Please check one

Now/Past/None

__/__/__Allergies
__/__/__Skin Rashes

__/__/__Fatigue Easily
__/__/__Low Energy
__/__/__Chronically Tired
__/__/__Depressed

__/__/__Memory Loss
__/__/__Moody Often
__/__/__Emotional Upset
__/__/__Nervous Breakdown
__/__/__Hyperactivity
__/__/__Nervousness
__/__/__Short-Tempered
__/__/__Perfectionist
__/__/__ 3 Hrs TV Daily

__/__/__Alcoholism
__/__/__Smoker
__/__/__High Blood pressure

__/__/__Grinding Teeth
__/__/__Clenching Jaw
__/__/__Jaw problems/ TMJ
__/__/__Orthodontic Care
__/__/__Dentures
__/__/__

__/__/__Tonsillitis
__/__/__Frequent Colds
__/__/__Childhood diseases
__/__/__Ringing in ears
__/__/__Hearing loss
__/__/__Glasses or Contacts

__/__/__Difficulty Sleeping
__/__/__Insomnia

__/__/__Overweight
__/__/__Diabetes
__/__/__Hypoglycemia
__/__/__Dizziness
__/__/__Cancer

Now/Past/None

__/__/__Poor digestion
__/__/__Laxatives use
__/__/__Stomach gas
__/__/__Constipation (often)
__/__/__Colitis
__/__/__Ulcer(s)
__/__/__Diarrhea
__/__/__Hemorrhoids
__/__/__Painful urination
__/__/__Frequent urination
__/__/__Kidney Problems
__/__/__Gall Bladder
__/__/__Heartburn

__/__/__Cold Hands
__/__/__Cold Feet
__/__/__Poor Circulation
__/__/__Numbness
__/__/__Leg Cramps
__/__/__Muscle Spasms
__/__/__Swollen ankles
__/__/__Shaking or Twitching
__/__/__Muscle soreness
__/__/__Hand Tremors
__/__/__Arthritis

__/__/__Asterioscierosis
__/__/__Vericose veins

__/__/__Broken Bones

__/__/__Heart Problems
__/__/__Chest Pains
__/__/__Heart Palpitations
__/__/__Cardiogram
__/__/__EKG

__/__/__Lung Problems
__/__/__Asthma
__/__/__Pneumonia
__/__/__Sinus Problems

Now/Past/None

__/__/__Fainting Spells
__/__/__Mononucleosis
__/__/__Hepatitis

__/__/__Epilepsy
__/__/__Parkinson's Disease
__/__/__Cerebral Palsy
__/__/__Multiple Sclerosis
__/__/__Polio

__/__/__Learning Disabilities
__/__/__Psychological Care

__/__/__Scoliosis
__/__/__Backaches
__/__/__Chronic Pain
__/__/__Headaches
__/__/__Neck Injury
__/__/__Neck Operation

__/__/__Cold Sores
__/__/__Sex Desire reduced
__/__/__Hormone Problems

__/__/__Irregular periods
__/__/__Vaginal Infections
__/__/__Menstrual Cramps
__/__/__Menopausal Problems

__/__/__Prostate Problems

__/__/__Other Diseases or Conditons

Specify_____
_____
_____

I certify that all of the information I have provided is true, complete and correct

Signed_____ Date_____