Posture

Do you wear corrective lenses?	Yes No	If Yes, for what condition? Last visit to your optometrist:
Do you wear braces, or have you had major corrective dental work done?	Yes No	If Yes,for how long? What type of work? Last visit to your dentist:
Do you wear corrective orthopedic soles?	Yes No	If Yes, for what condition?

For Women

Do you use contraceptives?	Yes No	If Yes, - Mechanical? - Chemical?
Are you pregnant?	Yes No	If Yes, Which Trimester:
Number of Pregnancies:	Number of Miscarriages:	Number of Abortions:
Do you perform regular breast self exams?	Yes No	Last visit to your gynecologist:
Are you menopausal?	Yes No	If Yes, do you take prescription hormones?

Trauma/ Accidents / Surgeries

Date of Trauma/Accident/Surgery:	Circumstances:	Brief Description:

Family History

Please indicate if any of your immediate family suffers or has suffered from any of the following conditions.

Condition	**Family Member(s)**	**Condition**	**Family Member(s)**
Alcoholism Drug Abuse		Parkinson's, Alzheimer's Disease, Depression, Mental Illness	
Allergies, Intolerances Sensitivities		Stroke, High Blood Pressure, Hormonal Imbalance	
Asthma, Bronchitis Pneumonia, Breast Cancer		Other / Cancers (Please List):	
Ulcers, Liver Disease, Colitis, Colon Cancer			
Kidney Disease, Kidney Stones, Prostate Cancer			