Have you had any of the following tests for this or a similar problem? (Please circle)

X-Ray MRI CT Scan Bone Scan Myelogram Other_____

If any circled please list dates (approx.): _____

Past Medical and surgical History:

List other medical problems (current & past)_____

List ALL surgery dates: _____

Medications/ Allergies:

Current Medications (including over the counter and non-prescription): _____

Do you take any Supplements? If yes, list:_____

Allergies; Food, Drug or Other: _____

_____

_____

_____

Social History:

Do you smoke? **Yes / No** If yes how many packs/ cigarettes per day____

Do you drink alcohol? **Yes / No** If yes how many drinks per week_____

_____

Do you use illicit/ recreational drugs? **Yes / No** If yes, what drug, and how often

_____

Does anyone in your family have?

Heart disease?_____ Diabetes?_____ Cancer?_____ High Blood Pressure? ___

_____ Arthritis?_____

Back Pain?____ Nerve Disorder?_____ Other?_____

_____

Do you have or have you recently had any of the following? (Please circle)

Weight Loss Weight Gain Chills Fever Night Pain Numbness Weakness

Bowel or bladder problems Breathing Problems Other _____

Have you seen a Naturopathic Doctor before? If yes, for what ailments and when:_____

_____

_____