

Health History Questionnaire

Name: _____
 Date: _____ Birthdate: _____
 Place of Birth: _____
 Sex: Male Female Height: _____ Weight: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Work Phone: () _____
 Home Phone: () _____
 Fax Number: () _____
 WHO Referred You To Us? _____
 Please List Known Diagnoses/and or Diseases: _____

 List Your Personal Health GOALS: _____

Check The Number of Courses of Antibiotics Taken:

Less than 5 5-10 More Than 10

Please Check All That Apply:

- I have been diagnosed with Heart Disease.
 I have a family history of Heart Disease.
 I wear a Pacemaker

SOC Index - Suppression and Obstruction to Cure Index

No. or Organs Removed (Includes Teeth)	
No. of Synthetic Drugs Used (Includes Prescription Medications)	
Amount of Smoking Per Day (Number of Cigarettes, Cigars, Etc.)	
No. of Steroid Type Drugs Used in the Last Year	
No. of Mercury Amalgam Fillings Current of Present.	
No. of Street Drugs Used Monthly (Includes Recreational Chemicals)	
No. of Known Allergies (Foods, Skin and Inhalants)	
No. of Unresolved Mental Factors (Stuck or Unresolved Emotions)	
I Am Responsible for My Body 0-Minimum 10-Maximum	
Amount of Fat In Diet, As Percent/10 incl. Processed Foods	

Orthopedic History: (Please Check All Past Injured Regions

Including Surgeries, Type & Date) EXPLAIN Circle R-Right L-Left

- Head _____
 Neck (Cervical) _____
 TMJ _____
 Shoulders R/L _____
 Elbows R/L _____
 Hands R/L _____
 Wrists R/L _____
 Thoracic Spine _____
 Lumbar Spine _____
 Hips R/L _____
 Pelvis R/L _____
 Knees R/L _____
 Ankles R/L _____
 Feet R/L _____
 OTHER: _____

***For Females Only:** (Please Circle & Explain)

Are You Currently Pregnant? **Y** **N**

Are You Currently Nursing? **Y** **N**

Are You Currently on Progesterone/Estrogen Therapy?

Y **N** (Type) _____

Have You Ever Had Any Abortions? **Y** **N** (Optional)

If Yes, How Many? _____

Are You Currently Using Birth Control? **Y** **N**

What Type? _____

Amount of Kg. Overweight _____

Personal Stress 0-10 (10-Maximum)	
Number of Sugar Type Products or Processes Foods Per Day	
Number of Exercise Sessions Per Week (Min. 20 minutes with HR about 100 BPM)	
Number of Alcoholic Drinks Per Day (not over 3/day for men; 2/day for women)	
Number of Cups of Coffee, or Tea per Day or any Caffeine Products	
No. of Extreme Toxic Exposures per Year Radiation, Pesticides, Insecticides, Etc.	
Number of Major Injuries in the Past Physical & Emotional Traumas	
Number of Major Infections in the Past or Present	
Number of Glasses or Water or Natural Fruit Juice per Day	
How Many Kilos Overweight 2.2lb=1 kilogram, as Seen by Client	