Intake and Medical History MINI Session

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:

Mark which session you are interested in:

	Breast Health Mini Assessment Scan
	Business or Goals Mini Assessment Scan
	Immune Mini Assessment Scan
	Emotional Affirmations Assessment Scan
	Nutrition/Food Sensitivity Assessment Scan
	Toxin and Pathogen Assessment Scan

Current Stresses (work, family, personal):

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Would you say you lead a low chemical life?	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
- [ ] Glaucoma
- [ ] Goiter
- [ ] Gout
- [ ] Heart Disease
- [ ] Hepatitis
- [ ] Hernia
- [ ] Herniated Disc
- Herpes
- [ ] 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
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Tumor Growths
- [ ] Ulcers
- [ ] Other ____________________

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