

WELCOME

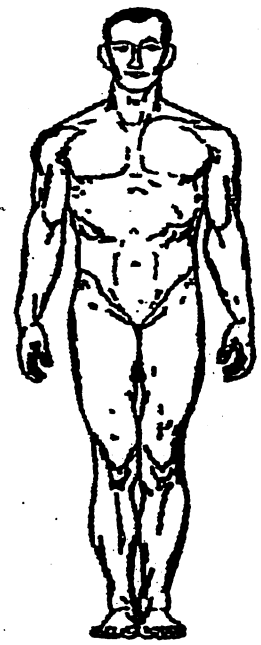
Patient Name:

Address:		State		Zip	
Home Phone:		Work Phone			
Email:					
Date of Birth:		Time/Place of Birth			
Emergency Contact:		Phone			
S	M	D	Children:	1	2
				3	+
Blood Type (please circle)		A	AB	B	O
Occupation:					
Referred by:					
Are you wearing (please circle)		Heel Lifts	Sole Lifts	Inner Soles	Arch Supports

WHY ARE YOU HERE TODAY?

DO YOU SEE ANOTHER ALTERNATIVE PRACTITIONER? (Please circle)

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Naturopath | <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Colonic Therapist |
| <input type="checkbox"/> Osteopath | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Herbalist |
| <input type="checkbox"/> Nutritionist | <input type="checkbox"/> Other: Please specify | |



HEALTH HABITS

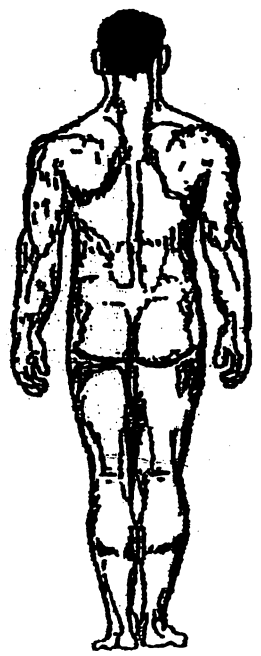
Please check which substances you use and describe how much you use:

Name of Substance	How often?
<input type="checkbox"/> Caffeine	
<input type="checkbox"/> Drugs	
<input type="checkbox"/> Tobacco	
<input type="checkbox"/> Soda	
Alcohol: <input type="checkbox"/> Wine	
<input type="checkbox"/> Beer	
<input type="checkbox"/> Hard Liquor	
<input type="checkbox"/> Other	

VITAMINS/NUTRITIONAL SUPPLEMENTS

Please list any current vitamins or mineral supplements you are taking, and the dosage:

Vitamin/Supplement	How often?



MEDICATIONS

Please list any current prescriptions you are taking:

Prescriptions	How often?

OCCUPATIONAL

Please check if your work exposes you to any of the following:

Exposure to any of these:	Describe the type
<input type="checkbox"/> Stress	
<input type="checkbox"/> Heavy Lifting	
<input type="checkbox"/> Hazardous Substances	
<input type="checkbox"/> Other	

MANN ANEAS O C C

SYMPTOMS QUESTIONNAIRE

CHECK the box if you are presently having these symptoms,
and CIRCLE the symptoms you have experienced in the past.

HEAD	MOUTH/THROAT	DIGESTIVE TRACT	MIND
<input type="checkbox"/> Headache	<input type="checkbox"/> Chronic coughing	<input type="checkbox"/> Nausea, vomiting	<input type="checkbox"/> Poor memory
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Gagging, frequent need to clear throat	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Confusion
<input type="checkbox"/> Faintness	<input type="checkbox"/> Sore Throat, hoarseness	<input type="checkbox"/> Constipation	<input type="checkbox"/> Poor comprehension
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Canker sores	<input type="checkbox"/> Bloated feeling	<input type="checkbox"/> Poor concentration
	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Belching, passing gas	<input type="checkbox"/> Poor physical condition
		<input type="checkbox"/> Heartburn	<input type="checkbox"/> Difficulty making decisions
		<input type="checkbox"/> Intestinal/stomach pain	<input type="checkbox"/> Stuttering or stammering
EYES	SKIN		<input type="checkbox"/> Slurred speech
<input type="checkbox"/> Watery or Itchy	<input type="checkbox"/> Acne		<input type="checkbox"/> Learning disabilities
<input type="checkbox"/> Swollen, red or sticky	<input type="checkbox"/> Hives, rashes, dry skin	JOINTS/MUSCLES	
<input type="checkbox"/> Bags or Dark Circles	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Pain/aches in joints	EMOTIONS
<input type="checkbox"/> Blurred/tunnel Vision	<input type="checkbox"/> Flushing, hot flashes	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Mood swings
	<input type="checkbox"/> Excessive sweating	<input type="checkbox"/> Stiffness/limitation of movement	<input type="checkbox"/> Anxiety, fear, irritability
EARS	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Pain or aches in muscles	<input type="checkbox"/> Anger, aggressiveness
<input type="checkbox"/> Itchy ears	<input type="checkbox"/> Scars – where?	<input type="checkbox"/> Feeling of weakness/tiredness	<input type="checkbox"/> Depression
<input type="checkbox"/> Earaches			
<input type="checkbox"/> Infections	HEART	WEIGHT	URINARY
<input type="checkbox"/> Drainage from ears	<input type="checkbox"/> Irregular/skipping heartbeat	<input type="checkbox"/> Binge eating/drinking	<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Food cravings	<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> High/ low blood pressure	<input type="checkbox"/> Compulsive eating	<input type="checkbox"/> Lack of bladder control
	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Numbness	<input type="checkbox"/> Painful urination
NOSE	<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Water retention	<input type="checkbox"/> Genital itch or discharge
<input type="checkbox"/> Stuffy nose	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Underweight/overweight	<input type="checkbox"/> Do urinate a lot or little
<input type="checkbox"/> Sinus Problems			
<input type="checkbox"/> Hay Fever	LUNGS	ENERGY/ACTIVITY	MEN ONLY
<input type="checkbox"/> Sneezing attacks	<input type="checkbox"/> Chest congestion	<input type="checkbox"/> Fatigue/sluggishness	<input type="checkbox"/> Erection difficulties
<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Asthma, bronchitis	<input type="checkbox"/> Apathy/lethargy	<input type="checkbox"/> Lump in testicles
	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Penis discharge
	<input type="checkbox"/> Difficulty of breathing	<input type="checkbox"/> Restlessness	<input type="checkbox"/> Sore on penis
		<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Other
WOMEN ONLY	Please check if you currently have or have had in the past:		
<input type="checkbox"/> Abnormal pap	<input type="checkbox"/> AIDS	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Cataract
<input type="checkbox"/> Bleeding between periods	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Breast lump	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Extreme menstrual pain	<input type="checkbox"/> Polio	<input type="checkbox"/> Migraine	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Headaches	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Nipple discharge	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Painful intercourse	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Breast Lump	
<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Prostrate problems	<input type="checkbox"/> Heat Disease	
<input type="checkbox"/> Abortion	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Multiple sclerosis	
<input type="checkbox"/> Miscarriages	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Frequent illness	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Cancer	
<input type="checkbox"/> Fever	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Numbness	<input type="checkbox"/> Asthma	<input type="checkbox"/> Mumps	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Other	<input type="checkbox"/> Measles	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Herpes
<input type="checkbox"/> Bowel movement			
Thick/Thin			
How often			
	Do you smoke?	YES NO	If yes, how much?