ADDITIONAL INFORMATION:

Height: _____ Weight: (Now) _____ (One Yr. Ago) _____ (Adult Maximum) _____ Age ____ (Adult Minimum) _____ Age ____
Known Allergies: _____

Blood Type: _____ Have You Ever Had a Blood or Plasma Transfusion? Yes / No

Habits:

Do You Smoke? Y / N What? _____ How Many / Day: _____ Since When? _____
Other Tobacco Products? Y / N What? _____ How Many / Day: _____ Since When? _____
Drink Coffee? Y / N Cups / Day _____ Drink Caffeinated Tea? Y / N Cups / Day _____
Colas / Soft Drinks? Y / N Number / Day _____ Glasses of Water / Day: _____
Alcoholic Beverages? Y / N Avg. No. / Wk _____ Mostly What? _____
Do You Eat Red Meat? Y / N Are You a Vegetarian? Y / N If So, For How Long? _____
Are You Dieting? Y / N If So, Describe: _____
Do You Eat in Fast Food Restaurants? Y / N If So, How Many Times / Week: _____
List Nutritional Supplements You Take: _____

Bowel Movement Frequency: _____ Difficulty? Y / N Approximate Number of Times You Urinate / Day: _____
Do You Sleep Well? Y / N If No, Describe: _____ Average Hours / Night: ____
Do You Have Sufficient Energy For Normal Activities? Y / N If No, Describe: _____

Do You Wear Corrective Lenses? Y / N What Is Your Uncorrected Vision? Right: _____ / 20 Left: _____ / 20
Has Your Vision Changed Recently? Y / N Explain: _____
Do You Wear Heel Lifts or Foot Supports? Y / N Explain: _____

Exercise:

What Sports Have You Played Seriously? _____
What Sports Do You Enjoy Now? _____
Are You In Training For a Particular Sport? Y / N Describe: _____
Do You Use a Heart Rate Monitor? Y / N If So, Target Range: _____
Describe Your Exercise Program: _____

XRAY HISTORY: (Include CAT, MRI, dye studies and dental) When was most recent x-ray / other study performed? _____

Age	Body Area	Type (Normal X-ray, CAT, MRI, etc.)	No. of Studies

FAMILY HISTORY:

	Living?	Age or Age At Death	Allergies	Arthritis	Alcoholism	Cancer	Depression	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Stroke	Other, Description
Father													
Father's Mother													
Father's Father													
Father's Grandparents													
Father's Siblings													
Mother													
Mother's Mother													
Mother's Father													
Mother's Grandparents													
Mother's Siblings													
Your Siblings													
Your Children													

WOMEN ONLY: Menstrual History

Age at Onset: _____ Are Your Periods Regular? Y / N Cycle: _____ days (start to finish) Use Birth Control Pill? Y / N
Your Flow Is: heavy medium light Date of Last Period: _____ Cramping? Y / N
PMS? Y / N If So, What: _____
Other Menstrual / Hormonal Symptoms: _____