Medical History:

Please rate your current health status:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you exercise beyond normal daily activities and chores? yes ❖ no
If **"yes"** please describe_______________
How often?_______________

How many alcoholic beverages do you drink per day?
☐ 0-1 ☐ 2-4 ☐ 5-6 ☐ 6 or more

Do you currently take any prescription medications? yes ❖ no
If **"yes"** please list:_______________
____

Do you currently take any nonprescription medications? yes ❖ no
If **"yes"** please indicate which ones:
☐ Aleve/Advil
☐ Antihistamine/decongestant
☐ Herbal supplements
☐ Other (please describe):_______________
☐ Antacids
☐ Aspirin
☐ Tylenol

Do you now have, or have you ever had, any of the following?

☐ Arthritis
☐ Bone disease / fracture
☐ Osteoporosis/osteopenia
☐ Circulation problems
☐ Pins and Needles
☐ Pacemaker
☐ High blood pressure
☐ Chronic Headaches
☐ Diabetes
☐ Other allergies
☐ Allergy to heat/cold
☐ Head injury
☐ Multiple sclerosis
☐ Muscular dystrophy
☐ Seizures/epilepsy
☐ Dizziness
☐ Development or growth problems
☐ Metal implants
☐ Symptoms in both arms and/or both legs
☐ Recent weight loss
☐ Thyroid problems
☐ Cancer
☐ Bowel/bladder problems
☐ Hernia
☐ Ulcers / GI problems
☐ Depression
☐ Previous surgery
☐ MVA (date:_______________)
☐ Other:_______________

Is there anything else you think we should know about your general health? Please explain.
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