

Do you have any of the following?

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Measles | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Venereal Infection | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Mumps | <input type="checkbox"/> Goiter | <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Influenza | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Body Piercings |

Please check the correct box for each item below:

Prev.	Now	General Symptoms	Prev.	Now	Gastro-Intestinal	Prev.	Now	Eye/Ear/Nose/Throat
<input type="checkbox"/>	<input type="checkbox"/>	Allergy _____	<input type="checkbox"/>	<input type="checkbox"/>	Belching or Gas	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Colon Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Deafness
<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Earache
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Hunger	<input type="checkbox"/>	<input type="checkbox"/>	Ear Discharge
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Ear Noises
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Thyroid
<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Pain over stomach	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Obstruction
<input type="checkbox"/>	<input type="checkbox"/>	Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds
<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Poor Digestion	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Eyes
<input type="checkbox"/>	<input type="checkbox"/>	Numbness or pain In arms/legs/hands	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Poor Vision
			<input type="checkbox"/>	<input type="checkbox"/>	Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis
						<input type="checkbox"/>	<input type="checkbox"/>	Sore Throats
						<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
		Muscles & Joints			Cardio-Vascular			Skin or Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Backache	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Boils
<input type="checkbox"/>	<input type="checkbox"/>	Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Bruising Easily
<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Pain over heart	<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	Pain Between Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Painful Tail Bone	<input type="checkbox"/>	<input type="checkbox"/>	Previous Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Allergy
<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart	<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	Spinal Curvature	<input type="checkbox"/>	<input type="checkbox"/>	Slow Heart	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive Skin
<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Skin Eruptions
<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	Swelling Ankles			
<input type="checkbox"/>	<input type="checkbox"/>	Twitching	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins			
<input type="checkbox"/>	<input type="checkbox"/>	Weakness						
		Respiratory			Genito - Urinary			For Women Only
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	Cramps or Backaches
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Flow
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes
<input type="checkbox"/>	<input type="checkbox"/>	Spitting Blood	<input type="checkbox"/>	<input type="checkbox"/>	Inability to Control Urine	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Cycle
<input type="checkbox"/>	<input type="checkbox"/>	Spitting Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Painful Discharge
			<input type="checkbox"/>	<input type="checkbox"/>	Prostrate Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge
						<input type="checkbox"/>	<input type="checkbox"/>	Pregnant at this time

Please list any PAST health challenges:

1. _____ Dates: _____
2. _____ Dates: _____
3. _____ Dates: _____

When any relaxation technique is used, you should be aware that the need for medication may change. It is, therefore strongly recommended that you request the medical physician who is prescribing your medication to monitor what you require, frequently. Please sign below indication that you have read the above statement and understand it.

Date: _____

Signature: _____