LIFESTYLE INFORMATION

Do you smoke? ☐ Yes ☐ No Packs per day: _____ Drink coffee? ☐ Yes ☐ No Cups per day: _____

Do you consume alcohol? ☐ Yes ☐ No Drinks per week: _____ Do you gamble? ☐ Yes ☐ No

My fitness level is: ☐ very poor ☐ poor ☐ fair ☐ good ☐ very good ☐ excellent

I exercise _____ hours per week at: ☐ mild ☐ moderate ☐ strenuous intensity.

I exercise by doing: _____

I sleep _____ hours per night. Do you awake rested? ☐ Yes ☐ No

Is your life stressful? ☐ Yes ☐ No How do you deal with stress? _____

The last time I felt great was: _____

How would you rate your emotional/psychological health? (1-10, 10 being excellent) _____

Have you ever had an unwanted sexual experience? ☐ Yes ☐ No

Have you ever experienced abuse? ☐ Yes ☐ No · If yes, please check:

☐ Emotional ☐ Physical ☐ Sexual ☐ Mental ☐ Spiritual

Are you or have you ever been depressed? ☐ Yes ☐ No Medications taken: _____

Do you have a counselor? ☐ Yes ☐ No

What do you do for self care? _____

HEALTH CONDITIONS

Previous health care experience: (Please check)

☐ Chiropractor ☐ Naturopath ☐ Massage Therapy ☐ Cranio-Sacral ☐ Other: _____

Doctor's Name: _____ **Phone Number:** _____

Please state if the following health conditions relate to you presently (✓), in the past (P) or family history (H):

Condition	
Arthritis	
Arm Pain	
Back Pain	
Hip Pain	
Leg Pain	
Neck Pain	
Shoulder Pain	

Condition	
Cancer	
Depression	
Diabetes	
Headache	
Infectious Disease	
Menstrual Problems	
Nervous Disorder	

Condition	
Abdominal Pain	
Constipation	
Diarrhea	
Gas/Bloating	
Urinary Problems	
Vomiting	
Weight Problems	

Allergies	
Asthma	
Cough	
Difficulty Breathing	
Sinus Infection	
Spitting Blood	
Tuberculosis	
Skin Condition	
Lupus	

Clumsiness	
Convulsions	
Dizziness	
Double Vision	
Epilepsy	
Fainting	
Light Headed	
Visual Problems	
Sexual Problems	

Bruise Easily	
Chest Pain	
Bleeding Disorders	
Hardening of Arteries	
Heart Attack	
High/Low Blood Pressure	
Stroke	
Heart Disease / Pacemaker	
Varicose Veins / Hemorrhoids	