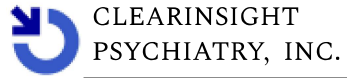


# INITIAL MEDICAL QUESTIONNAIRE



**Patient Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Today's Date:** \_\_\_/\_\_\_/\_\_\_

**Reason for your visit:** \_\_\_\_\_

**Any current stressors:** \_\_\_\_\_

## MEDICAL HISTORY

|  |  |   |
|--|--|---|
| <input type="checkbox"/> No Existing Condition<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Arterial Sclerotic Disease<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Blindness/Visual Impairment<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Carpal Tunnel Syndrome<br><input type="checkbox"/> Chronic Pain<br><input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Deafness/Auditory Impairment<br><input type="checkbox"/> Dermatitis or Other Skin Issues<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Digestive Disorders<br><input type="checkbox"/> Epilepsy/Seizure<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Hypercholesterolemia<br><input type="checkbox"/> Hypertension<br><input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Migraines<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Obesity<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Parkinson's Disease<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Sexually Transmitted Disease (STD)<br><input type="checkbox"/> Other:<br>_____<br>_____ |
|--|--|---|

| CURRENT MEDICATIONS | OVER THE COUNTER SUPPLEMENTS |
|---------------------|------------------------------|
| _____               | _____                        |
| _____               | _____                        |
| _____               | _____                        |
| _____               | _____                        |

Any allergies to medication/food:  No  Yes \_\_\_\_\_

Date of your last physical examination: \_\_\_\_\_

Any past surgeries:  No  Yes \_\_\_\_\_

Any past trauma:  No  Yes \_\_\_\_\_

Any illicit drug use:  No  Yes \_\_\_\_\_

If you are female, do you have an irregular menstrual cycle?  No  Yes \_\_\_\_\_

If you are female, are you currently pregnant?  No  Yes