# HISTORY

Name:_____ Occupation:_____

Date:_____

Hospitalizations:_____

Surgeries:_____

Illnesses:_____

Family History (parents, self, siblings)

High Blood Pressure_____ Other_____
Diabetes _____ Allergies: _____
Heart Disease _____
Cancer _____
Lung Conditions _____
Arthritis _____

Exercise: Y or N, if so what activities and how often:_____

_____

Typical Diet:_____

Caffeine Y or N how much?
Alcohol Y or N how much?
Tobacco Y or N how much?

Supplements:_____

Medications:_____

Purpose of Visit: (if multiple, please rank them in order of importance)

_____

_____

_____

_____

Goals anticipated from treatments:_____

_____

_____

Your level of commitment: 1 2 3 4 5 6 7 8 9 10 (1 = little commitment, 10 = high level)