCANTY
()REGULAR EVERY ____DAYS ()IRREGULAR
()NO PERIOD IN ____MONTHS ()TWO OR MORE PER MONTH
()ABNORMAL SINCE ____YEARS OF AGE
()MENSTRUAL PROBLEMS BEFORE FIRST CHILD ()MENSTRUAL PROBLEMS AFTER FIRST CHILD

MENSTRUAL BLOOD COLOR IS: ()PINK ()RED ()BROWN ()BLACK ()OTHER_____

I HAVE/HAVE HAD: ()ENDOMETRIOSIS ()CONSTIPATION WITH PERIODS ()DIARRHEA WITH PERIODS

ORGAN DROP: ()UTERUS IN POSITION ()UTERUS OUT OF POSITION ()BLADDER PROLAPSED

I AM/HAVE BEEN: ()ON BIRTH CONTROL PILL _____ ()TOTAL YEARS ON BCP_____
Name
()MENOPAUSE AT AGE ____ ()HYSTERECTOMY AT AGE____

I AM ON HORMONE REPLACEMENT: ()ESTROGEN ()PROGESTIN ()ORAL ()PATCH
()WILD YAM CREAM ()BIO-IDENTICAL FORMULATION

I HAVE BREAST SORENESS: ()BEFORE PERIOD ()DURING PERIOD ()AFTER PERIOD ()ALL MONTH LONG
I HAVE: ()FIBROCYSTIC BREASTS ()HAD BREAST CANCER
()PRODUCE MILK BUT NOT PREGNANT OR NURSING
MY BREASTS ARE: ()FIRM ()SOFT AND SAGGY ()HAVE IMPLANTS ()HAD REDUCTION SURGERY

I: ()HAVE_____CHILDREN ()BEEN PREGNANT ____ TIMES ()LIKE CHILDREN ()DISLIKE CHILDREN
()WANT MORE ()DON'T WANT MORE ()AM STERILE ()HAVE FEAR OF PREGNANCY

I GET: ()BLADDER INFECTIONS ()YEAST INFECTIONS ()YEAST INFECTIONS AFTER ANTIBIOTICS
()VAGINAL BURNING/ITCHING ON ()INSIDE ()OUTSIDE
()VAGINAL DRYNESS ()PAINFUL INTERCOURSE

I URINATE: ()____TIMES PER DAY ()____TIMES AT NIGHT ()MORE FREQUENTLY THAN NORMAL
()WITH PAIN ()WITH DIFFICULTY STARTING/STOPPING ()WITH ITCHING OR BURNING

MY URINE COLOR IS: ()PALE YELLOW ()BRIGHT YELLOW ()DARK YELLOW ()OTHER_____
()CLEAR ()CLOUDY ()WITH MUCUS IN IT ()VARIES A LOT

MY URINE HAS: ()ODOR DESCRIBE_____

I HAVE / HAD: ()VENEREAL DISEASE ()GENITAL HERPES ()HERPES I ()HIV/AIDS

MY LIBIDO IS: ()NORMAL ()EXCESSIVE ()INCREASED ()DIMINISHED ()ABSENT
LIBIDO MEANS DESIRE FOR SEXUAL RELATIONS.

continue at diagram on next page

MALE SPECIFIC

I AM: ()OVERLY TIRED ()EXHAUSTED ()GETTING TOO OLD FOR ANYTHING ()IMPOTENT

MY PROSTATE: ()NORMAL()ENLARGED ()HAD CANCER ()REMOVED

I HAVE:()PAIN ON URINATION ()DIFFICULTY STARTING URINE FLOW ()DIFFICULTY STOPPING FLOW
()DRIBBLING OF URINE ()DECREASED STREAM SIZE ()PAIN OR PRESSURE AFTER SEX
()GET UP TO URINATE ____TIMES PER NIGHT ()BURNING DISCHARGE

MY URINE COLOR IS:()PALE YELLOW ()BRIGHT YELLOW ()DARK YELLOW ()OTHER_____
()CLEAR ()CLOUDY ()WITH MUCUS IN IT ()VARIES A LOT

