Any family health conditions: ☐ Yes ☐ No Please list: _____

Other health problems? _____

_____

List surgical operations or hospitalizations and years they occurred: _____

_____

Pregnancies? _____

List of medications you now take: _____

_____

Rate your diet:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent
Rate your sleep habits:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent
Rate your exercise:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent
Rate your mental state:	☐ Poor	☐ Fair	☐ Medium	☐ Good	☐ Excellent

List and describe any auto accidents or other accidents/injuries: _____

_____

_____

List and describe any childhood injuries/accidents/hospitalizations/illnesses: _____

_____

Anything else you feel we should know about? _____

_____

Draw in your face.
Show area(s) of pain or unusual feeling.
Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.
Mark areas of radiation. Include all affected areas.

Numbness ● ● ● ● ●
● ● ● ● ●
● ● ● ● ●

Pins & Needles ○ ○ ○ ○ ○
○ ○ ○ ○ ○
○ ○ ○ ○ ○

Burning X X X X X
X X X X X
X X X X X

Aching * * * * *
* * * * *
* * * * *

Stabbing / / / / /
/ / / / /
/ / / / /