Full Body and Emotional Balance Assessment Scan Intake and Medical History

Name:		Date:
Address:		
City:	State:	Zip Code:

Phone:	**Cell:**	Other:
Email Address:		
REQUIRED:	**Date of Birth:**	
	Birth place (City and State):	
	Sex: M / F	

Marital Status:	Single	Married	Separated	Divorced	Widowed
Occupation:			Employer:		
Physician:			Chiropractor:		

Please describe any concerns you have and your objectives in seeking wellness services here:

Current Medical Problems / Medications:
Past Medical Problems / Medications:

Prior Abnormal Lab Tests, X-Rays, EEG, etc.:

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Prior Hospitalizations / Surgeries:

Allergies / Drug Intolerances:

Current Stresses (work, family, personal):

Would you say you lead a low chemical life?	Yes	No
Do you feel better or worse away from home?	Yes	No
Are you pregnant?	Yes	No
Have you been struck by lightning or electrical current?	Yes	No

Personal History: Please check if you have had any of the following medical conditions:

- ☐ Aids/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lumps
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Congenital Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Disorders
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Mental/Emotional Problems
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatoid Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems

- [ ] Glaucoma
- [ ] Goiter
- [ ] Gout
- [ ] Heart Disease
- [ ] Hepatitis
- [ ] Hernia
- [ ] Herniated Disc
- [ ] Herpes
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Tumor Growths
- [ ] Ulcers
- [ ] Other _____

Family History: Please indicate if any family members have had any of the following medical conditions and if so, indicate who on the line below:

- [ ] Alcohol Problems
- [ ] Cancer
- [ ] Congenital Problems
- [ ] Diabetes
- [ ] Heart Disease
- [ ] Hepatitis/Liver Disease
- [ ] Hypertension
- [ ] Mental/Emotional Problems
- [ ] Stroke
- [ ] Other