Check if any blood relative has or has had any of the following:

- ☐ Stomach Ulcers
- ☐ Kidney Disease
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Migraine
- ☐ Asthma
- ☐ Diabetes
- ☐ Bleeding Tendency
- ☐ Allergies
- ☐ Arthritis
- ☐ Colitis
- ☐ Nervous Breakdown
- ☐ Gout
- ☐ Alcoholism

Please list all medications, with dosage: _____

_____

Please list all vitamins and other supplements, with dosage: _____

_____

Do you have any allergies? No ☐ Yes ☐ If yes, to what? _____

_____

Do you exercise? No ☐ Yes ☐ What do you do and how often? _____

_____

What does your diet primarily consist of? _____

_____

Do you: Drink soda? No ☐ Yes ☐

Drink coffee? No ☐ Yes ☐ decaf ☐ How much and how often? _____

Drink alcohol? No ☐ Yes ☐ What kind and how often? _____

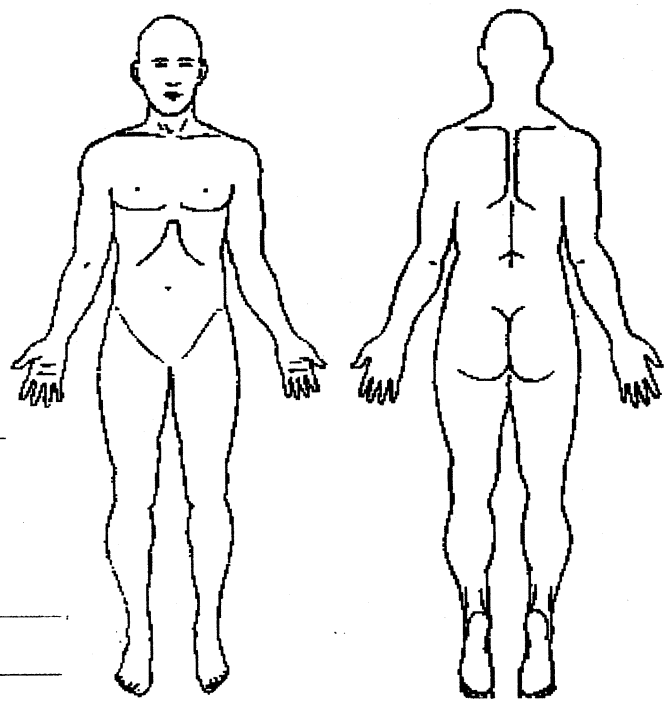
Smoke? No ☐ Yes ☐ How many per day? _____

Quit smoking _____ ago.

Please indicate any painful, numb, sensitive or injured areas on the figures:

Describe the sensation:

- ☐ stabbing
- ☐ dull ache
- ☐ burning
- ☐ radiating
- ☐ constant
- ☐ intermittent
- ☐ other



Rate the severity of the sensation from 1-10

(10 being most sensation) _____

Does your pain/sensation interfere with:

☐ Work? ☐ Sleep? ☐ Daily routine? ☐ Other? _____

_____