

MEDICAL HISTORY – Please check Yes or No for conditions that apply to you

	YES	NO
Vascular Disorder		
Rheumatoid Arthritis		
Osteoarthritis		
Heart Trouble		
Pain or tightness in chest		
Low Blood Pressure		
High Blood Pressure		
Fainting spells		
Bruise Easily		
Diabetes		
Low Blood Sugar		
Shortness of breath		
Hard to Remember		
Cancer		
History of Substance Abuse		

	YES	NO
Smoker		
Are you pregnant?		
Autoimmune Disorder		
Hepatitis		
Neck Pain		
Back Pain		
TMJ (Jaw problems)		
History of Seizures		
Allergies		
Pacemaker/Implants		
Stroke		
Asthma		
Other:		

On the body diagram below, please mark the areas of your symptoms as they are at this moment.

