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

Please describe any concerns you have and your objectives in seeking wellness services here: (feelings, location, when X started etc.) You can email this information when you return this form if it is easier.

Current **Medications and what they are for:**

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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
- ☐ 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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