



## HEALTH HISTORY

Please ✓ any of the following conditions that you are currently experiencing or have experienced in the last 6 months.

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| <input type="checkbox"/> Lower back pain             | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Asthma              |
| <input type="checkbox"/> Upper/mid back pain         | <input type="checkbox"/> Ringing in ears     | <input type="checkbox"/> Regular colds/flu   |
| <input type="checkbox"/> Neck pain                   | <input type="checkbox"/> Nervous/anxiety     | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Low blood pressure  |
| <input type="checkbox"/> Tired / fatigue             | <input type="checkbox"/> Allergies           | <input type="checkbox"/> Chest pain          |
| <input type="checkbox"/> Tension in body             | <input type="checkbox"/> Digestive problems  | <input type="checkbox"/> Heart condition     |
| <input type="checkbox"/> Numb/tingling in arms/hands | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> Numb/tingling in legs/feet  | <input type="checkbox"/> Constipation        | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Muscle cramps/sprains       | <input type="checkbox"/> Weight problems     | <input type="checkbox"/> Depression          |

Other conditions \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Which of the above conditions is the worst \_\_\_\_\_  
\_\_\_\_\_

Describe severity of the condition \_\_\_\_\_  
\_\_\_\_\_

What treatments have you tried prior to today \_\_\_\_\_  
\_\_\_\_\_

List all surgery you have had and at what age \_\_\_\_\_  
\_\_\_\_\_  
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List all major fractures, falls or accidents over the last 10 years \_\_\_\_\_

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List any other previous illness that has not been mentioned above \_\_\_\_\_

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Are you pregnant or is there any possibility that you are pregnant \_\_\_\_\_

If applicable, at what stage in the pregnancy are you \_\_\_\_\_

## LIFE STYLE

How many hours do you sleep each night \_\_\_\_\_ Time you retire \_\_\_\_\_ Time you rise \_\_\_\_\_

How often do you exercise  Daily  Twice or more daily  Weekly  Never

If applicable, what exercise do you do and the duration \_\_\_\_\_

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Do you smoke Y/N \_\_\_\_\_ Number per day \_\_\_\_\_ How long have you smoked \_\_\_\_\_

What drugs (medical or recreational) are you currently taking (include dosage) \_\_\_\_\_

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What vitamin or mineral supplements are you currently taking (include dosage) \_\_\_\_\_

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Do you have any food allergies \_\_\_\_\_

Indicate your normal/general diet:

Meat & 3 veg  Vegetarian  Vegan  High protein  Macro  
 Wheat free  Gluten free  Dairy Free  Other \_\_\_\_\_

Daily intakes of:

Sugar \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Alcohol \_\_\_\_\_ Water (ltr) \_\_\_\_\_

