Do you have any allergies (medications, topicals, foods, etc.) that are severe or life threatening: **YES** **NO**
If yes, please describe: _____

Personal Habits:

Please circle the following substances that you have used more than once in the past month:

Tobacco (Smoke / Chew) **Coffee/ Black tea / Cola**

Alcohol **Recreational drugs**

Do you follow any particular diet regimens or restrictions? If yes, please describe in detail:_____

_____

_____

Do you exercise regularly? **Yes** **No** What type?_____

How long?_____How often? _____

Rank your level on a scale of 1-10 for most weeks:

Stress_____ Sleep_____ Energy_____

Mood_____

_____

How is your appetite?_____ Cravings?_____ When do you eat?

_____

Daily normal bowel movements?_____ How many per day or week?

_____

Serious Injuries/Chronic Illnesses: _____

_____

Date of last physical/annual exam _____ Date of last blood tests: _____

Personal and Family History:

Please check the "Self" box next to each condition that applies to you and please list closest family members who have each of the following conditions. Please note whether condition applied in the past (P) or is currently applicable (C).

	Self	P/C	Relation	P/C		Self	P/C	Relation	P/C
Alcohol/Drug Addiction					Headaches				
Allergies					Heart Disease				
Anemia					Hepatitis				
Arthritis					High Blood Pressure				
Asthma					Kidney Disease				
Cancer					Mental Illness				
Depression					STDs				
Diabetes					Stroke				
Eczema					Tuberculosis				
Epilepsy					Other:				