

Please indicate frequency of the following:

	Yes	No	How Much		Yes	No	How much		Yes	No	How much
Coffee	___	___	_____	Tobacco	___	___	_____	Water intake	___	___	_____
Drugs	___	___	_____	Alcohol	___	___	_____	Soda Pop	___	___	_____
Exercise	___	___	_____	Sleep	___	___	_____	Sugar	___	___	_____

What are the main problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health concerns that you have:

Do you have any known allergies?

List any accidents, surgeries or hospitalizations (please include dates):

Please list any lab results and date of last blood test:

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad	Your Comments
Significant other	___	___	___	___	___	_____
Family	___	___	___	___	___	_____
Diet	___	___	___	___	___	_____
Sex	___	___	___	___	___	_____
Self	___	___	___	___	___	_____
Work	___	___	___	___	___	_____
Exercise	___	___	___	___	___	_____
Spirituality	___	___	___	___	___	_____

