MEDICAL HISTORY

	YES	NO
Are you in generally good health?	____	____
Have you had recent surgery or hospitalization?		
If so, please specify: _____		
Are you currently taking any medications? Please include over-the-counter medications and vitamins.		
_____		
_____		
Have you had recent tests such as an x-ray or MRI??_____		
Have you ever taken steroids (for example, cortisone, prednisone)?	____	____
Are you **currently** seeing any of the following?		
Medical doctor	____	____
Osteopath	____	____
Psychiatrist/Psychologist	____	____
Chiropractor	____	____
Do you have, or have you ever been diagnosed as having, any of the following:		
Cancer	____	____
If yes, please describe what kind: _____		
Heart problems	____	____
High blood pressure	____	____
Asthma	____	____
Emphysema	____	____
Chemical dependency (for example, alcoholism)	____	____
Thyroid problems	____	____
Diabetes	____	____
Multiple sclerosis	____	____
Rheumatoid arthritis	____	____
Other arthritis	____	____
Depression	____	____
Hepatitis	____	____
Tuberculosis	____	____
Stroke	____	____
Kidney disease	____	____
Anemia	____	____
Epilepsy	____	____
Other _____		
Are you pregnant?	____	____
Have you recently lost or gained more than 10 pounds?	____	____
Are you experiencing any bowel/bladder irregularity?	____	____
Do you experience any numbness/tingling in your buttock or genital region?	____	____
Do you have any numbness/tingling in **BOTH** hands or feet at the same time?	____	____
Do you experience weakness in your legs or balance problems during walking?	____	____
Do you have any dizziness related to moving your head or neck?	____	____
Do you experience blurred vision, nausea, or difficulty breathing?	____	____
How would you rate your stress level? _____		
How many caffeinated beverages do you drink per day? _____		
How many packs of cigarettes do you smoke per day? _____		
How many days per week do you drink alcohol? _____		