Name: _____ Height: _____ Weight: _____

Please describe your problems as accurately as possible: _____

_____

_____

_____

_____

Name of Your Family Doctor: _____ Date of Last Visit: _____

Was It for This Ailment? _____Yes _____No. Were Any Other Doctors Consulted for This Ailment? _____Yes _____ No

If So, Please List Them: _____

What Was the Doctor's Diagnosis for Your Ailment? _____

What Was His Prescribed Treatment? _____ Did It Help? _____Yes _____No

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Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O — OCCASIONAL F — FREQUENT

O F

GENERAL
- ☐ ☐ Allergy
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness or Fainting
- ☐ ☐ Headache
- ☐ ☐ Neuralgia
- ☐ ☐ Numbness

MUSCLE & JOINT
- ☐ ☐ Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Foot trouble
- ☐ ☐ Low back pain
- ☐ ☐ Neck pain or stiffness
- ☐ ☐ Pain between shoulders
- ☐ ☐ Sciatica
- ☐ ☐ Swollen joints

Pain, numbness or cramps
- ☐ ☐ Shoulders
- ☐ ☐ Arms
- ☐ ☐ Feet

DATE OF LAST: (Approx.)
- _____ Physical examination
- _____ Blood test
- _____ Chest x-ray
- _____ Spinal x-ray
- _____ Dental x-ray
- _____ Urine test

O F

GASTRO-INTESTINAL
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Distension of abdomen
- ☐ ☐ Gall bladder trouble
- ☐ ☐ Pain over stomach

EYES, EARS NOSE & THROAT
- ☐ ☐ Earache
- ☐ ☐ Ear noises
- ☐ ☐ Eye pain
- ☐ ☐ Nasal obstruction
- ☐ ☐ Sinus infection

CARDIO-VASCULAR
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heart beat
- ☐ ☐ Slow heart beat

HABITS
- ☐ ☐ Alcohol
- ☐ ☐ Coffee
- ☐ ☐ Tobacco
- ☐ ☐ Drugs

O F

RESPIRATORY
- ☐ ☐ Chest pain
- ☐ ☐ Chronic cough
- ☐ ☐ Difficult breathing
- ☐ ☐ Spitting up blood

SKIN
- ☐ ☐ Bruise easily
- ☐ ☐ Dryness
- ☐ ☐ Skin eruptions (rash)

GENITO-URINARY
- ☐ ☐ Bed-wetting
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Inability to control kidneys
- ☐ ☐ Kidney infection or stones
- ☐ ☐ Painful urination
- ☐ ☐ Prostate trouble

FOR WOMEN ONLY
- ☐ ☐ Irregular cycle
- ☐ ☐ Lumps in breast
- ☐ ☐ Menstrual cramps

Pregnant ☐ Yes ☐ No

Date of last period _____

No. of Children _____

Please list any broken bones: _____

Please list any surgery: _____

Please list medication now taking: _____

History of family cancer? (Father, Mother, Sister, Brother, etc.): Yes _____ No _____

I HAVE READ ALL OF THE ABOVE STATEMENTS AND HAVE ANSWERED TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____

CASE HISTORY