Name:______________________________ Date:____________

Do you have or are you currently being treated for: Check **Y or N**

	Y	or	N		Y	or	N
Cancer	☐		☐	Heart Disease	☐		☐
High Blood Pressure	☐		☐	Stroke	☐		☐
Angina/Chest Pain	☐		☐	Tuberculosis	☐		☐
Osteoporosis	☐		☐	Headaches	☐		☐
Arthritis	☐		☐	Rheumatic Fever	☐		☐
Diabetes	☐		☐	Hepatitis	☐		☐
Ulcers	☐		☐	Fibromyalgia	☐		☐
Hearing Loss	☐		☐	Fainting	☐		☐
Hernia	☐		☐	Kidney Disease	☐		☐
Seizures	☐		☐	Bronchitis	☐		☐
Pregnant	☐		☐	Depressed	☐		☐
Under stress	☐		☐	Have a Pacemaker	☐		☐
Allergies/Asthma	☐		☐	Other:____________			

In the past 3 months, have you had or do you experience: Check **Y or N**

	Y	or	N		Y	or	N
A change in your health	☐		☐	Nausea/Vomiting	☐		☐
Fever, chills, sweats	☐		☐	Urinary tract infection	☐		☐
Numbness, tingling	☐		☐	Unexplained weight change	☐		☐
Difficulty swallowing	☐		☐	Change in appetite	☐		☐
Shortness of breath	☐		☐	Change in bowel function	☐		☐
Dizziness	☐		☐	Change in bladder function	☐		☐
Upper respiratory infection	☐		☐	Other:____________			

What makes your pain worse: Check **Y or N**

	Y	or	N		Y	or	N
During exercise	☐		☐	Bending forward	☐		☐
After exercise	☐		☐	Bending backward	☐		☐
Sitting	☐		☐	Coughing	☐		☐
Standing	☐		☐	Sneezing	☐		☐
Walking	☐		☐	Other:____________			

What reduces your pain: Check **Y or N**

	Y	or	N		Y	or	N
Lying down	☐		☐	Pain pills	☐		☐
Sitting	☐		☐	Muscle relaxant	☐		☐
Standing	☐		☐	Aspirin	☐		☐
Walking	☐		☐	Nothing	☐		☐
Manipulation	☐		☐	Other:____________			

I currently have difficulty with (check all that apply):

☐Driving	☐Getting up from a chair	**Are your symptoms**: (check one):
☐Walking	☐Bending at the waist	☐Getting worse ☐The same

List any medications you are taking, including non-prescription drugs, vitamins and herbals:

____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________