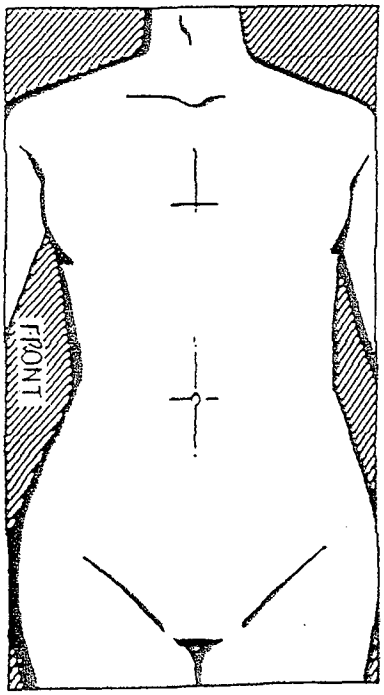
MY URINE HAS ()ODOR DESCRIBE _____

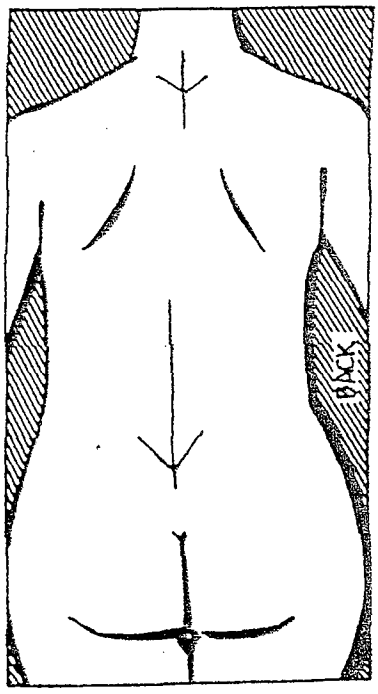
I HAVE: ()HERNIA_____ ()PAIN IN TESTICLES OR SCROTUM

I HAVE / HAD: ()VENEREAL DISEASE ()GENITAL HERPES ()HERPES I ()HIV/AIDS

MY LIBIDO IS:()NORMAL ()EXCESSIVE ()INCREASED ()DIMINISHED ()ABSENT
LIBIDO MEANS DESIRE FOR SEXUAL RELATIONS

USE THE DIAGRAMS BELOW TO MARK ALL AREAS OF PAIN OR DISCOMFORT YOU HAVE EXPERIENCED IN THE PAST 90 DAYS. DESCRIBE YOUR PAIN/DISCOMFORT IN THE MARGINS AND CONNECT WITH ARROW TO EACH AREA THE DESCRIPTION APPLIES TO.





ARE YOU CURRENTLY SEEING ANY OTHER HEALTHCARE PROFESSIONAL SUCH AS DENTIST, MASSAGE THERAPIST, ACUPUNCTURIST, PSYCHOLOGIST, ETC? PLEASE EXPLAIN.

PLEASE FILL OUT YOUR FAMILY HEALTH HISTORY ON THE CHART BELOW
PUT AN "N" IN THE BOX IF HAVE IT NOW OR A "P" IF HAD IN THE PAST

	ALCOHOLISM	ALLERGIES	ALZEIMER'S DISEASE	ARTHRITIS	ASHTMA	ATHEROSCLEROSIS	CANCER	DIABETES	EPILLEPSY	GLAUCOMA	HEADACHES	HIGH BLOOD PRESSURE	KIDNEY DISEASE	OBESITY	OSTEOPOROSIS	SINUS PROBLEMS	STROKE	THYROID PROBLEM	TUBERCULOSIS	ULCERS
YOU																				
SPOUSE																				
CHILDREN																				
MOTHER																				
FATHER																				
MATERNAL GRANDPARENTS																				
PATERNAL GRANDPARENTS																				
SISTERS																				
BROTHERS																				

USE THIS SPACE TO ADD ANYTHING ELSE YOU WOULD LIKE TO SHARE ABOUT YOUR HEALTH CONCERNS OR THAT YOU THINK THE DOCTOR SHOULD KNOW

Please review this form to be sure your answers are accurate and sign below. Thank you for choosing our clinic. We look forward to working with you on your health goals.

Signature_____ Date_____