Health History- Please check any of the following conditions that apply to your health

- ☐ Fatigue
- ☐ Glasses/ contact lenses
- ☐ History of head injury
- ☐ TMJ problems
- ☐ Sinus infections
- ☐ Dizziness
- ☐ Headaches
- ☐ Nasal congestion
- ☐ Asthma
- ☐ Allergies
- ☐ Shortness of breath
- ☐ Heart murmur
- ☐ Chest pain
- ☐ High/low blood pressure
- ☐ Diabetes
- ☐ Goiter
- ☐ Numbness
- ☐ Seizures
- ☐ Limb Weakness
- ☐ Unsteadiness of gait
- ☐ Loss of balance
- ☐ Mood change
- ☐ Anxiety
- ☐ Hyperactivity
- ☐ Depression
- ☐ Insomnia
- ☐ Arthritis
- ☐ Allergies
- ☐ Low back pain
- ☐ Mid back pain
- ☐ Neck pain
- ☐ Muscle cramps

Females only

- ☐ Birth control
- ☐ Hormone therapy
- ☐ Pregnancy
- ☐ Cramps
- ☐ Irregular menstruation

Daily Living

Do you smoke? □Yes □ No If yes, how many packs per week? _____

Have you ever smoked in the past? □Yes □ No If yes, when did you quit?_____

Do you take birth control? □Yes □ No Have you ever taken birth control in the past? □Yes □ No

Do you consume alcohol? □Yes □ No If yes, how many drinks per week? _____

Do you consume caffeine? □Yes □ No If yes, how many drinks per day?_____

Do you exercise? □Yes □ No If yes, how many times per week and what type?_____

Do you have a high stress level? □Yes □ No If yes, list reasons:_____

_____

Do you sleep well? □Yes □ No How many hours a night? _____

Adult Illness (es): Please list all Health Conditions/diseases (Please include date of diagnosis if possible).

_____

Surgery (ies): Please List all surgical procedures.

_____

Trauma (s): Please List any significant falls and traumas

_____