Name

Date of birth

Time of birth

Place of birth

Past Medical History

Have you ever been diagnosed with a medical condition? If so, please circle body part involved:

Brain	Ears	Thyroid	Heart Disease, Cardiovascular Disease
Nerves	Nose	Blood sugar	Blood Pressure high or low
Strength	Throat	Obesity	Stomach concerns, pain, maldigestion
Sensation	Balance	Anorexia	Intestinal, Ulcerative Colitis, Crohn's
Gait abnormalities	Hearing	Fatigue	Sexual organ
Skin diagnoses	Mental health		Auto-immunity
Breasts	Chronic pain	Arms, Legs, Hands, Feet	Genetic Syndromes
Insomnia	Cancer		

Please describe:

Medications prescribed

Supplements

How many servings of fruits and vegetables do you eat daily?

How many times a week do you drink alcohol? Use recreational drugs?

How many hours of sleep are you getting at night on average?

Where are your “hot spots”?

Please circle concerns:

Relationships

Spiritual pursuits

Exercise

Diet

Grief, Anger

Pain

Physical complaints

Please describe: